WORLD PSYCHIATRIC ASSOCIATION
SECTION ON FORENSIC PSYCHIATRY

Consensus on Ethics in Forensic Psychiatry

1. Introduction

Ethically good behaviour is more than important, but necessary in each and every act of human life and in relationships with others. In professional practice, this need can take on a greater dimension, since the relationship between those involved might be vertical, that is, there may be some kind of hierarchy.
This consensus is intended to address some important issues in forensic psychiatry only as a first document of the WPA forensic psychiatry section on this subject. As it can be seen, the guidelines are provided in different ways by different authors, and they are all quite valuable. There is the expectation that it will be progressively expanded and improved by other colleagues over time.

2. General Principles

2.1) The ethics of dual agency: serving two masters

The fiduciary relationship of psychiatrists has been to their patients since time immemorial. This was codified in the Hippocratic oath but reinforced by multiple other declarations since.[1]
It has been argued that that sacred role has been eroded with time and societal change. Government agencies, employers, reporting laws, hospital and teamwork expectations amongst others have made that relationship less of a clear doctor patient relationship than most suspect.[1]
Nonetheless it is in forensic psychiatry that the threat looms large.[2] The ethical challenge is especially critical as the forensic psychiatrist is often placed in a position where they serve two masters, for example the patient and the third party requesting the medicolegal question. The tension inherent in this create significant ethical challenges and places ethical quandaries at the forefront for instance public safety versus care.[3]

This is more than the mandated breaches of confidentiality that populate the practice of medicine but rather the role of the forensic psychiatrist who now assesses for courts, lawyers, tribunals and other third parties. Especially in many national forensic psychiatric systems that becomes complicated as the psychiatrist can also be a treating physician.[3,4] How then can a forensic psychiatrist looking after a patient, and thus with a fiduciary relationship with the patient, also provide an objective report to a third party, be it a judge, jury or tribunal?

In addition, in some jurisdiction there is a duty to protect the public, sometimes legislated, sometimes in case law. And forensic psychiatrists often assess persons with a higher risk of violence.[5] So then when do they break confidentiality and restrict liberty using mental health legislation? And if so in what jeopardy do they put themselves?

In the post-Tarasoff era, the duty to protect and warn has been incorporated into clinical practice. This means that the duty once owed to patients is now owed to the broader community as well. The patient's interest has to be weighed against the interests of society.[6] Additionally, many patients in the forensic psychiatry system are there because of risk issues. Getting consent for research for example may well be considered coercion as refusal may be perceived to impact liberty acquisition.[7] This may explain why it is harder to get patient consent for research in forensic settings.

One clear solution to avoid the conflict inherent in these dual roles is to identify the dual (or more) masters, then get different forensic psychiatrists to take on different roles. For example, one forensic psychiatrist does the assessment (for instance assessing competence to stand trial or criminal responsibility) and another is the treating psychiatrist. This will then reduce the likelihood of the obvious conflict in serving two masters and avoid the core of the dual agency issue.[8]

That of course is easier said than done given the significant health human resource issues that exist. We do not have enough physicians, psychiatrists and definitely insufficient forensic psychiatrists to do this, even in well-funded and resourced countries.[9]

Given the high stakes work that forensic psychiatrist are involved in, where liberty and risk issues dominate, how can we navigate this tricky space? Some recommendations are for forensic psychiatrists to be aware of their competing and dual roles. The worst outcome is when a patient being assessed for risk, sentencing, fitness to stand trial or criminal responsibility is unaware of the true consequences of them sharing information with the psychiatry assessor during the assessment for the courts and shares critical information, assuming is confidential as in the core physician-patient relationship.[10]

Training programs should teach about dual agency and how to reduce the associated risk. Role clarity is key. If the forensic psychiatrist cannot avoid the dual agency, this needs to be identified and declared. More importantly patients need to be informed and consent to proceed be obtained, in an ongoing manner.[10] Sometimes the informed consent is obtained once only during a lengthy assessment process. Notwithstanding the expectation that the forensic psychiatrist is a truth-teller and will provide objective opinion to the third party requesting their assessment, the core of the psychiatrist's responsibility remains a fiduciary responsibility to the patient.[11] In unavoidable dual agency conflicts, the patient must be made aware of the dual agency and the jeopardy they find themselves in and provide informed consent to proceed. Silence then is an option for the patient.

Dual agency in forensic psychiatry raises profound ethical challenges, demanding careful navigation between competing duties to the individual being assessed and institutions. Some of the obvious tensions arise and pit Confidentiality vs. Duty to Report, Beneficence vs. Objectivity and Autonomy vs. Institutional Goals.[3,4,10]

While it may not always be possible to avoid serving dual masters, ethical practice requires transparency, role integrity, and a commitment to minimizing harm.[10] It is important too for the practicing forensic psychiatrist to familiarize themselves with the standards and expectations of their local and or national professional organizations, many of whom have already provided guidance for practitioners. By acknowledging the inherent tensions in serving dual masters and employing strategies to address them, forensic psychiatrists can meet professional standards.

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2.2) Restrictive practice

Forensic-psychiatric and custodial settings are by their very nature restrictive settings. The use of specific types of restraints may be appropriate in limited, legally justified circumstances, typically involving harm to self or others. Such interventions can have a significant negative impact on the person's emotional and physical well-being. There are a lot of more subtle forms of restrictions though, e. g. only being allowed to have certain possessions, not being able to use the internet, not being able to make oneself a hot drink, not having intimate relationships, etc., etc. All types of restraints and restrictions must be kept to a minimum. For details on types of restraint, see e. g. NHS England (2025), for reduction of measures of restraint: WHO (2019).

Definitions

Means of restraint

- Physical restraint – staff holding or immobilizing a patient by physical force but without the use of instruments
- Mechanical restraint - applying instruments of restraint, such as straps, to immobilize a patient
- Seclusion - involuntary placement of a patient alone in a locked room, typically one designed for that purpose
- Chemical restraint - forcible administration of medication for the purpose of control[1]

Restrictive practice

Considering the wider context of restrictiveness, Tomlin et al. (2019) defined restrictive practice as "the extent to which phenomena created, maintained or augmented by forensic psychiatric care – directly or

[1] This is dealt with in a separate section of this guidance

indirectly – are experienced by a resident as negative constraints on their autonomy, self or personhood."

Guidance

Means of restraint

1. All efforts must be made to prevent the use of means of restraint.
2. Means of restraint must only be used to prevent serious harm.
3. The use of means of restraint must be lawful (that is in accordance with the law of the country), legitimate (in its purpose), proportionate (i. e. the least restrictive way to meet the intended aim) and necessary (no other less restrictive measures are available to reach the aim).
4. The use of means of restraint must be limited in frequency and duration.
5. Only recognized techniques and safe equipment must be used and staff trained accordingly.
6. Patients must not be restrained face down.
7. The use of means of restraint must be ordered by a doctor following a personal examination of the patient.
8. Service users subjected means of restraint should be under constant supervision.
9. During the use of means of restraint service users must have meaningful human contact, access to therapeutic interventions and to fresh air.
10. The ongoing necessity of the use of means of restraint must be reviewed by health care staff at regular intervals.
11. Means of restraint must never be used as a form of punishment, humiliation, to cause suffering or for the convenience of staff, including due to staff shortages.
12. Services must work to understand events leading up to incidents that resulted in the use of means of restraint. After each such event a debriefing should be held with the service user and the event should be analysed with a view to learn lessons for the future.
13. Each institution where means of restraint are used should have a policy outlining how to prevent and reduce their use and promote alternative measures.
14. Research has shown that staffing levels, material environment, rules, therapeutic programs and initial and ongoing training in de-escalation all have an effect on the use of means of restraint and this knowledge should be used to implement strategies to reduce their use.
15. Each use of means of restraint must be recorded in an appropriate register. Data from that register must be reported to the hospital managers and supervising bodies and analysed in order to work to reduce their use.

Restrictive practice

1. Restrictions in service users' autonomy should only be applied following an individual risk assessment.
2. Only restrictions which are necessary for the purpose of preventing risk to self or others or to maintain the therapeutic atmosphere should be applied.
3. Each restriction should be documented with reasons in the service user's file.
4. There must be an appeal process for service users to challenge restrictions applied to them.
5. Blanket policies ("one size fits all") should be avoided as far as possible. Their use must be proportionate and necessary and authorized by the hospital management.
6. Restrictions should be reviewed regularly with a view to assess whether they are still necessary.

