

# **Ethical Considerations and Political Abuse Within Forensic Psychiatry**

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## **Introduction**

The traditional and fundamental values within the medical profession take on a vastly different light when considering the unique challenges that materialise within the ever-expanding field of forensic psychiatry. It is a field brought to being through controversy and contention, and exists within modern medical discourse as a practice seemingly still rife with incoherence, largely due to its straddling of the personal and political spheres. Whilst traditional ethical dilemmas abound, the added burdens of treating criminality open up broader and even more complex sets of ethical questions, whilst providing greater scope for abuse and exploitation. Despite this inherent quandary, there has been insufficient discussion of these fundamental matters. As such, an appropriate and relevant framework of ethics has not yet been settled upon within forensic psychiatry, in sharp contrast to other medical practices (1).

## **The Competing Roles of Autonomy and Beneficence**

The role of the doctor is often defined according to its underpinning ethical principles as defined by Beauchamp and Childress: justice; beneficence; non-maleficence and autonomy (2). Often, a dilemma which presents itself in medical practice is one caught between the two poles of beneficence and autonomy; the difficulty in supporting a patient's right to make their own decisions contends with the medical knowledge of the consequences of those choices. Traditionally, doctors undertook a more paternalistic role, in that the apparent best outcome for the patient, the duty of beneficence, would overrule patient choice, the right of autonomy. However, more recently, this has developed into a greater stress on autonomy with the creation of an equal partnership between doctor and patient, an attitude cemented by the General Medical Council as a pillar of good medical practice (3).

## **Autonomy**

In order to explore these opposing roles, an understanding of the concept of autonomy is fundamental. Kant is often thought of as the father of moral autonomy, and his theories on the human condition can be used to understand the importance of autonomy as well as the relationship between doctor and patient (4). Kant views all rational humans as bound by the same common moral law and therefore as equal and deserving of respect and dignity by all other rational humans.

However, Kant's conception of autonomy is based upon rational decision-making, which begs the question of whether irrational decisions can be considered autonomous. If irrational decisions cannot be considered autonomous, this poses the idea that the state may be given the power to force individuals to live their lives in a completely moral and rational manner. The great variety in moral ideas across individuals would make this prospect impenetrably complex and indeed, most would view, oppressive. Within the broader concept of personal autonomy, a principle which does not consider the rationality or morality of the act, the decision is value-neutral and thus forms the basis for current medical ethical understanding of the term. However, the principle of personal autonomy also poses difficulties, particularly within the context of mental illness (5).

The conflict between autonomy and beneficence presents itself far more sharply within the realm of psychiatry, where its balance is fundamentally altered with legislation allowing health-professionals to over-ride a patients' decision making. The paternalistic nature of psychiatric treatment again derives its power from a precedence bestowed upon beneficence. Accompanying this is the perceived defence that the principle of autonomy is not compromised by the patients' lack of capacity. This coercion, occasionally forceful, involved in the treatment of some psychiatric patients, competes with the ideal of beneficence many patients and doctors expect from the medical profession, creating immeasurable difficulties for the psychiatrist in maintaining the classical role of a doctor. Nonetheless, beneficence is commonly used as a justification for the countermanding of patient autonomy. This justification both assumes a correct medical understanding of what defines mental illness as well as a lack of capacity in psychiatric patients. The presence of a mental illness, which underpins the legislative powers of the psychiatrist (6), although superficially seems simple to define, is in fact monumentally complex, as the definitions of mental health conditions are not set in stone and indeed change often and vary vastly across the world.

Even viewed through a traditional lens of mental illness, a patient's mental illness does not infer a lack of capacity. Historically, it has been argued that the refusal of psychiatric treatment is not a valid decision due to the patients' lack of insight. The mental illness has removed the ability to introspectively recognise that they are ill, and therefore has also removed their ability to understand the risks and benefits surrounding treatment. Hence, the rights of autonomy do not apply as the mental illness has already taken away the capacity for autonomy (7). Taking the definition of insight as the ability to recognise one's experiences as pathological (8), the possession of insight is therefore intimately related to the patient's and doctor's beliefs surrounding their experience. Therefore, insight may be viewed simply as the patient conforming to the doctors understanding of what constitutes mental illness, and thus is inherently value-based.

