Humane Forensic Practice Serves Social Justice

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In response to a call for revision of the current procedures for involuntary treatment in Massachusetts, this commentary explores the ethics basis for such institutional reform. In the decades since the landmark *Rogers v. Commissioner* decision of 1983, the ethics foundation for forensic psychiatry has evolved from a purist approach that prioritized legal values above therapeutic ones. Building on systemic approaches by Gutheil et al. and Ciccone and Clements, Candilis and Martinez, for example, have argued that a robust professional ethic requires moving beyond the strict role theory of the adversarial system to consider broader approaches that integrate multiple perspectives: the ultimate goal is protection of vulnerable people and ideas. In this commentary, we suggest that the current system for involuntary treatment does not protect the vulnerable people it ought to serve, failing the neglected goal of social justice.

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This important piece by Biswas *et al.*[1] examines the unintended consequences of the process for involuntary treatment in Massachusetts following the 1983 *Rogers* v *Commissioner* decision by the Massachusetts Supreme Judicial Court.[2] The authors make a strong case that the delays in treatment inherent in the current adversarial system result in mental deterioration that deprives patients of liberation from symptoms and leads to a more severe course of illness. The authors describe the current process as a consequence of "the steady development of a mental health jurisprudence dedicated to the preservation of human rights,"[1] acknowledging that self-determination and autonomy are critical aspects of this perspective (Ref. 1, p 447). While we agree that autonomy is an important ethics principle, it is only one aspect of human rights. Empowering patients to make informed decisions about their treatment is central to the practice of medicine and law; but the key word is "informed." When a person is unable to make an informed decision about treatment due to mental illness, the unwavering pursuit of autonomy becomes a distortion of human rights.

The U.S. legal system addresses conflicting values by pitting them against one another. Similarly, the current system of mental health jurisprudence is a battlefield where individual good vies with social good and medical values clash with legal ones. These polarized constructs can lead to tunnel vision, obfuscating rather than elucidating the complex human condition. In contrast, the human mind traffics in ambivalence. From molecules to cells to circuits, the brain is engaged in a constant, active, and sophisticated balancing act; not "either/or," but "both/and." At the intersection of medicine and the law, forensic psychiatry is ideally positioned to navigate conflicting values and uncover complex truths.

The ethics foundation of forensic psychiatry has evolved in recent decades to embrace a homeostatic balance between conflicting principles.[3] In their theory of decision analysis, Gutheil and colleagues[4] pointed out the complexity of interactions between individuals, their institutions, and society at large. They suggested a decision-making system that balances the tension of values, tension between professions, and tension between objective and subjective factors. They eschewed a purist view of strict roles and argued for a collaborative network that addresses the moral claims of the individual, clinician, and society all at once. Ciccone and Clements[5] also embraced this synthesis in their systems approach to

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forensic psychiatry. They suggested an ethics model that reflects "the inevitable conflict between two different levels of good and suggests homeostatic mechanisms for dealing with such conflicts" (Ref. 5, p 265). Their dialectical approach offers a broader, more nuanced perspective on the problem of involuntary treatment: "Respect for individuals is a more useful concept than rights and autonomy concepts in the development of a medical ethic . . . we must redefine respect for individuals to include empathy and concern for the individual's best interest, rather than only respect for reason" (Ref. 5, p 275). As Biswas *et al.*[1] point out, there is an inherent paradox in forgoing a best-interest model for substituted judgment when incompetency stems from treatable mental illness; if the person were competent, he would not need involuntary treatment.

Beyond balancing conflicting principles, the ethics practice of forensic psychiatry requires attention to the stories of marginalized individuals. In his narrative approach to forensic ethics, Ezra Griffith called for a cultural formulation, contending that there could be no justice in ethics frameworks that ignore the different treatment of dominant and nondominant groups.[6] Matthew Wynia and colleagues[7] similarly pointed to the importance of advocating for the disenfranchised in their 1999 article in the *New England Journal of Medicine*, arguing that "professions protect not only vulnerable persons but also vulnerable social values" (Ref. 7, p 1612). Candilis and Martinez[8] built on these ideas in their unifying ethics theory of robust professionalism, integrating the complex personal, social, and institutional commitments of forensic work. They described the forensic encounter as a moral relationship and proposed using an individual's narrative to enrich the way that principles are applied to specific cases. Biswas *et al.*[1] echo the call for a more nuanced approach to individuals and their stories: "A single law [to determine capacity for those with mental illness] cannot address the entire problem . . . it is a blunt instrument" (Ref. 1, p 450).

More recently, Alec Buchanan[9] connected the principle of respect for persons with a respect for human dignity. He suggests correctly that "the link between dignity and vulnerability may be that we see people as needing a minimum level of wellbeing and freedom to act in pursuit of their goals" (Ref. 9, p 15). Buchanan specifically points to the importance of dignity in issues of competence: "Respecting dignity when people are not competent to make their own choices seems to require us to do things other than simply respect their decisions. It seems to include, for instance, acting to ensure that their best interests are protected" (Ref. 9, p 13). Buchanan's call echoes that of Ciccone and Clements decades earlier.