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2.3) Countertransference and the need to recuse oneself

The intersection of mental health assessments and the legal system places forensic practitioners in a unique and challenging position. Forensic psychiatrists are tasked with providing expert opinions that may

influence critical legal decisions, such as determining an individual's competency to stand trial, evaluating criminal responsibility, or assessing the risk of future violence. Given the high-stakes nature of these evaluations, it is essential that forensic examiners maintain objectivity, impartiality, and emotional resilience. One of the most significant threats to these qualities is countertransference, the unconscious emotional responses an evaluator may experience in reaction to the individual they are assessing. Countertransference can not only compromise the quality and fairness of forensic evaluations but may also necessitate recusal from the case to protect the integrity of the assessment process.[1]

Countertransference, a term originally coined by Freud, refers to the emotional reactions, biases, and projections that the clinician may experience toward a patient.[2] While the phenomenon of countertransference has long been recognized in clinical psychiatry and psychotherapy, it takes on a particularly potent form in forensic psychiatry due to the complex, emotionally charged, and at times, disturbing nature of the cases examined. Forensic psychiatrists often evaluate individuals involved in criminal behavior, such as violent offending, sexual offenses, or repetitive recidivism.[1] These evaluations can provoke intense, and sometimes conscious, unconscious, and emotional reactions. The associated feelings which may stem from personal history or biases can undermine an examiner's objectivity.[2]

A forensic psychiatrist who is dealing with an individual accused of a violent crime may experience a range of intense emotions. For instance, a forensic psychiatrist might develop strong negative feelings towards a perpetrator of a heinous crime or, conversely, excessive sympathy for a defendant who presents as emotionally vulnerable.[3] While such reactions are human and often unconscious, they pose significant risks to the assessment process. Emotional reactions like these can cloud clinical judgment and influence an evaluator's conclusions about fitness to stand trial, risk of recidivism, or criminal responsibility.[4]

The risk of countertransference is heightened by several factors unique to the field of forensic psychiatry, including the moral and ethical implications of violent offenses, the stark narratives of victimization and pathology, and the evaluator's role in providing testimony that may influence legal outcomes. The emotional intensity of the forensic setting demands that evaluators develop heightened self-awareness and emotional regulation skills to guard against such biases.[3,4,6]

Given the complex emotional dynamics inherent in forensic assessments, it is crucial for evaluators to engage in ongoing self-reflection and emotional regulation. A failure to acknowledge and manage emotional responses can lead to the distortion of clinical judgment.[5] Forensic psychiatrists should be trained to recognize the signs of countertransference and assess how it might influence their thinking. However, even with training, identifying countertransference can be challenging, as emotional reactions may not be immediately apparent to the evaluator. The subtlety of countertransference means that forensic psychiatrists need to develop strategies for recognizing emotional bias, such as journaling reflections, engaging in regular supervision, or utilizing peer support and consultations.[5,6]

While self-awareness is necessary, it is not always sufficient to prevent countertransference from influencing an evaluation. Emotional responses to the individual being assessed may be so ingrained or unconscious that they undermine objectivity before the evaluator is able to detect them.[6] In these cases, the forensic psychiatrist has an ethical responsibility to recuse themselves from the case. Recusal, in this context, refers to an examiner's voluntary withdrawal from the assessment process when emotional bias, cognitive fatigue, or other factors impair their ability to conduct an objective and impartial evaluation.[7]

Recusal is a critical safeguard in forensic psychiatry to ensure the accuracy, fairness, and integrity of the evaluation. An assessor who recognizes that countertransference is affecting their judgment must step aside, not only to protect the individual being assessed but also to preserve the credibility of forensic psychiatric practice.[7] When countertransference biases go unchecked, the potential consequences for the individual under evaluation are severe: wrongful or misguided conclusions, such as the misjudgement of a defendant's mental state, risk of reoffending, or determination of criminal responsibility, may significantly impact the outcome of a trial or sentencing.[6,8]

The decision to recuse oneself, however, is not always straightforward. In forensic settings, where time and resources are often limited, and where multiple stakeholders may have a vested interest in the outcome, evaluators may feel compelled to proceed despite internal emotional turmoil.[9] Nevertheless, the ethical responsibility to recuse oneself is paramount. Forensic psychiatrists should be aware of the potential

harms of continuing an evaluation when their emotional and/or cognitive state has been compromised, even if those emotions are unconscious or difficult to articulate. The evaluator's role is not to be a passive observer of the assessee's emotions but to remain actively engaged in ensuring that their emotions do not undermine the objectivity of their conclusions.[7]

Recusal is not limited to situations where emotional factors are at play. Cognitive impairment, which may be the result of fatigue or stress, is another critical concern in forensic psychiatric evaluations. The emotional weight of dealing with disturbing cases over extended periods can lead to cognitive fatigue, characterized by reduced concentration, lapses in judgment, and difficulty synthesizing complex information.[10] Cognitive fatigue impairs the evaluators' ability to make sound judgments, and has the potential to further complicate the issue of impartiality.[11]

Cognitive fatigue can manifest in subtle ways, and forensic psychiatrists may find it difficult to recognize when their cognitive capacities have been compromised.[11] Institutions and professional organizations should therefore foster environments that encourage self-reflection and self-assessment and offer support when needed. Additionally, it is helpful to set mandatory rest periods for evaluators involved in high-stakes cases. This approach helps prevent cognitive fatigue and also encourages a culture of self-care and accountability within the field.[12]

Reducing the impact of countertransference and cognitive impairment on forensic psychiatric evaluations requires a multi-layered approach. First, institutions should provide regular training on emotional regulation, self-reflection, and recognizing the signs of countertransference, empathy fatigue, and cognitive fatigue.[12] Peer consultations and support can also be valuable tools for ensuring that assessors are aware of how their emotional and/or cognitive states may be influencing their evaluations.[13]

Moreover, forensic psychiatrists must be encouraged to build support networks, where they can discuss difficult cases and receive feedback from more experienced professionals. Such networks can help prevent burnout and provide the emotional resilience necessary for maintaining impartiality.[14] In addition, institutional safeguards such as routine debriefing sessions, psychological support services, and a culture that values well-being can mitigate the risks associated with countertransference and cognitive fatigue.[15]

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2.4) Cultural Competence in Forensic Mental Health

Cultural competence in forensic evaluation involves the practitioner's ability to accurately identify, interpret, and incorporate an examinee's cultural, linguistic, and social background into their assessment. This process begins with clinicians becoming aware of their own cultural assumptions and biases, and then gaining deeper cultural knowledge, applied skills, and experience through ongoing practice. In forensic contexts, being attuned to cultural nuances shapes how symptoms manifest, communication styles emerge, and beliefs about mental health are expressed, all of which are essential for producing valid and unbiased evaluations.

Common Cultural Biases

- Assessment tool bias: Many standardized instruments (e.g., MMSE, MoCA, HCR-20) were normed on WEIRD (WEIRD: Western, Educated, Industrialized, Rich, and Democratic) populations. Applying them indiscriminately risks misdiagnosis in diverse individuals.
- Linguistic and cultural misinterpretation: Failing to account for culturally specific expressions or communication patterns (e.g., African American Vernacular English) can skew clinical judgments.
- Contextual oversight: Ignoring socio-cultural stressors, such as systemic racism or migration experiences, leads to incomplete understanding of an examinee's behavior.
- Allegiance and adversarial bias: Evaluators may unconsciously favor the side who engages them (defense vs prosecution), known as "allegiance bias," affecting neutrality.

Cognitive and Emotional Biases

Beyond culture, forensic evaluators are susceptible to general cognitive and emotional biases:

- Anchoring, confirmation bias, contextual bias: Pre-existing case narratives or media coverage can skew data collection and interpretation.
- Emotion/countertransference: Strong emotional responses to testimonies may nudge assessors toward biased conclusions.

Best Practices & Guidelines

Recent Delphi-based consensus among forensic experts recommends 28 essential cultural practices across case phases, e.g., using structured interviews, adapting tools, engaging cultural knowledge holders. Core steps include:

1. Cultural formulation interview (CFI): a structured tool adapted for forensic settings that uncovers personal cultural interpretation and identity.
2. Self-reflection and supervision: regular bias check-ins through peer consultation, cultural humility, disclosure of allegiance sources.
3. Use of interpreters/cultural consultants: collaborating with cultural brokers improves rapport and accuracy.

