

Ethics, Risk and Recovery—Challenges in Forensic Practice

Joseph C. Ferencz^{1,2}

¹Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Canada;

²Forensic Psychiatry Program, St Joseph's Healthcare Hamilton, Hamilton, Canada

The practice of recovery-oriented care with individuals who have been found unfit to stand trial or not criminally responsible, and who are subject to review board dispositions, presents a variety of ethical tensions. The assessment and management of risk in a rehabilitative context raises issues of autonomy, confidentiality, and conflicting roles. Awareness of and, where possible, resolution of these conflicts is necessary for the success of the recovery paradigm in this context.

Key words: Forensic psychiatry, ethics, risk, recovery, autonomy, confidentiality, conflicting role

An aspect of forensic psychiatry that receives a great deal of attention is that of assessment, whether it be of fitness to stand trial, criminal responsibility, or risk of violence. Much has been written about the importance of separating the assessment role from that of the treating clinician. It is clear that failure to do so can undermine objectivity [1]. However, much less clear has been the guidance for forensic clinicians who are placed in the roles of caregiver and risk manager [2,3].

The clinical care of individuals with severe mental illness can be one of the most rewarding aspects of forensic practice. Individuals who have come in contact with the legal system as a result of psychiatric issues are often able to benefit greatly from the treatment and rehabilitation offered in forensic facilities and programs. But the care of these individuals is fraught with ethical issues, which must be acknowledged and managed. The coercive nature of involuntary treatment must be counterbalanced by legal safeguards, and treatment should only take place with capable informed consent from patients or substitute decision-makers. Patients must be notified and reminded of any limits to

confidentiality, which may be more common in the forensic environment than in the civil sphere. Despite custodial responsibilities, clinicians must be reminded that the focus of their work must always be care [4].

In recent decades, the treatment and rehabilitation of people with mental illness have been widely influenced by the recovery model of care [5]. More recently, this paradigm has begun to gain traction in forensic mental health services [6]. The increased application of recovery principles in this area has brought into relief numerous apparently incompatible features. For example, the recovery model emphasizes the individual's well-being and autonomy in decision-making, whether it be treatment or other goals, such as personal activities, employment, or place of residence. This is in contrast to the more traditional and restrictive model of care found in secure facilities, which may involve coerced treatment, prescribed activities, and at times highly restrictive living arrangements [7]. Furthermore, the act of risk assessment itself, long a cornerstone of forensic practice, may have harmful consequences in and of itself [8].

The compatibility of the recovery model with the agenda of forensic psychiatric care has been recently addressed in the literature. Several themes are emerging. First, recovery-oriented best practices from general psychiatry can and should be applied to forensic populations. Hope, empowerment, and social reintegration are achievable goals within the overarching context of secure care, keeping in mind the need to do additional work of addressing the causes and consequences of offending. Second, the importance of therapeutic relationships in building trust and facilitating autonomy in goal setting and problem-solving is becoming clear [9,10]. Numerous promising steps have been taken toward building such therapeutic alliances in the forensic context. Efforts to include forensic patients in the decision-making process, as well as the assessment and formulation of risk, have recently highlighted promising results in patient satisfaction and outcomes [11,12].

The application of recovery principles in forensic care has become increasingly prominent in recent years and will no doubt continue to grow. Not only has this trend brought to light many of the difficulties of traditional models of care, such as stigmatization, isolation and disempowerment, but it has also highlighted the importance of patient involvement and, where possible, autonomous decision-making as an important component of the therapeutic enterprise. Finally, it brings into clear focus the importance of the therapeutic alliance to treatment and the maintenance of public safety.

Conflict of Interest: none

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Corresponding author

Dr. Joseph C. Ferencz, Forensic Psychiatry Program, St. Joseph's Healthcare Hamilton, 100 West 5th Street, Hamilton, ON L8N 3K7, Canada; ferencz@mcmaster.ca