CLINICAL ETHICS

# Ethical dilemmas in forensic psychiatry: two illustrative cases

**Piyal Sen, Harvey Gordon, Gwen Adshead, Ashley Irons**

*J Med Ethics* 2007;**33**:337–341. doi: 10.1136/jme.2006.017806

One approach to the analysis of ethical dilemmas in medical practice uses the ''four principles plus scope'' approach. These principles are: respect for autonomy, beneficence, non-maleficence and justice, along with concern for their scope of application. However, conflicts between the different principles are commonplace in psychiatric practice, especially in forensic psychiatry, where duties to patients often conflict with duties to third parties such as the public. This article seeks to highlight some of the specific ethical dilemmas encountered in forensic psychiatry: the excessive use of segregation for the protection of others, the ethics of using mechanical restraint when clinically beneficial and the use of physical treatment without consent. We argue that justice, as a principle, should be paramount in forensic psychiatry, and that there is a need for a more specific code of ethics to cover specialised areas of medicine like forensic psychiatry. This code should specify that in cases of conflict between different principles, justice should gain precedence over the other principles.

See end of article for authors' affiliations

Correspondence to:
Dr P Sen, Priory Secure Services, Department of Forensic Psychiatry, Chadwick Lodge, Chadwick Drive, Eaglestone, Milton Keynes, MK6 5LS, UK; piyalsen@blenheimhealth.com

Received 23 June 2006
Accepted 27 June 2006

The ''four principles plus scope'' approach to medical ethics provides a simple, accessible and culturally neutral framework for dealing with this difficult and confusing area of medicine.[1 2] These principles are: respect for autonomy, beneficence (benefit to patients), non-maleficence (not to harm) and justice, along with concern for their scope of application. However, there is some reason to think that this approach may have limitations in psychiatric practice, and the practical application of the four principles in different psychiatric specialities has not been closely analysed.[3 4] Specifically, it may be hard to know how to choose or balance the principles when they conflict with one another, and the scope of application is complicated when the doctor has dual professional loyalties. The nature of application would very much depend on the case and will often require a certain amount of imagination, rather than the strict use of logic.

The practice of forensic psychiatry illustrates some of these difficulties. It includes all aspects of the care and treatment of offenders with mental disorders or patients posing similar problems of antisocial behaviour. Because the patients are offenders and are in hospital for treatment, both for their own benefit and to reduce risk to society, the forensic psychiatrist thus has an ethical obligation towards both the patient and to the wider society. This would also include addressing the interests of the patients on the same ward and staff working on the ward, who might be at risk from the patient. Balancing the ethical principles for all these groups, especially when they might be in conflict, would thus present a complex challenge. Health professionals in forensic psychiatry are often confronted with dilemmas that highlight the need for different ethical guidelines in this field over and above those for general psychiatry.[5 6] In this paper, we try and illustrate some of these dilemmas by discussing the case histories of two patients from our clinical practice. We will use these cases to argue that forensic mental healthcare may need different or additional principles for ethical analysis, and that the moral emphasis in forensic psychiatry may vary from that in general medicine.

The publication of case histories of forensic patients itself raises an ethical dilemma, as some forensic patients may be identifiable from press coverage. Both the patients described here were/are detained in a high-security hospital. Their capacity to consent was/is thus potentially compromised by their mental illness, and by their detention and perceived lack of volition. We approached the two patients described here, and their responsible medical officers. The patients and responsible medical officers have read through the paper before giving, and confirming that the patients have the capacity to give, written consent to publication. Both the case histories are linked to key ethical questions relevant to forensic psychiatry. The case histories are discussed first to illustrate the limitations of the ''four principles plus scope'' approach.

## CASE HISTORY NO 1

The patient is a 32-year-old man with schizophrenia. He has been in a maximum-security hospital for over 20 years, most of which he has spent in special care. His schizophrenia is accompanied by abnormalities of neurodevelopmental origin, characterised by right frontotemporal dysfunction and generalised frontal lobe abnormality.