The intrinsic value-laden nature of mental health assessment can also be demonstrated by considering the case of anorexia nervosa. When assessing the formal reasoning of a patient with anorexia nervosa, studies have not definitively found impairment of formal reasoning (9). Rather, it is the values with which they make their decisions which is disordered; the preference of losing weight over life. Their perceived impairment of capacity is therefore not due to their conventional mental reasoning but the abnormal and harmful prioritisation of moral values which have been altered by the alleged disease process. As such, the mental condition is considered a disease because of the change in values it engenders (5). This is not confined to eating disorders, with recent research suggesting that even with severe mental illness the majority of patients are still able to make competent complex medical decisions (10). If patients with mental illnesses previously thought to lack capacity in fact maintain capacity, albeit perhaps according to a set of modified value judgements, this poses serious difficulties for the defence of beneficence in abolishing their autonomy.

### **The Role of the Forensic Psychiatrist**

Although these questions of autonomy and beneficence also form the ethical bedrock of forensic psychiatry, the dilemmas are made even more complex through their inextricable relationship with those within the justice system. One of the key foundations of the justice system remains that of innocent until proven guilty (11). Indeed, due process and fair trial are global markers of a fair and equal society and furthermore, their absence represents a violation of basic human rights as described by the UN Declaration (12).

Within the field of forensic psychiatry, the founding principles of the judicial and medical systems appear increasingly blurred, for example with the prospect of preventative detention, a solution applied to dangerous severe personality disorder suggested by the UK government (13). This presents itself as immensely problematic when one considers that the implications appear directly contradictory to the pillars on which our justice system is based. Pushing medical practice into this ethical grey area has its precedence in the USA, where their Supreme Court stated in 1997 that “states have a right to use psychiatric hospitals to confine certain sex offenders once they have completed their prison terms, even if those offenders do not meet mental illness commitment criteria” (14). In such a scenario, psychiatric hospitals have been subverted from their supposed goals of the treatment of mental illness to their use as a method of wrongful incarceration. As medical explanations for supposedly deviant behaviour have become predominant in understanding and treating patients who pose an ongoing significant risk to society, so has responsibility increasing fallen to forensic psychiatrists to detain and manage those individuals too (15). The medical justifications for detention within forensic psychiatry are therefore incredibly complex where decisions are made with greater focus on society, rather than the welfare of the patient.

These circumstances therefore, again bring into focus the role of the doctor in psychiatry. Their paternalistic role is further exemplified within forensic psychiatry, as the psychiatrist takes on the role of arbiter and avatar of the wider “system” against the deviant or aberrant individual. Indeed, even the universally, presupposed, foundation of the therapeutic relationship, trust, does not exist within this sub-speciality, as scepticism instead becomes fundamental. For the patient, this lack of trust results from the doctors’ role as their incarcerator, and for the doctor, this derives from the patient being coloured by actions deemed morally reprehensible and perhaps, a fear for their own safety. Although these dual, competing responsibilities seem unavoidable for forensic psychiatrists, these patients are perhaps the most vulnerable and in the greatest need of functional attachments and relationships (16). If the psychiatrist is asked to not only support and care for their patients, but in addition, consider wider society too, their role as a doctor in society could be called into question where balance is unattainable. This raises the fundamental quandary of whether the ethical dilemmas discussed can be remedied whilst two conflicting responsibilities are merged within one specialty (17).