4. Empirically validated adaptation: adapting and re-norming instruments for specific populations, following robust statistical methods.
5. Outcome monitoring: analyzing assessment fairness across ethnic groups and conducting equity audits.

Ethical & Legal Implications

Ethical standards (e.g., APA, WPA forensic ethics) mandate evaluators strive for fairness and competence. Culturally biased assessments can undermine procedural justice, leading to wrongful outcomes or reduced credibility . Embedding cultural competence into training, licensing, and policy is strongly advocated.

Moving Forward: Training & Research Needs

To enhance equity, forensic systems should:

- Mandate training in cultural competence and cognitive bias mitigation from forensic education through ongoing licensure.
- Encourage empirical research to adapt tools for diverse groups and test bias-reduction strategies.
- Set up policy frameworks requiring cultural competence standards in forensic agencies.

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3. Ethical guidelines for expert assessments in criminal sphere
Please see the consensus "paper on prison psychiatry" on this web page.

4. Ethical guidelines for expert assessments in civil sphere

4.1) Right and benefits of a person with mental illness to marry: ethical considerations

Before the advent of modern psychiatric treatment, most patients with severe mental illness were shunned and did not marry.

However, with increased awareness, early interventions and modern treatments, the vast majority of patients recover substantially; marry and have children and families. Despite this, psychiatrists are often asked whether the patient with mental illness could be married.

The following points need to be considered:

1. It is alleged that persons with mental illness are not able to work, earn money to sustain a family and female patients with mental illness are not apt at domestic chores and home-keeping. This cannot be generalised as many patients with mental illness recover well, some may be functionally better than those without mental illness.
2. It is widely believed that mental illnesses are incurable and life-long. However, outcome studies[1,2] have provided robust evidence to show good outcome of schizophrenia, especially in developing countries.
3. Sex is a basic human need, enlisted first tier in the 5-tier hierarchy of physiological human needs.[3] Marriage may also provide, in some cultures or religions, sexual needs in a socially acceptable manner.
4. Rehabilitation programs provide for basic needs such as food, shelter clothing, occupation, recreation etc, but not sexual needs.
5. Marriage provides to the patient with mental illness for all the rehabilitation needs including sexual needs and children with a family. In the event of death of spouse, the children can/might look after the patient.
6. Marriage provides to a person with mental illness, a life of dignity with least/ no stigma.
7. Marriage of persons with mental illness decreases the burden on the State to maintain them.
8. Not allowing a person (does not excluded a person with mental illness) to marry person of her choice by the family is reckoned as domestic violence as per The Protection of Women from Domestic Violence Act 2005.[4,5]
9. The Universal Declaration of Human Rights (1964) article 16 states that everyone has a right to marry and have family.[6]
10. Nevertheless, courts have taken note of the good recovery with treatment and disallowed divorce of persons with mental illness. Concealment of history of mental illness at the time of marriage, in itself, is not to be taken as fraud. It is to be dealt by the 'doctrine of caveat emptor'.[9]. According to the latter if the other party does not want to marry a person with mental illness, the party should make specific enquiries regarding the same before marriage. If no enquiry was made, or if enquiry was made and the other party told he/she has a mental illness, it will not be reckoned as fraud. However, if enquiry was made, but false information was provided it would be taken as fraud, and the marriage would become voidable.
11. Matrimonial disputes are referred to the Family Court, for reconciliation to prevent dissolution of marriage.[10]
12. It widely believed that mental illness and marriage are incompatible. However Courts have refuted these claims.[12]
13. Problems in marriage of persons with mental illness are because of mishandling. Marriage can be solemnized, after acute symptoms abate in the state of recovery; maintained for about a year.
14. The Psychiatrist must be aware of the respective country's legislation on marriage and social and religious beliefs. The psychiatrist's task is to integrate them, and guide the patient and family as to the suitable time of solemnization of marriage and to prescribe medicines that are safe for the mother and baby.[13]

Thus it can be stated that, for marriage, two persons must agree to marry and certain other condition are to be fulfilled.

Conclusion: All persons with mental illness have a right to marry. Mental illness in itself cannot be a bar to marriage.

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4.2) Divorce and Mental Illness: Ethical reflections using the Indian context

Divorce may generally be a consideration when one party decides to break the marriage and take a divorce on ground of mental illness in the other partner; or the party with mental illness may seek divorce from the other party on the ground of cruelty. Psychiatrist's opinion may be sought, both in clinical settings and in courts.

- The psychiatrist should be aware of the religious values, societal norms of the parties especially with regard to gender differences in coping with the "need" for divorce versus restitution of conjugal rights; and the local legislative provisions on marriage and mental illness.

- Christian[1] and Islamic marriages[2] are sacrosanct, intended to be permanent unions. While divorce is permissible, it is considered as a last resort.[1,2] Hindu religion considers marriage a permanent sacramental union between husband and wife; with no place for divorce.[3] In fact, there is no equivalent word of *talaq* (divorce) in Hindi language. This information, although religious in nature, is important for the psychiatrist to know.
- The society, by and large, does not approve divorce even in the setting of mental illness (MI). However, with changing times people are going for divorce, even though the stigma for divorce continues, with divorced women being at a higher risk for abuse.
- Patriarchal influences are evident when one talks of divorce.[4] More men are intolerant of MI, abandon/ divorce their mentally sick wives. In contrast, more women make efforts to prevent the dissolution of marriage even when husband has MI.
- Legislations: In the marriage legislations, Special Marriage Act (SMA) 1954[5] and Hindu Marriage Act (HMA) 1955[6], there is provision for divorce on the 7 grounds which encompass infidelity, cruelty, desertion, severe mental illness, and others; with 4 additional grounds for women. Despite the provisions, it is difficult to get divorce in Asian/ conservative countries like India because: 1) It is the principle of Courts to prevent divorce. All matrimonial disputes are sent to the Family Court for conciliation (Family Court Act 1984).[7] If conciliation fails, the case is taken up by the Courts. 2) The party seeking divorce on ground of (alleged) MI would have to prove that the other party is suffering from MI, which is not easy as there are no blood tests for MI, and the party with MI (alleged) generally denies the presence mental illness in the Court. 3) Thus, the party may seek divorce of ground of 'Cruelty'. The abnormal behavior, such as make false allegations of infidelity, or behaving inappropriately may be alleged as cruelty, not mental illness. 4) The respondent, when a women, generally denies the mental illness, and maintains that the inappropriate behavior was a reaction to dowry harassment meted to her and sues the husband under Section 498A (Of Cruelty by husband and relatives of husband)[8], Dowry Prohibition 1961[9], and Protection of Women from Domestic Violence 2005[10], which have severe penal provisions. The aim of the woman's side is to scare the husband and his family so that the case is withdrawn. It may be mentioned that in India despite the prevailing Dowry Prohibition 1961, the practice of dowry continues, so the allegation of demanding dowry is true. Generally, the case may continue for years. In the whole process, mental illness is often forgotten. 5) Husbands may also seek divorce of the ground of desertion, rather than MI. In a typical case when a woman develops of symptoms of SMI after marriage, there is a hue and cry and the woman is sent back to her parents' home and often abandoned. Husband does not pay for her treatment costs, neither provides her emotional support. After the woman is treated, her parents try to send her back but the husband generally does not accept her. After a few years husband may file a petition for divorce on ground cruelty and/ or desertion /or severe MI. In such a scenario the husband is legally not entitled for divorce of any of these grounds because it is a maxim of law, recognized and established, that "no man shall take advantage of his own wrong".[11]
- The above mentioned women–centric laws,meant to protect women are being looked upon as anti-men laws. Recently, the Supreme Court admitted a plea against these women centric laws.[12]
- In India, we see the 'Indian Paradox'. Women psychotic illness who are subjected to cruelty, deprived of maintenance, and separated, seek restitution of conjugal rights, rather than divorce.[13]
- Over the years Courts have been stringent and disallowed divorce on the ground of MI. In a landmark judgement the Supreme Court ruled, "Man can't dump wife on grounds of schizophrenia. It is a treatable, manageable disease, on par with hypertension and diabetes.[14]
- In April 2022, the UK introduced 'no-fault divorce'[15] to modernize the process, reduce conflict, and simplify the process by allowing spouses to state that the marriage has irretrievably broken down without needing to assign blame. This is akin the divorce by mutual consent in SMA S 28[5] and HMA (Section 13-B).[6]
- Divorce on the ground of "Irretrievable breakdown of marriage" is significant in the setting of mental illness. The Rajya Sabha (Upper house of the Parliament) approved an amendment to the Marriage Law Amendment Bill 2010. The Bill amends the HMA and SMA and provides for divorce on the ground of 'irretrievable breakdown of marriage.' The wife has the right to oppose the grant of a divorce on the ground that the dissolution would result in grave financial hardship.[16] The same has not been approved by the Lok Sabha because great opposition from various sections of society. Until now "Irretrievable breakdown of marriage" is not a ground for divorce under HMA 1955 in India. Despite this, in the rarest of rare case, the Supreme Court passed a decree of divorce utilizing its

power under Article 142 to do **'complete justice'** on the ground of 'Irretrievable break down of marriage' without referring the parties to a family court.[17]