He has assaulted other patients on numerous occasions in the past, some very seriously. Most of these attacks have been sudden and completely impossible to predict. He expresses various delusional beliefs about the power that he acquires by attacking others. Since the last attack, he has been nursed entirely in seclusion, frequently under close observation. This has involved him not being allowed to mix freely with other patients and being kept away from them at all times, including mealtimes.

While it was accepted that such a solitary life was not helping his mental state, it was judged to

**Abbreviation:** ECT, electroconvulsive therapy

be too risky to bring him out of this situation in the absence of any recognisable clinical improvement. The patient's quality of life and mental state could be improved by use of some measure of restraint when he is interacting with other patients in the general-ward area. This would be in the form of a restraining belt around his chest, which would keep his hands at the side of his body so that they could not be used to attack others. This would help to ensure that he spent more time in association with and also protect the safety of, other patients.

Also, it allows for the possibility of engaging him with some limited form of occupational therapy to improve his quality of life. However, it was not possible to get his consent to the use of restraints even intermittently, as he was not capable of giving free and fair consent. The clinicians also continued to be concerned about the safety of other patients on the ward if he was brought out into association without any form of restraint. Conversely, there was considerable anxiety among the staff about using restraint. The hospital management also raised concerns about the ethics of using mechanical restraint and the risk of bad publicity for the hospital.

In the US, substantial flexibility is allowed in the use of mechanical restraint, but a state court in Montana established constitutional requirements for the use of such procedures in psychiatric hospitals.[7] In the UK, there is no formal legal framework for its use,[8] but the Code of Practice[9] provides some guidance on its use, clearly stating that it should almost never be used, and if used, this should be justified only in an emergency to prevent significant harm, and leaves it to the clinical judgement of the treating team. The ethics committee of the British Medical Association[10] emphasises the need to act in the patient's best interests, but does not develop the idea further. The issue is additionally complicated as mechanical restraint is largely discussed in the context of prohibiting any intervention involving tying or hooking a patient by tape or by part of the patient's garment to any structure, which is not the same as a garment for the patient's hands. Thus, there continues to be a considerable amount of ethical debate on the use of mechanical restraint in the UK.[11]

The question arises whether restraint could be seen as a form of treatment for mental disorder. Courts in the UK have also been taking an increasingly wide view of what constitutes medical treatment for mental illness, as illustrated by the case of tube-feeding as part of the treatment for anorexia nervosa and enforcement of caesarean section under the Mental Health Act 1983.[12 13] However, despite these supportive cases, in the absence of a formal legal framework and clear guidance, there is considerable anxiety about the use of mechanical restraint, especially in a maximum-security hospital.

## CASE HISTORY NO 2

The patient is a 27-year-old man who has a severe treatment-resistant schizophrenic illness. Before admission to this hospital, he was treated successively in different settings. He had been detained in the special-care ward continuously since his admission, after a fatal assault on a patient in another hospital.

His stay has been characterised by periods of relative health alternating with periods of withdrawal and aggression, when he would become very depressed. During these periods, he talks about hearing ''voices'', which instruct him to attack staff. He also refuses to have food and drink at these times. The only treatment that helps him to recover to some degree from these depressive episodes is electroconvulsive therapy (ECT). This is given against his will under the relevant mental health legislation. He has to be forcibly restrained while an intravenous line is inserted and he is anaesthetised. Nutrients are injected through the intravenous line when he is under the influence of the anaesthetic agent. The staff find it distressing to have to forcibly restrain the patient so often, and to inject him with nutrients against his will. They feel that restraining him compromises their caring relationship with him. Also, they feel they are deceiving him by injecting him with nutrients when he is not in a conscious state. However, this is the only way to keep him alive until he recovers from his depression after a few weeks of ECT.