When individuals with mental illness are committed without treatment, there are two frequent outcomes. The first scenario is well characterized by Biswas *et al.*[1]; they languish in a medical institution, "rotting with their rights on"[10] or receiving treatment on an inconsistent, emergency basis that is traumatic and ineffective. Another common scenario is that they are discharged, despite remaining actively in crisis, and subsequently arrested for a (usually) minor criminal offense. These encounters with law enforcement can be deadly; up to 25 percent of fatal police shootings in the United States in 2015 and 2016 involved individuals who had mental illness.[11] To appreciate the regularity of this diversion to the criminal justice system, one need only look as far as our jails and prisons, where the rate of serious mental illness far exceeds the rate in the general population.[12,13]

The failure to treat involuntarily hospitalized individuals contributes to the disproportionate arrest and incarceration of the most vulnerable people in our society. People of color with mental illness are overrepresented in prisons.[14–16] This is a result of systemic racial bias; but racism is not the only marginalizing force at work in the incarceration of people with mental illness. Incarcerated individuals are not only people of color who are disproportionately affected by serious mentally illness, they are also far more likely than the general population to be low-income, under-employed, under-housed, and under-educated.[17] These intersecting, multiply-marginalized identities lead to exponential stigmatization and disempowerment.[18]

Even when they are once again involuntarily institutionalized this time in jail many of these vulnerable individuals will continue to be deprived of treatment for weeks to months until their attorneys finally argue that they are incompetent: not to refuse treatment, but to stand trial. This well-known back door to treatment comes at an astronomically high cost, not just for the state, but for these most marginalized citizens who endure the repeated trauma of commitment, arrest, detention, and incarceration.

When they finally receive treatment, most will be restored to competence and go on to stand trial.[19] Whether justice is ultimately served in these cases is another matter. Many will be incarcerated for acts that they had no capacity to understand or control. Despite the lack of *mens rea*, they will not pursue an insanity defense because, in many jurisdictions, success would lead to longer confinement. Others, having experienced the deleterious effects of extended, untreated mental illness, will be found not competent and not restorable. According to the landmark *Jackson v. Indiana*[20] decision, they are subject to civil commitment proceedings. Those who are ultimately found not competent, not restorable, and not committable will have their charges dropped. They will be swiftly discharged, often with little planning, no housing, and no leverage to continue outpatient treatment. While only a minority of defendants fall into this category, those who do are vastly overrepresented in the criminal justice system and in forensic psychiatric settings. With no justice and no treatment, the cycle of illness, arrest, and trauma is free to accelerate: the brakes are cut.

Social justice is integral to the ethics mission of many professions; in medicine, it requires promoting the fair distribution of health care resources and working actively to eliminate discrimination in health care.[21] In forensic psychiatry, ethics approaches have evolved to integrate social context, multiple perspectives, and the narratives of vulnerable individuals. These more nuanced approaches all indicate that respect for individuals encompasses far more than just autonomy. But current adversarial procedures for involuntary treatment prioritize autonomy above all else, not just at the expense of human dignity, but at the expense of social justice. There can be no justice of any kind when the most vulnerable citizens are deprived of appropriate health care and left to languish in medical, forensic, and correctional institutions. The gross discrepancies in life expectancy for persons with mental illness that may, as Biswas *et al.* suggest, result in part from treatment non-adherence, represent another social injustice.[1]

The goals of psychiatry and the law are often not the same; but a set of procedures that pits one against the other is no longer a solution. As Ciccone and Clements[5] pointed out in the early days of *Rogers*, "Working in a setting that calls for a balanced tension can be disturbing to those who want a neat ethical system with ideal resolutions to problems, but this does not express the human social condition . . ." (Ref. 5, p 273). Across professions, judges, attorneys, and physicians take different approaches to achieve the common goal of protecting vulnerable people, but there may already be more common ground than the current procedures acknowledge.

Attorneys and judges find themselves in a situation similar to physicians when they recognize that a vulnerable person in their care needs treatment. As Schouten and Gutheil[22] pointed out in their empirical assessment of the costs of the *Rogers* decision, the vast majority of petitions pursued to completion (99.1%) were granted by the courts. They hypothesized that "despite requirement for substituted judgment analysis, judges may exhibit some bias toward the more humanitarian (but less libertarian) traditional best-interest analysis" (Ref. 22, p 1350). Similarly, they suggested that "some attorneys might yield to their own interpretation of fiduciary responsibility and present a *pro forma* or less-than-aggressive opposing argument" (Ref. 22, p 1350). Forensic psychiatry is not the only profession that benefits from an integrated ethics approach that protects vulnerable people.

While the prospect of reform may be daunting, Elizabeth Wolgast[23] reminds us why we must move forward: "The motive for tackling these gargantuan projects of reform is that the alternative is a further thinning in the meaning of responsibility on one side while nurturing institutions that defeat it on the other. A decision to change is acutely a moral decision, and moral courage is needed to make it" (Ref. 23, p 157). Some forensic authors have already suggested that the strict, strong, or narrow professional role may well be the concept that allows for what Wolgast described as the "further thinning of individual responsibility" (Ref. 23, p 157). It is the broader view of professional role that allows redress of social inequities and their visitation on vulnerable persons. More recent commentators[24] contend that "we will have to look carefully at the connection between professional role and institutional or societal needs if we are to develop the 'moral courage' to seek reform" (Ref. 24, p 109). The moral courage to reform is at the core of social justice.

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