- A major problem is that the judiciary and lawyers have limited knowledge of mental illness. Thus, they are not able read in-between the lines. Eg the Allahabad High Court *ruled that "mental illnesses, like schizophrenia, do not automatically justify divorce under the Hindu Marriage Act without clear evidence of severe impact." However,* granted divorce on the ground on desertion on the presumption that the wife with schizophrenia deserted the husband.[18]
- Role of Psychiatrist:
    1) The main task of the psychiatrist is to follow the law, manage and guide the patient and the family.
    2) Within this framework the psychiatrist should try to save the marriage because this would have a positive effect on the patient, family and outcome of illness.
    3) Husband (and his family) and patient should be informed about 'Rights' and 'Duties'. If the party with mental illness has been deprived of treatment or subjected to undue stress, remedial measures should be suggested.
    4) Decision on divorce should be taken when the patient has minimal/ no symptoms and good mental health capacity. Family member /Guardian) may also be encourage to help in decision making.
    5) As an Expert the psychiatrist is expected to read in between the lines and give his opinion on points of relevance.
        1. Diagnostic label: The more benign diagnosis should be communicated to the patient/ family/ Court. Eg if the diagnosis of schizophrenia is doubted, the diagnosis of Psychosis Not Otherwise Specified should be communicated.
        2. Need for identifying and treating underlying mental disorder.

        2. Point out when a party is taking advantage of his own wrong. Eg symptoms have continued because no treatment was given or cruelty was meted out to the patient; or desertion is by the husband, not by the wife.
    3. Last but not the least if divorce is inevitable the alimony should include expenses for treatment and rehabilitation (education and vocational training) of the patient.

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4.3) Ethics on assessing parents in acrimonious divorces

An "acrimonious" or "high conflict divorce" is a prolonged procedure of legal separation, emotionally intense for the parties involved, and hostile[1]. During this time the partners remain engaged in frequent disputes long after the initial breakup, with high-conflict families experiencing "intermittent outbursts of anger and routinely engage in long legal disputes in court regarding child custody issues".[2] These conflicts typically involve chronic litigation, poor communication, allegations of abuse or neglect from the one party to the other or allegations of violence and abuse of the children, characterized by "verbal and physical aggression, overt hostility, and distrust".[3]

The exposure of children to ongoing parental hostilities, often with the aim of hurting the other partner, puts them at greater risk of experiencing adverse developmental and academic outcomes.[4] Individuals engaged in this type of divorce usually engage the children in the dispute, something that can lead to parental alienation. Alienation commonly occurs in high conflict divorces, the child expressing intense rejection of and resisting contact with one parent.[5]

This dispute often involves psychiatrists and child and adolescent psychiatrists (in the case of allegations of maltreatment or abuse). Forensic psychiatrists (when available) are preferred by the courts as specialists of assessing mental illness and personality disorders as well as assessing dangerousness and paraphilias.

Forensic psychiatrists can be accessed via many pathways. Most commonly by the court, as a court appointed expert or as a technical advisor to one or the other plaintiff's side. They can be also approached by the public prosecutor who wants an independent assessment before he/she makes the decision to take the case to trial or not.

Full psychiatric assessment is the main aim. Parental ability should also be assessed with the appropriate questions as well as the observation of the parents responses about the child's personality, favourites (activities, food etc), strengths and weaknesses etc. Differences between the answers of the two parents should be explored.

The recognised ethical problems (autonomy, informed consent, confidentiality and privacy) that forensic psychiatrist faces are all too present in assessing parents locked in this kind of catastrophic dispute. However, the important ethical dilemma of the "double agency" is weakened as the opposing parties and the legal procedure they are involved are already having a public dispute and many other agencies courts, lawyers, the police and social services are involved. The forensic psychiatrist is free from this worry since all is public.

Objectivity and bias: To avoid bias the specialist should be fully aware of his own emotions and preconceptions. The assessment should be approached with "equality" ie full assessment for at least two individual sessions with each party. The completion of the same personality questionnaires and the

assessment of IQ is mandatory as well as any other test that is clinical meaningful and can quantify the clinical impression. Following this, suggesting to both parties a meeting face to face can be useful in assessing directly the interaction between the two ex-partners focusing on the well-being of their offsprings. Clinical practice has shown that this is rarely agreed but the offer should be made and the party refusing should be noted.

In all cases though impartiality during the assessment. Writing the report and the conclusions/recommendations is mandatory as is important to assess the individuals referred using a multidisciplinary approach.

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5. Ethical guidelines for forensic psychiatric treatment

5.1) Managing and treating mental disorders in prisons.

Treatment for individuals with mental disorders requires confidentiality to be guaranteed, in any care provided, and in any location. The inclusion of confidentiality and care for any individual guarantees the participation of the mental health team for individuals deprived of liberty.

Worldwide, the prevalence of mental disorders in prison populations is higher than in the general population, according to some systematic reviews (Weber K et al 2023, Salize HJ et al 2023, Bearanyi G et al 2022).

The data can be interpreted from different perspectives, and it is important to point out the ethical treatment to be carried out, with regard to different moral interpretations regarding the individual deprived of liberty and with mental disorders. The role of the forensic psychiatrist is of utmost importance, avoiding moral questions precisely in the environment in which he or she finds himself or herself (Arnau Peiró F et al 2022). Furthermore, the service of the forensic psychiatrist is commonly linked to public agencies that have their own convictions translated into public policies (Mussie KM et al 2021, Schopp RF 2009).

An individual deprived of liberty who presents a psychiatric disorder deserves to have comprehensive care, but encounters logistical difficulties, in addition to issues involving the mental health team (in terms of number of employees, for example). Regardless of the prison system used, individuals with mental disorders must have access to multidisciplinary monitoring that is independent of their prison situation (De Viggiani N 2006). To this end, specialized assessment (including via telemedicine) can be seen as one of the key monitoring approaches. It´s important to first understand the individual´s needs and then formulate a specific therapeutic plan. It´s also important to consider the possibility of including group workshops for psychotherapeutic support, understanding the role of the mental health team in the comprehensive care of this individual (including the public health system) - Hidayati NO et al 2023, DePalma A et al 2022).

This comprehensive care allows for individualized treatment, while also understanding the importance of group psychotherapy activities. These factors, combined with pharmacological adherence, aim to improve signs and symptoms and, consequently, reduce the risk of psychiatric hospitalization, even though the

prison environment is considered a risk factor for stress (Combalbert N et al 2014, Gómez-Figueroa H et al 2022). This is perhaps one of the greatest challenges the forensic psychiatrists can face, given the trust and hope placed in them. However, it is important to remember that they do not necessarily have to live up to the expectations placed upon them (Prost SG et al 2022).

Despite the deprivation of liberty, adherence to drug treatment deserves emphasis, and should be provided by the local municipality directly to the prison system which, through the services provided, allows and guarantees clinical follow-up (Mundt AP and Baranyi G 2020).

Regarding mental health needs of women prisoners, they are related to the difficulty of access to mental health services in prisons. A history of detention can affect a detainee's access to health care. In particular, imprisoned women are less likely to have a regular source of health care or receive regular care than the general population (van den Bergh BJ et al 2011).

Psychotic symptoms deserve attention due to the need for quick and effective intervention, and it is important to train the team working in the prison sector (Fazel S et al 2012). Multidisciplinary monitoring allows early interventions, preventing psychiatric outbreaks (Martin MS et al 2013).

Another point that is often discussed by the general population is the association between individuals deprived of freedom and the diagnosis of antisocial personality disorder, but which does not correlate with the global epidemiology of this diagnosis (Fazel S et al 2016), reflecting the influence of morality in the population discourse, with the mental health team having another challenge in the educational sense, in providing scientific data that avoid such comparisons.