## LIMITATIONS OF THE FOUR-PRINCIPLES APPROACH

The four-principles approach has a number of limitations in forensic psychiatric practice. It assumes that patients will either have capacity to be autonomous or only lack autonomy for discrete periods. What is not discussed is how autonomy should be conceptualised when patients are in long-term residential care, and where patients are compulsorily detained and the healthcare professionals perceived to be (and to some extent are) controlling and coercive. Autonomy is a concept that needs to be expanded and refined when thinking about patients with chronic dependency needs.[14] Because some of our patients lack the capacity to make decisions for themselves, they also lack the capacity to give consent. Again, it is not clear what consent means when patients are detained, and their primary therapeutic relationship is with people who are also responsible for their detention. In addition, many treatments used are invasive or restricting in a way that is utterly different from those of voluntary patients. In the case of the 32-year-old patient, he would like to associate more with other patients, but his risk to others means that his wishes cannot be met. Thus, concern about benefiting other patients over-rides his wishes, and equally does him harm. The other interesting question is whether patients in such settings could ever meaningfully consent to such coercive measures. Is there a parallel here with an individual consenting to something as coercive a slavery? In the 27-year-old patient's case, the issue is that he is being given treatment in the face of his refusal, and while he is unconscious, to reduce the risk of his causing harm to others. He also has to be restrained to be anaesthetised. To do him good, the staff must not only breach his autonomy by forcibly restraining him, they must also to some extent deceive him. Although he seems better for it, there is no feedback about what his own thoughts are about this situation.

In the first case, the only benefits available to the patient were bought at the cost of his liberty, to an extreme degree. It is perhaps not surprising that the staff feel anxious about this, as it must have seemed the antithesis of the ''care'' that they were trained to provide. Furthermore, the criticism of the hospital can have knock-on effects on patient and staff morale in the whole hospital.[15] The situation has parallels to the proposed ''right'' of general practitioners to remove violent patients from their caseload.[16] Do the staff have the right to expect protection when they work in milieus that are not dangerous? At the same time, do those in management have a duty to protect the institution from criticism?

The principle of beneficence to the patient is rarely absolute for a forensic psychiatrist, as it is often not clear whether ''benefiting the patient'' entails making the patient feel better or making the patient behave better. The clinician is often caught up in a web of divided loyalties, balancing the requirements of the State or the ward community with concern for the patient's welfare. In the case of the 32-year-old patient, it could well be argued that the clinician is more concerned with the beneficence of the ward community, including other patients and staff, as compared to the beneficence of the individual patient. However, in the case of the 27-year-old patient, it could be argued that keeping him alive by injecting him with fluids and electrolytes does fulfil the ethical duty of beneficence towards him.

One aspect of beneficence to a patient is to seek his willingness to accept treatment. Seeking consent before any coercive measure is undertaken could be perceived to be showing appropriate ethical concern for the patient's beneficence. However, problems arise when beneficence to the patient comes into conflict with beneficence to the wider system, as was evident in the first case.

This raises the issue of capacity in those who lack capacity to give consent long-term, as was the case with the 32-year-old patient. Similarly, in the case of the 27-year-old patient, the clinical team was not seeking his consent or his capacity to consent, before injecting him with fluids and electrolytes when he was partially conscious. One could argue that in this case, the principle of beneficence was in conflict with the principle of autonomy. In such cases, it has been recommended that either the patient makes an advance statement regarding his treatment, or that an advocate may be able to ''speak for the patient''.[17] Implementation of such advance statements would be complex and require a lengthy period of development before they can be implemented in any system, particularly in forensic settings.[17] However, in view of the complex and ethically sensitive treatment interventions used at times in forensic practice, they would be of particular use in cases like that of the patients discussed in this paper. Of course, an advance statement can only be considered seriously when the patient has made it with full capacity. Again, it must be emphasised that consideration of such advance statements would be to offer a course of action that is more ethically balanced. Purely from a legal standpoint, as these are forensic patients detained under compulsory treatment provisions of the Mental Health Act, the clinician has the right to enforce treatment without consent from the patient.

Both the cases discussed raise the question of non-maleficence. ''Do no harm'' is clearly a good principle; short-term breaches of the principle are usually justified in the interest of long-term benefits for the patient (the prescription of cytotoxic chemotherapy being the best example). However, in both the cases discussed, it is not clear that the harm done was always in the patient's interest. Although one could argue that in both cases the patient did obtain some benefit, it might be argued that others benefited more. Regarding the use of mechanical restraint, for example, it may be hard for the clinicians to be certain about whose interests should prevail in their understanding of their duty of care. However, it could be quite legitimately argued in both cases that the long-term benefits would outweigh the short-term damage to their autonomy (the 32-year-old patient) and the therapeutic relationship (the 27-year-old patient).

The question of respect for justice becomes harder when patients are indefinitely detained, at least partly, because of their risk to others. Detention on the grounds of public safety makes it necessary for forensic psychiatrists to think about justice as fairness for their offender patients, as well as for the public. Here, the health and justice issues become mixed-up together in a way that is arguably different from justice issues in other branches of medicine. Justice as a principle in medicine is perhaps most often discussed in relation to resource allocation, and fairness of access to care. In forensic psychiatry, there is a real dilemma about the ways in which offender patients are actively treated with less justice, in terms of claims to liberty and personal autonomy, as well as access to care. There must be a concern that the stigma of both a violent past and a psychiatric history encourages a type of injustice where the ethical claims of forensic patients are repeatedly ''trumped'' by the claims of others. However, the counterargument is that justice is for every individual, not just the patient, and will have to take account of broader societal needs.

Lastly, the scope of the ethical duties of forensic psychiatrists includes the interests of other parties; not just the ''public'' whose safety justifies detention but also the needs of staff and other patients. The traditional medical model presumed by most theoretical approaches to medical ethics, involves only two parties: the doctor and the patient. The degree to which third parties can have a claim on that relationship has been a matter for debate. However, in forensic work, it is taken as given that third parties have a claim; in a way, that is different even to other doctors whose work involves third parties, such as public health or obstetrics. The best analogy is that of paediatrics or general practice, where whole families may be involved: but in those cases, there is not the same degree of anxiety about risk and safety.

## Could the four principles be applied another way?

It might be argued that the patients are benefiting from medical intervention to some degree, albeit in an imperfect way, and that this justifies the harm (and possible wrong) done to them. Particularly in the case of the 27-year-old patient, the forcible use of ECT and the consequent injection of fluids and electrolytes, though painful for staff caring for him, has the effect of saving his life in the longer term. In the other case, it could be argued that the restraints ensure a better quality of life for the patient by insulating him from the harm caused by long-term seclusion. It might further be argued that, as the only ethical alternative to hospital treatment for both patients is treatment in prison, which would take even less account of the patient's health needs, overall, they were receiving better care than anywhere else.

However, the fact that a patient might receive worse treatment elsewhere is hardly a justification for coercive treatment in hospital. The question here is what benefits to those patients justify the massive intrusion into their liberty and autonomy; an intrusion which is likely to be long term. There is another relevant issue as to whether the patients in question should have been prosecuted for their attacks on staff and patients at the hospital's instigation. The staff perceive that causing harm to others is actually bad for the patient, because of the possible legal consequences. Is being tried for a criminal offence a medical harm that mental hospitals should try and prevent occurring?

There remains a question of the extent to which the main benefit of those restraining interventions actually accrues to others rather than to the patients themselves. Here we raise the questions of how, in a long-term care setting, the four principles can be applied to a community rather than on an individual basis. In a community, benefiting staff and other patients does benefit the concerned patients too because of the knock-on effects for the atmosphere and relationship on the wards.

But, to apply the four principles in this way would change the individual emphasis of most bioethical analysis, and instead look at patients as nodal points in a network of relationships. Instead of seeing the duties to the different patients as conflicting, and setting the interests of the staff and patients against the concerned patients, one might argue that to take other people's interests into account is to do justice to the reality of dependency relationships. Individuals with long-term dependency needs arguably have a more complex experience of autonomy.[14] If this is so, then a more complex analysis of benefits and harms might also be required in a network of dependent relationships, which benefits one benefits another.

Where this argument fails may then be in relation to justice. Respect for justice is usually couched in individual terms, especially in the discourse of rights. If a violent patient is restrained primarily to protect the staff, then such restraint might be seen as ''cruel and unusual'' in human rights terms.

The emphasis then becomes crucial, because, if the restraint is justified in terms of benefit to the patient, then the restraint is understood as a necessary though a painful treatment, and not a violation of human rights. Also, regarding protection of others, the restraint can only be seen as cruel and unusual if it is a disproportionate response to the harm being prevented. The question is whether and to what extent discussions about justice, and respect for justice, can accommodate both a more communitarian vision of autonomy, and proper prevention of exploitation of the vulnerable. The vulnerability of forensic patients is often overlooked because of their frightening behaviour, but they are rendered extremely vulnerable because of their mental disability, and also because they are detained against their will.