Ensuring continuity of psychiatric treatment can be considered one of the pillars of reducing the frequency of crises and, consequently, of criminal recidivism, too. Providing training to prison staff aims to detect early signs and symptoms of worsening psychiatric conditions, for early intervention is essential. This is because immediate recognition of a crisis and transfer to an appropriate location (such as a hospital) are fundamental for proper treatment. (Fovet T et al 2022).

The reintegration of individuals deprived of liberty and who have a psychiatric disorder into society depends on their autonomy regarding the proposed treatment, ensuring full access to care.

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5.2) Right to receive or to refuse treatment: ethical guidelines

Most mental illnesses are amenable to treatment, so mental healthcare legislations have provided for right access treatment.[1] However, recent legislations allow psychiatric patients to also refuse treatments in certain situations.[2] Psychiatrists find it difficult to deal with the ensuing clinical challenges.[3,4]

For example, many patients in the community with drug abuse/ dependence (alcohol and others drugs) and serious mental illness (bipolar disorder/ other psychotic disorders) are not receiving treatment because they do not consent for treatment and it is difficult to bring them to the hospital and enforcing the right to treatment is problematic.[5,6] Many such patients inflict violence (psychological/ physical/ economic/ sexual (marital rape)) on family members and others, and could get involved is crime. Thus, the right to life (to live with dignity) of family members might be eroded.

It is important to remember that there are significant cross-cultural variations in legislations and their implementations. In developed/ western countries treatment of mental illness is largely the State's responsibility. There is emphasis on rights of people with mental illness (PwMI); apparently to prevent them from cruelty or exploitation. In developing countries, on the other hand, families still play a significant part in care of PwMI.[4]

Recommendations:

- Psychiatrists must have detailed knowledge of provisions of the local Mental Healthcare Legislation, and also comprehend the limitations of the same. They should also be aware of the socio-cultural background of the local community, the beliefs and ways of dealing with PwMI.
- Psychiatrist should make best use of the legislation to uphold the rights of PwMI.
- When there in conflict between Right to receive versus the Right refuse treatment, all attempts should be made to uphold the right to receive treatment (positive right), especially when there are significant symptoms (ie a clear need for treatment); and the rights of immediate family members to live a life of dignity are under threat or are being eroded.
- Establish rapport with patient/ family/ Nominated Representative, solicit their consent and active participation in the care of the patient as co-care-givers.
- When confronted with challenging situations wherein difficulties arise in upholding the right of the patient to receive treatment, because of the limitations in legislations, concerted efforts should be made to psycho-educate the patient and his family about the seriousness of the symptoms and need for treatment.
- The aim should be treat / help the patient/ family in accordance with the legislative provisions and socio-cultural settings.
- In Courts a psychiatrist should be able to read between the lines ie apprise the court of the probability of MI in a case, highlight the need for confirming the same and referral to a psychiatrist for treatment.

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5.3) Coercive treatment: treatment without or against consent

Introduction

Coercive treatment in forensic psychiatry involves providing medical or psychiatric treatment to individuals without or against their consent. This intervention raises profound ethical, legal, and human rights issues.[1]

General Principles

1. Respect for Autonomy:
   Respecting patient autonomy is fundamental. Coercive treatment must only occur if autonomy is substantially compromised by severe mental illness posing significant risk.
2. Beneficence and Non-maleficence:
   Treatment must aim primarily at benefitting the individual, preventing harm, and promoting recovery, rather than convenience for institutions or societal expedience.
3. Justice:

Equitable access to care and consistent application of coercive measures are essential, avoiding discrimination based on ethnicity, socioeconomic status, or diagnosis. [2,3]

Ethical Guidelines

1. Necessity and Proportionality:
   Coercive treatment is ethically justified only if necessary to prevent significant harm to the patient or others, and if no less restrictive alternative is effective.
2. Clear Clinical Criteria:
   Treatment without consent must be guided strictly by clear clinical criteria and evidence-based practices, adhering to international standards such as the Mandela Rules and Istanbul Protocol.
3. Transparency and Accountability:
   The rationale for coercive treatment must be clearly documented, regularly reviewed, and open to external scrutiny to prevent misuse and ensure accountability.

Procedural Safeguards

1. Independent Review:
   Decisions about coercive treatment must be subject to independent judicial or administrative clinical review within a defined timeframe.
2. Informed Re-evaluation:
   Regular reassessment of the patient's mental state and the necessity of ongoing coercive treatment is mandatory.
3. Right to Appeal:
   Individuals subjected to coercive treatment must have an accessible and transparent appeal process. [4,5]

Communication and Cultural Competence

1. Effective Communication:
   Efforts must be made to communicate clearly and effectively with patients, utilizing interpreters or cultural mediators when necessary.
2. Cultural Sensitivity:
   Treatment practices must consider and respect the individual's cultural context and beliefs to reduce coercion and increase voluntary compliance. [5]

Conclusion

Coercive treatment poses complex ethical dilemmas but remains justified under strict criteria of necessity, proportionality, and respect for human rights. Ethical application demands rigorous adherence to international standards, transparency, accountability, and cultural competence to balance individual rights with societal safety.

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5.4) Admission to forensic facilities. Ethical concerns

Ethical issues during admission to forensic facilities should be managed through a structured, transparent, and multidisciplinary approach that recognizes the unique dual obligations to both patient care and public safety.

Forensic clinicians must maintain clear boundaries between their therapeutic responsibilities and any roles related to social control or legal processes. The primary obligation remains the well-being and treatment of the patient, with justice as a guiding principle when conflicts arise between patient autonomy, beneficence, non-maleficence, and societal interests.[1]

The use of structured clinical ethics support services, such as moral case deliberation (MCD), is recommended to help staff navigate complex moral dilemmas. MCD facilitates open, interdisciplinary dialogue, allowing professionals to reflect on cases, understand diverse perspectives, and develop shared values and solutions tailored to forensic settings.[2,3] However, access to such services is less established in forensic psychiatry compared to general psychiatry, highlighting a need for broader implementation and ethics training.[4]

Facilities should establish detailed policies and procedures addressing confidentiality, informed consent, and the management of divided loyalties.[2] Regular orientation, ongoing ethics education, and the presence of an ethics committee are essential to foster an ethical climate and anticipate or address potential violations.

Patients with decision-making capacity retain the right to make their own medical decisions, including the appointment of surrogate decision-makers. It is ethically unjustifiable for wardens or prison officials to serve as surrogates unless explicitly chosen by the patient.[5] Shared decision-making should be promoted whenever possible, and patient should be involved in care planning to the extent that security and legal constraints allow.

Confidentiality must be maintained within the limits of the law, with clear communication to patients about the potential for information to be used in legal proceedings.[6] Documentation should be accurate, avoid stigmatizing language, and only share necessary health information with law enforcement to ensure appropriate follow-up and aftercare.

Awareness of cultural, socioeconomic, and educational differences is critical to providing equitable care and avoiding bias or discrimination. Policies and staff training should address these issues explicitly.
Security measures should be balanced with the need for therapeutic engagement. For example, privacy during history-taking and physical examination should be maximized without compromising safety, and the use of restraints or coercive measures should be justified, proportionate, and subject to ethical review.[5]
In summary, ethical management during admission to forensic facilities requires a combination of clear ethical frameworks, institutional support structures, respect for patient rights, and ongoing staff education, all tailored to the specific challenges of the forensic environment.

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5.5) Ethical Principles in the Treatment of Substance Use Disorders: Dignity, Access, and Responsibility

Substance use and addiction are complex phenomena that intersect with individual experience, public health, and social justice (Csete et al., 2016). Individuals who use or are dependent on substances are full members of society, entitled to the same fundamental rights, protections, and responsibilities as all other citizens. Their intrinsic human dignity must be recognized and respected in every circumstance, including within healthcare, social services, and correctional systems. Substance use disorders (SUDs) are disproportionately prevalent in correctional populations (Fazel, Yoon, & Hayes, 2017).

Studies across consistently show that over half of all incarcerated individuals have experienced problematic substance use in the year prior to incarceration. Traditional models of addiction treatment in prisons have typically emphasized abstinence and disciplinary responses to drug-related behavior. However, such models often overlook the complex needs of people who use drugs and may even contribute to further harm (Borschmann, Mortality After Release from Incarceration Consortium, & Kinner, 2024; Sander, Shirley-Beavan, & Stone, 2019).