The issue of justice clearly presents forensic psychiatrists with a non-medical role as well, illustrating why the general medical code of ethics fails to take into account the diverse considerations applying to forensic psychiatry. Patients might argue that they are being denied justice because they are made subject to punitive measures such as restraint, seclusion or compulsory treatment. Staff might argue for justice in terms of seeking protection from serious assaults. Members of the public and likely victims would argue for justice in very similar terms. It is the job of the forensic psychiatrist to balance these competing claims to justice when arriving at a clinical decision. Perhaps the closest analogy within the medical profession would be the decisions taken by a doctor managing patients with infectious or communicable disease, where in some cases the patient's illness may pose a risk to others.

### Conflicts of interest and ethical principles: to whom is the duty of care owed?

The Declaration of Hawaii, as approved by the General Assembly of the World Psychiatric Association in Vienna, states that a patient can be given forcible involuntary treatment only if ''serious impairment is likely to occur to the patient or others'' without it. In England and Wales, there is legislation that gives psychiatrists authority to treat patients forcibly against their will if they refuse treatment, specifically where the act of refusal is a product of the patient's disordered mental state. The necessary elements here are the evidence that treatment is in the patient's ''best interest'' and reduction in risk of harm to self or others.[18 19]

However, available guidance does not address the impact of repeated forcible treatment on not only the patient, but also on the relationship between the patient and the health care professionals, and on the professionals themselves. Most people who enter the caring professions seek to help patients, and do them good; to this extent, the healthcare professions are somewhat idealised. It is often painful and distressing to staff to act in ways that the patient clearly experiences as harmful and even malevolent.

It may be little comfort in such cases that the staff have acted legally insofar as they have not been negligent according to their professional standards. According to the good medical practice guidelines of the General Medical Council, a doctor would be acting unprofessionally if he did not have the care of the patient as his ''first concern''.[20] However, the guidelines are silent on what needs to happen when the care of one patient conflicts with the care of another. This is the situation in the case of the 32-year-old patient, where the medical practitioner has multiple ''first concerns'' as he is also responsible for the welfare of the other patients on the ward. If the doctor always puts other people's concerns first, then who will attend to the interests of the patient, especially those patients who are perhaps ''unattractive'' or frightening to others? The relationship between the forensic psychiatrist and the patient is particularly vulnerable because of this ''two hats'' problem, in which the distinction between therapeutic authority, and coercion on behalf of others can get increasingly blurred.[21]

If the basic medicomoral objective for doctors is to benefit patients with least harm, then, arguably, forensic psychiatry must sometimes part company from medicine, as the forensic medicomoral objective is said to be, primarily, the protection (benefit) of the public by controlling patient behaviour. If this seems unlikely, it may be thought provoking to consider the words of an English Home Office Minister to a forensic psychiatrist: ''Don't expect the public to pay your salary if you don't protect the public''.

Where does this leave the practising forensic psychiatrist, when faced with ethical dilemmas of the type mentioned in this paper? The American Academy of Psychiatry and the Law endorses the following definition of forensic psychiatry, as adopted by the American Board of Forensic Psychiatry:

> Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters….[22]

The forensic psychiatrist thus practises his subspecialty at the interface of two professions, medicine and law. The highest concern for law would be justice, which is one of the four ethical principles in the practice of medicine. We argue that in cases of ethical conflict within the four-principles approach, the principle of justice would be the broadest and fairest principle to adopt for the forensic psychiatrist. This concept of justice would incorporate not only justice for the patient, but also justice for society. In that sense, it will be a departure from a purely medical role. It is here that a special Code of Ethics for forensic psychiatry might have some use.

## CONCLUSIONS

These cases highlight some ethical dilemmas common in forensic clinical practice. We would also argue that, although the four-principles approach may work well in the context of traditional dyadic doctor–patient relationships, it has limitations in the forensic domain: firstly, because the principles are often in conflict with one another; secondly, because the forensic psychiatrist may have duties to third parties other than the patient, which are not covered by the four-principles approach; and, lastly, because forensic practice requires special attention to justice.

(1) We would also stress that the principle of autonomy, while still important, is probably less relevant in forensic psychiatry compared with other medical disciplines. This brings us to the question of whether forensic psychiatrists are morally justified in trying to compulsorily treat mentally disordered offenders posing a risk to others, and whether their needs would be better served by the normal prison system without any attempt at treatment. The greatest irony of the situation is that the subject himself is often a victim of abuse in his/her earlier years when society has failed to offer him/her the protection when he/she was most in need of it. This is taken into account by the courts who consider the level of responsibility of a mentally disordered offender to be less than that of a criminal with no mental disorder. Treatment of the mental disorder through forensic psychiatrists as agents of society is one way for society to repay some of its debt to these individuals. Consequently, society could also benefit from the resultant reduction in risk after treatment. Eventual liberty for the patient would help to balance the effects of loss of autonomy. This is a way of resolving the medicomoral dilemmas described in this article and also satisfies the broader requirements of justice.

(2) One of the dangers of forensic psychiatry as a speciality is the scope for possible abuse of power as agents of the state, thus destroying the basic trust inherent in the doctor–patient relationship. This situation has arisen in certain countries like the former Soviet Union.[23–25] The authors take the view that the highest ethical principle of all is the individual clinician's duty to maintain life, both that of the individual patient and that of other patients, staff, visitors and the general public. The need to balance such principles makes the dual requirements of therapy and security not seem incompatible, but rather complementary.

(3) It may be that a specific code of ethics for forensic psychiatrists would be of help. This would also assist general psychiatrists, especially those who work with patients who are detained. Such a code of ethics exists for general psychiatry in other countries,[26] and there have been calls to develop such a code for British psychiatry.[27] A specialist code might be helpful insofar as it would open-up discussion about cases like ours, which have traditionally received little bioethical analysis. This issue was discussed at the Royal College of Psychiatrists' Faculty of Forensic Psychiatry Annual Conference.[28] However, it might be argued that codes or statements may encourage a rigid approach to analysis, which may not do justice to the complexities of individual situations. In this context, it might be mentioned that the American Academy of Psychiatry and the Law publishes Ethical Guidelines for the Practice of Forensic Psychiatry.[22] These include comments on the limitations of medical ethical guidelines in forensic psychiatric practice on issues like confidentiality and consent. The last issue mentioned in the Code is on honesty and striving for objectivity, but that refers more to the forensic psychiatrist providing an honest and objective opinion to the Court even though he might be instructed by one side or another, as opposed to the dilemmas in the case of a detained patient.

These cases serve to illustrate that there are domains of medicine, which need specific ethical analysis not found in the usual account of bioethics. Some American commentators have recognised this and concluded that forensic psychiatrists cannot operate within a framework of medical ethics.[29] However, it is by no means certain that forensic psychiatrists as a group would want to come out of medicine and call themselves forensicists, where one is not acting as a doctor and therefore can be involved ethically in giving any kind of evidence in court without any consideration for patient welfare. Such an extreme position is unlikely to be acceptable to most forensic psychiatrists in the UK, particularly as medicolegal advice provided by the forensic psychiatrist to the courts is primarily based on medical and psychiatric knowledge and expertise. The same view has recently been expressed by the Royal College of Psychiatrists in a Council report dated June 2004.[30] We take the view that a code of ethics reflecting a balance between beneficence and justice would go a long way towards offering a framework on which to base forensic practice.

## Authors' affiliations

**Piyal Sen,** Priory Secure Services, Department of Forensic Psychiatry, Chadwich Lodge, Milton Keynes, UK
**Harvey Gordon,** Oxfordshire Mental Healthcare NHS Trust in Forensic Psychiatry, University of Oxford, Oxford, UK
**Gwen Adshead,** Broadmoor Hospital, Crowthorne, Berkshire, Harvey Gordon, Oxford Clinic, Oxford, UK
**Ashley Irons,** Capsticks Solicitors, London, UK

Competing interests: None.

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