Despite tight controls, substance use persists in many prison systems. Where use occurs clandestinely, risks increase: lack of sterile injection equipment, shared paraphernalia, and delayed medical intervention all contribute to poor outcomes. Moreover, zero-tolerance policies often isolate individuals who use drugs and may discourage them from seeking help (Bielen et al., 2018).

Harm reduction-based addiction work is informed by harm reduction philosophy, trauma-informed care, and motivational interviewing (Palmateer et al., 2022). Its core assumptions include:

- *Substance use is a coping strategy* that often originates in trauma, marginalization, or mental health challenges
- *Not every incarcerated person is ready or able to achieve abstinence* immediately or at all.
- *Respectful, nonjudgmental engagement* builds trust and opens the door for meaningful, long-term change
- *Harm reduction is not resignation but responsibility*—reducing risks is ethically and practically imperative in environments where drug use cannot be fully eliminated

Harm reduction addiction work is not about lowering standards; it is about raising the quality of care (van Santen et al., 2023). It challenges punitive reflexes with compassionate realism and replaces exclusion with engagement. While systemic barriers remain—such as stigma, policy constraints, and limited

resources — there is growing evidence that this model offers measurable benefits both within and beyond the prison walls.

As prisons reflect society's margins, they also represent opportunities for change. Harm reduction-based addiction work allows correctional institutions to become sites not just of containment, but of healing, connection, and human potential.

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6. Research ethics

6.1) Ethical Principles for Forensic Mental Health Research

Introduction

Forensic mental health research involves some of the world's most vulnerable populations: individuals with mental disorders who are also under legal or custodial control. These individuals face intersecting vulnerabilities: limited autonomy, coercive settings, and diagnostic uncertainty. Ethical research in this field must actively advance justice, ensure oversight, and prevent exploitation. International frameworks like the Belmont Report[1] and the Declaration of Helsinki[2] provide foundational principles, but application requires adaptable, culturally sensitive implementation.

Dual Vulnerability & Informed Consent

Participants are often simultaneously subject to mental illness and legal restraint. This dual vulnerability necessitates:

- Voluntary informed consent, rigorous capacity assessments, and protection from coercion.[1,3]
- Special attention to privacy guarantees for biometric or neural data.[3,5]
- Safeguards that protect the right to refuse participation in in research in custodial settings without disadvantage.[1,6]
- Ethical literacy among clinicians and researchers to preserve rights amid systemic complexity.[2]

Risk-Benefit Balance & Scientific Integrity

Balancing risks and benefits is a core ethical duty, including scientific validity, transparency, and protection from therapeutic misconception.[7,8]

- Research must avoid unnecessary harm and offer clear, potential benefits.[7]
- Ethical breaches involving coercion or inadequate oversight must be prevented.[9]
- All training and protocols should prioritize ethical safeguards in high-risk contexts.[8]

Confidentiality & Data Protection

Maintaining confidentiality and data protection includes:

- Robust safeguards for sensitive data, including neuroimaging outputs.[10]
- Feasible and enforceable protections, even in resource-limited environments.[11]
- Proactive regulation of "neuroprivacy" and ownership of brain data.[5,12]

Oversight, Conflicts of Interest & Institutional Responsibility

Independent ethical review is essential to ensure accountability[13]:

- Ethics boards should be independent of governmental or funding sources.[14]
- Structural safeguards must prevent misuse of psychiatric authority.[15]
- Transparent institutional review processes and international monitoring improve accountability.[16]

Justice in Recruitment & Benefit Distribution

Justice demands equitable participant selection and fair distribution of research benefits:

- Avoid targeting vulnerable groups solely due to institutional access or convenience.[17]
- Historical and systemic injustices must be acknowledged in design and recruitment.[18]
- Cultural competence tools enhance fairness and ethical validity.[19,20]

Emerging Challenges: AI, Neurotech & Carceral Settings

- Algorithms in forensic contexts must be validated, bias-free, and transparent.[21,22]
- Neurotechnologies raise ethical questions about privacy and legal application.[23, 24]
- Extended confinement without periodic review challenges principles of proportionality and dignity.[25]

Ethical Variability and Common Standards

While legal systems and clinical structures differ, shared ethical standards include:

- Respect for autonomy and informed participation.[26]
- Minimization of risk and harm.[2]
- Confidentiality, data protection, and privacy rights.[27]
- Justice in research design, access, and benefits.[28]
- Institutional independence in oversight.[29]
- Maintaining research integrity from planning research through to publication.[30]

Recommendations

1. Establish forensic-specific ethics committees across all research contexts.[31,32]
2. Standardize informed consent safeguards across settings and capacities.[32]
3. Implement core benchmarks for data privacy and AI use.[33,35]

4. Ensure equity in participant recruitment.[36]
5. Train professionals in ethical reasoning, cultural competence, and role boundaries.[37]

Conclusion

Ethical forensic mental health research must apply universal principles while adapting to practical realities. Respect for autonomy, minimization of harm, justice in selection, and independence of oversight are essential. Realization of these principles requires collaborative practice, reflective inquiry, and structural reform to uphold human dignity in forensic psychiatric research.

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6.2) What research is needed to advance thought in this area now?

Forensic psychiatry is a continually evolving discipline that requires ongoing theoretical and empirical development to meet contemporary challenges. Advancing thought in this area today requires a multifaceted research agenda—one that bridges knowledge gaps, refines assessment and treatment approaches, and responds to societal needs, as well as evolving legal and ethical frameworks.

As forensic psychiatry works within legal systems, ongoing research into the ethical implications of psychiatric testimony, criminal responsibility, involuntary treatment, and confidentiality is essential. With evolving legal standards and growing scrutiny of expert witnesses, both empirical and normative research are needed to guide best practices, promote transparency, and reduce potential biases in forensic evaluations (Candilis et al., 2010).

Forensic psychiatry must more effectively address how mental illness intersects with race, gender, socioeconomic status, and cultural background. Disparities in diagnosis, treatment, and sentencing among marginalized populations require empirical investigation. Research is needed to identify systemic biases and develop culturally informed approaches that promote equity and accuracy in forensic evaluations (Metzl & Roberts, 2014).

The COVID-19 pandemic accelerated the use of digital platforms in psychiatric assessment and treatment, highlighting the need for studies to consider the reliability, validity, and ethical implications of remote forensic evaluations (Shore et al., 2020). Telepsychiatry in forensic settings presents both opportunities and challenges in relation to access, rapport-building, and confidentiality.

While existing tools, such as the HCR-20 or Static-99, provide established methods for assessing violence or recidivism risk, they also have notable limitations, including cultural bias, limited dynamic adaptability, and over-reliance on historical data (Singh et al., 2014). There is a pressing need for research to develop and validates dynamic, culturally sensitive, and technologically integrated risk assessment models—potentially incorporating machine learning algorithms (Douglas et al., 2017).

One key area requiring further exploration is the neurobiological basis of violent and criminal behaviors in psychiatric populations. Recent advances in neuroimaging and genetics have opened new roads for understanding the interplay between brain structure/function and behaviors such as impulsivity, aggression, and moral decision-making (Glenn & Raine, 2014). Emerging forms of criminal behavior - such as cybercrime, terrorism, and offences associated with artificial intelligence - present unique challenges for forensic psychiatric assessment. These areas often involve distinct psychological profiles and require novel conceptual models (Meloy & Yakeley, 2014). Research must evolve to examine how traditional forensic constructs (e.g., intent, capacity, dangerousness) apply in these new contexts. Integrating neuroscience with forensic risk assessment could improve the objectivity and predictive power of forensic evaluations, while also supporting more tailored treatment strategies. There is also limited longitudinal data on the long-term outcomes of forensic patients, particularly regarding reintegration, relapse, and recidivism following psychiatric treatment. Longitudinal studies are essential to evaluate the effectiveness of various treatment approaches and legal interventions, including community-based programs, forensic assertive community treatment, and competency restoration programs (Skeem et al., 2011).

Another key area requiring attention is prison mental health research, given growth in the international prison population and the hgh prevalence of mental disorders amongst incarcerated individuals (Emilian et al., 2025). Ethical concerns rightly require careful consideration amongst these groups, and services must align with international human rights standards, and be made subject to appropriate oversight (UN General Assembly, 2015). Despite this, there are serious concerns in many jurisdictions, with widespread substance misuse, gang activity, prolonged and excessive detention, misuse of solitary confinement, violence, coercion, abuse, torture, and, in some states, the death penalty (Forrester et al, 2024). Although the scale of the need is considerable, high quality research in prison settings has historically been limited because of ethical, political and logistical barriers. These must now be overcome because of the urgent need to produce interventions that can meet the presenting needs of this population, and is both effective and humane.

Research in forensic psychiatry must be attuned to cultural, gender, and socio-economic disparities. Evidence shows that marginalized groups are often disadvantaged at every stage of forensic assessment and legal adjudication. Future studies should address these biases and aim to inform public policies that promote greater equity and justice.

In sum, advancing thought in forensic psychiatry requires a coordinated, interdisciplinary research agenda that is empirically robust, ethically grounded, and socially responsive. Only through such comprehensive inquiry can the field continue to serve the dual aims of justice and mental health in a humane and scientifically informed manner.

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6.3) Ethics in Case Studies in Psychiatry

Ethical considerations in psychiatric case studies encompass several critical domains, reflecting the unique challenges of psychiatry as a medical discipline that intersects with complex issues of autonomy, consent, risk, and vulnerability.

Historically, psychiatry has faced unique ethical dilemmas due to the nature of mental illness, the vulnerability of patients, and the power asymmetry inherent in the therapeutic relationship. From the 19th century to the present day, there has been a continuous effort to balance the need for treatment with respect for the patient's dignity and autonomy.

The case study, as a fundamental tool for teaching, research, and clinical reflection, presents a fertile ground for ethical conflicts. Confidentiality vs the duty to protect, informed consent, patient decision-making capacity, and social stigmatization are recurrent and critically important issues.

Unlike other medical specialties, psychiatry faces the complexity of assessing an individual's competence to make decisions, a crucial aspect of obtaining informed consent for treatment or research participation. Since the 1970s, bioethics has provided a framework of principles (autonomy, beneficence, nonmaleficence, and justice) that have been adapted to the psychiatric context, though their application presents specific challenges.

First, informed consent is paramount but often complicated by the nature of psychiatric illnesses, which may impair decision-making capacity. Ensuring that patients understand the purpose, risks, and benefits of participation in case studies or research is essential, with special attention to fluctuating capacity and the potential need for surrogate decision-makers or enhanced consent processes.

Second, confidentiality and privacy are fundamental ethical obligations, given the stigma and potential social consequences associated with psychiatric diagnoses. Case studies must rigorously protect patient identity and sensitive information, balancing transparency for scientific validity with respect for patient dignity and rights.

Third, the risk of coercion or undue influence is heightened in psychiatry, especially when patients are involuntarily hospitalized or subject to coercive measures such as restraint or seclusion. Ethical practice requires that any use of coercion be justified only under exceptional circumstances where it is the least restrictive means to ensure safety, and that alternatives be actively sought. Transparent, balanced decision-making processes involving patients and caregivers improve ethical legitimacy and acceptance.
Fourth, research involving high-risk populations, such as those with suicidal ideation, demands careful ethical scrutiny. Excluding such patients from studies may limit generalizability but including them requires ensuring that the comparator arm receives at least the standard of care to avoid withholding effective treatment. The risk of suicide-related events should be contextualized as primarily due to the underlying condition rather than research participation, and potential risks must be clearly communicated during informed consent.

Fifth, conflicts of interest, particularly in forensic or disability evaluations, must be vigilantly managed to maintain objectivity and honesty. Psychiatrists must avoid bias related to financial or referral pressures and prioritize ethical integrity over external influences.

Sixth, evolving areas such as psychiatric genomics and precision psychiatry introduce novel ethical challenges, including implications for identity, privacy, data protection, and equitable access to emerging interventions. These require multidisciplinary approaches and sensitivity to sociocultural contexts.
Finally, psychiatry faces ongoing ethical challenges related to human rights, the balance between autonomy and beneficence, and the need for continuous revision of ethical codes to reflect changes in knowledge, culture, and societal values. Engaging stakeholders, including patients and families, in shaping ethical frameworks is critical for contemporary psychiatric practice and research.

In the current context of digital psychiatry, new ethical dilemmas emerge related to the privacy and security of sensitive data, artificial intelligence algorithms used for clinical decision-making, and the alteration of the traditional therapeutic relationship.

The rise of these technologies demands continuous reflection on how to protect vulnerable patients and ensure equity in access to mental health services. In summary, the state of the art of ethics in psychiatric case studies reveals a field in constant evolution, where bioethical principles are applied in complex ways to safeguard the dignity and rights of patients.

The future challenge lies in integrating new technologies and research advances without
compromising trust, confidentiality, and autonomy,the pillars of humanistic and ethical psychiatric practice.

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7. Human rights

7.1) Informed and formed consent in forensic psychiatry and how coercive environments can impact it

It is a fundamental position that people forensic psychiatrists assess with or without mental illness are members of society that possess rights under the law and who are able to claim those rights, which includes the right to decide what happens to their bodies. All mentally capable people have the right to make autonomous decisions for their lives based on free and informed consent.[1] Forensic psychiatrists have a duty to ensure that a capable patient is appropriately informed and that the consent is fully transparent and voluntary.[2]

In forensic psychiatry, where dual agency seems to be the norm, consent applies not only to treatment but also to the actual assessment, usually for courts or similar.[2]An appropriate assessment of consent—whether for psychiatric evaluation or treatment—is legally and ethically essential. Forensic psychiatrists operate in jurisdictions with legislated requirements for obtaining consent for treatment, and they must comply with these requirements. They too must understand fully the extent to which the assessment they wish to complete on the patient can or will impact the lives of the persons they assess.[2]

Respecting the dignity, autonomy, privacy and confidentiality of individuals, forensic psychiatrists have specific obligations, both ethical and legal, as stewards protecting information provided by their patients. The rights to autonomy, privacy and confidentiality also entitle individuals to exercise control what information they share, what research they participate in or what treatment they take.[3,4] Knowing that their privacy will be respected gives patients the confidence to share sensitive personal data. Their privacy is protected by the duty of confidentiality of all who are involved in our care.[5]

Communication is key if informed consent is to be obtained. Forensic psychiatrists must provide patients with the information they need to allow them to make informed decisions and if there is any concern should be able to communication with their legal counsel before agreeing to an assessment.[3] Forensic psychiatrists must answer any questions to the best of their ability and in accordance with evidence- based practice.[3]

Consent is a process that includes a capable person making a voluntary decision with the correct facts and information made available. It is common practice for the assessor or treater to get the patient to sign a form to indicate they understood what was told to them and that they agree to proceed. Forensic psychiatrists must recognize that a signed consent document alone does not ensure that the process of informed consent has taken place in a meaningful way or that the ethical requirements have been met.[4]

Given the high stakes assessments in forensic psychiatry, documenting the process and outcome of the consent procedure is important. Tacit or express consent should be relied upon less frequency in forensic psychiatry than other branches of medicine.[6]

Although different jurisdictions define the essential elements of consent differently, the core elements generally imply voluntariness, adequate disclosure of information, proper material representation, appropriate communication, specific to the assessment or treatment and can only be provided to mentally capable and/or legally competent persons.[1,6]The patient should have an opportunity to ask questions and to receive understandable answers. Consent may change over time and for different types of assessment and circumstances. Hence, consent must be an ongoing process.[6]

Communication about the consent process should recognize the diversity of culture, language, literacy, and verbal skills, and if a potential barrier exists, it should be addressed properly.[6]

Forensic psychiatric patients occupy a place of jeopardy. They are located in a system that monitors risk and titrates their liberty against behaviour. Compliance and adherence generally tend to be looked upon with benevolence, whist resistance and non-compliance is met with disapproval. Also, those being assessed may be more agreeable and provide information that puts them in jeopardy in order to obtain the approval of the assessing forensic psychiatrist. Research in forensic psychiatry is tricky.[7] Research on subjects who have a forensic psychiatric history raises serious ethical and legal concerns. Researchers must be particularly sensitive to the issue of capacity and the nature of the assessment, especially when the research may involve little or no benefit to the patient.[8] How then can forensic psychiatrists obtain informed consent from patient whose very future is at stake. This is a coercive environment and freely given consent an oxymoron. This means that forensic psychiatrists have a special duty to ensure that patients within the forensic system are capable of providing free and informed consent to psychiatric research.

Treatment of mental disorders is something that psychiatrists (and forensic psychiatrists) are expected to provide to their patients. It may seem obvious and natural that patients should take medications to improve their mental state, be it psychosis or other mental disorders. However, consent is required from a capable patient, and that is especially important in the forensic system.[1] How voluntary can consent be when the physician offering you the treatment is the same one that will decide or advise on your privileges and or liberty?

This is a delicate environment and one that forensic psychiatrists need to be cognizant about. It may be difficult for some to accept that forensic psychiatry operates largely in an ethical delicate space, that the environment has strong coercive elements to it. Awareness of key ethical principles and being alert to the many aspects of consent is critical to safe ethical forensic psychiatry practice.[6]

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7.2) Hunger strike

Definition

Hunger strike is a form of protest where individuals fast in order to achieve a (political) goal. It is therefore to be distinguished from medical conditions which cause severe weight loss as well as restricted eating due to symptoms of a mental disorder, e. g. paranoia.

After using up all glucose, the body starts utilising body fat and after that muscles and vital organs at which point the process becomes dangerous. Hunger strikers die after 60 to 70 days though those on „dry hunger strike" (without drinking) considerably quicker. Even if the hunger strike is terminated, there might be long-term negative psychological and medical consequences. Individuals who hunger strike rarely wish to die but may be prepared to take the risk of serious health consequences and death in order to achieve their goals. Ethical considerations and issues of managing persons on hunger strike are set out e. g. by the World Medical Association (2020).

Ethical challenges

The main ethical challenge for medical personal is to balance helping the ill person and respecting their autonomy even if this means they might die. This is particularly challenging in custodial and closed medical settings where authorities often put pressure on doctors to terminate the hunger strike by force feeding the individual as they worry that death in custody might result in the individual gaining martyr status and triggering public protest.

Another challenge is to determine whether the individual is in fact on hunger strike following an autonomous decision or as a result of a mental disorder in which case the management would be very different and consist of treating the underlying disorder and possibly force-feeding the individual to save their life until capacity is restored and they can make their own autonomous decisions again.

Guidance

As also highlighted by the World Medical Association's Declaration of Malta from 2017, where a prisoner (or patient) refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a refusal, he or she shall not be fed against their will. The following step should be taken by the doctor:

1. Physicians need to ascertain the individual's intention as well as capacity to make such decision.
2. They need to rule out that the decision to hunger strike is a result of acute mental disorder or pressure put upon the individual by others.
3. The consequences of the refusal of nourishment shall be explained by the physician to the person.
4. Capacity should be assessed by at least one other independent physician.
5. Physicians need to respect autonomy and this includes the decision to hunger strike and refuse artificial feeding.
6. Particular challenges arise once hunger strikers develop cognitive impairment or fall unconscious as they then cannot make autonomous decisions anymore. It is therefore important for the physician to ascertain the individual's wishes in such a situation beforehand. Advance instructions have to be followed.
7. Physicians should resist pressure from authorities to act in a way not in line with the individual's wishes, in particular they must not force feed individuals without their consent and contrary to their autonomous decision.
8. Physicians should conduct a thorough medical assessment at the beginning of a hunger strike and regularly during the fasting.
9. The intention to continue to fast should be assessed daily.
10. All assessments must be recorded in detail.

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8. Special topic

Ethical Use of Artificial Intelligence in Forensic Psychiatry

There is no universally agreed definition of artificial intelligence (AI).[1] AI encompasses all computer systems that undertake tasks that would usually require the direct or indirect involvement (or oversight) of human intelligence.[2,4] The use of artificial intelligence (AI) in forensic psychiatry introduces powerful tools for risk assessment, data analysis, and decision support. While these technologies may enhance objectivity and efficiency, they also raise serious ethical concerns, especially in contexts where legal rights, liberty, and clinical judgment intersect.

This document outlines the core ethical challenges posed by AI in forensic settings, including risks of bias, opacity, and misuse. The aim is to guide its responsible integration, ensuring that innovation serves justice, respects human dignity, and upholds the ethical foundations of forensic psychiatric practice.

Ethical Promise and Perils of AI in Forensic Psychiatry

AI systems offer potential to:

- Enhance objectivity in risk assessments and forensic reporting.[5,6]
- Support early detection of psychiatric deterioration and improve workflow efficiency.[7]
- Provide educational tools for trainees and decision support for experts.[8]

However, these benefits are counterbalanced by serious ethical risks:

- Bias and discrimination, especially against racial, ethnic, and neurodivergent groups.[6,9,10]
- Lack of transparency in algorithmic decision-making (black-box systems).[8,11]
- Erosion of autonomy, especially in coercive settings where consent may be impaired.[12]
- Overreliance on AI in expert testimony, potentially undermining clinical judgment.[5,13]
- Privacy threats, particularly concerning neuroimaging and biometric data.[14]
- Potential for generative misuse, including fabricated evidence and misinformation.[15]

Ethical Principles Under Pressure

Using artificial intelligence in forensic psychiatry raises important ethical tensions that must be addressed with care. While AI can bring improvements in consistency, speed, and decision-making, it also challenges core principles of medical ethics: justice, nonmaleficence, autonomy, and accountability.[16,17]

Justice may be supported by AI's ability to reduce personal bias and standardize evaluations. However, if AI systems are trained on biased or unbalanced data, they risk reinforcing discrimination, especially against already marginalized groups.[6,9]

Nonmaleficence, or the duty to avoid harm, is challenged when AI misclassifies individuals or overestimates risk. These errors can lead to unnecessary restrictions, wrongful detention, or stigmatization.[8,16]

Autonomy is at risk in forensic settings, where consent is often limited. If AI tools are used without proper explanation or gather personal data without awareness, they undermine informed consent and individual rights.[18]

Accountability becomes unclear when AI systems work as "black boxes." Without transparency, it can be difficult to know who is responsible for a decision, raising serious concerns in legal contexts.[11,19]

In short, ethical principles still apply, but their meaning must be reconsidered when AI enters forensic psychiatry. Protecting fairness, avoiding harm, respecting rights, and ensuring responsibility are essential for any ethical use of AI in this field.

Safeguards for Ethical Integration

To ensure AI serves justice without compromising ethical standards, the following safeguards are essential:

- Transparency & Explainability: Prioritize interpretable AI systems; all algorithmic contributions must be auditable and disclosed in expert reports.[11]
- Bias Mitigation: Regular fairness audits using diverse, representative datasets must be mandatory.[6,9,10]
- Human Oversight: AI must support – not replace – clinical and ethical reasoning. Experts remain responsible for all forensic opinions.[5,7]
- Informed Consent & Neuroprivacy: Special attention must be paid to consent capacity in forensic settings. Neurodata and personal information require enhanced safeguards.[12]
- Regulatory Compliance: Adhere to national, regional and international frameworks (e.g., China's Interim AI Measures Act, African Union Continental Articificial Intelligence Strategy, EU AI Act, OECD AI Principles) and forensic standards (e.g., Mandela Rules, Istanbul Protocol).[11,17,18,19,20]
- Educational Accountability: Forensic psychiatrists must be trained in the ethical implications and limitations of AI technologies used in their practice.[11,16,22,23]

Recommendations for Global Practice

1. Do not deploy AI in high-stakes legal decisions (e.g., criminal responsibility, involuntary admission) without interpretability and human oversight.[5,7,11]
2. Ensure that courts, attorneys, and stakeholders are educated on AI limitations when used in forensic evidence[16,22]
3. Prohibit the use of AI-generated content (e.g., deepfakes, synthetic testimonies) in forensic settings without stringent authentication protocols.[15,24]
4. Establish independent forensic ethics bodies to oversee the development, validation, and application of AI tools in forensic psychiatry.[11,12,17]

Conclusion

AI can augment forensic psychiatric expertise and procedural justice, but only within a framework that safeguards human rights, ensures interpretability, and reinforces the primacy of ethical judgment.

As forensic psychiatry evolves, the ethical use of AI must be seen not as an inevitability, but as a responsibility.

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9. Working group

ABDALLA-FILHO, Elias (editor)
ABOAJA, Anne
ALMEIDA, Susana Pinto
ALVES, Paola Figueiredo MT
CHAIMOWITZ, Gary A.
DOUZENIS, Athanassios
FORRESTER, Andrew
ISAAC SEMA, Carlos Hugo
MARTINEZ, Vitor
NARDI, Antonio Egídio
OPITZ-WELKE, Annette
OROZCO, Karina
SHARMA, Indira
SRINIVASARAGHAVAN, Jagannathan
VIEIRA, Fernando MRS
VÖLLM, Birgit
VON SUCRO, Lívia

November, 2025.