### **Confidentiality within Forensic Psychiatry**

This role of the forensic psychiatrist as both the defender of their individual patients as well as society as a whole impacts every facet of a doctors responsibilities. For example, confidentiality which is now of the utmost importance becomes a difficult question: what rights do forensic patients have to confidentiality? Confidentiality is defended, both as a theoretical ethical principle and as a professional responsibility (18), as paramount to the trusting relationship between a doctor and their patients, and therefore, fundamental to the therapeutic agency of a physician. This is of even greater importance within psychiatry, where a patient must disclose deeply intimate and potentially stigmatising elements of themselves to their doctor.

This dissemblance of the importance of confidentiality within forensics is exemplified in a Canadian case where a psychiatric report was made public by a judge who deemed transparency to be of greater importance than the accused’ right to confidentiality (19). This irrevocably damaged the relationship between the patient and doctor, but also the relationship that this patient, as well as all future patients, would forever have with the judicial and medical systems.

Indeed, this case demonstrates that the most comprehensive and competent forensic psychiatrists can be of the greatest danger to the patients under their assessment. Under one definition, the greatest doctor is the one who can create the best rapport with their patient, gaining the most information, and therefore increasing the likelihood of a correct diagnosis and effective treatment. However, whilst out-with forensics this can be upheld, a better rapport within the judicial system is more likely to result in self-disclosure and even incrimination on the part of the patient, therefore resulting in a greater risk of incarceration, perhaps indefinitely. The assessment report in such a case, would not be in aid of their patient, but the courts and judicial system. Rather than upholding the paradigm of the medical profession: "first, do no harm" (20), the ethical root of the judicial system, truth, becomes foremost for forensic psychiatrists. Furthermore, the assessment reports forensic psychiatrists write do not deal only with ever changing medical terms of diagnosis and treatment but of problematic legal terms such as "insanity", which contribute to the ongoing stigmatisation and detriment of their patients (21).

The question of confidentiality is not only of interest to the doctor and their patient but of interest to politicians and the electorate, for the question ultimately comes down to the competing interests of patient and public welfare. Given that forensic psychiatrists are duty bound to over-ride their responsibility to their patients in order to protect the public, this proposes that public welfare is of higher importance compared with that of their patient, contrary to the traditional ethical principles of medicine.

### **Psychiatry and the State**

The ultimate power for detention lies at the state level in mental health legislation, thereby enabling the potential for state manipulation into the definition and treatment of mental health patients. Through its governance in law, the final decisions about psychiatric patients therefore, lie not with doctors but with politicians and in democracy, the electorate. This is particularly prevalent within the field of forensic psychiatry which amasses huge media and public interest. Allowing politicians to control the treatment and detention of psychiatric patients with the most serious crimes explains the role of societal perception in their medical management. The first duty of care of a politician is not to the patient, but to serve society, and perhaps more pragmatically phrased, those within it that constitute their electorate.

The role of politics within forensic psychiatry can be traced back to its very inception, where even the specialty of psychiatry in general, was, in places adopted and utilised by the state for the purpose of policy making and treating prisoners. Therefore, in addition to the ethical differences between the roles of psychiatrists and other doctors, their origins are completely different. The role and place for the traditional doctor arose at the beginning of civilisation as a result of a basic need for medical care (22), while the development of psychiatry has historically emerged from a more abstract and contemporaneous need in the industrial, urban political community (23). Further to this, the modern social climate plays a huge role in psychiatric diagnoses and treatment which removes psychiatry to an even more acute degree from the traditional role of the doctor, which classically deals with illnesses with a clear organic basis. The lack of clear-cut boundaries and understanding of psychiatric illnesses leaves the speciality open for supposition, interpretation, and ultimately, abuse and manipulation.

For politicians, their ostensible duty is to serve society, based upon a civic, democratic understanding of public opinion. This duty, more often than not, assumes superiority to their duty to

an individual patient, whilst the perhaps self-serving nature of politics further obscures the reasons behind the detention and treatment of psychiatric patients. Therefore, if the treatment of forensic patients is not determined by the ethical principles underpinning the medical profession but rather the values of the general public and elected politicians, an understanding of the principles which underline public opinion is necessary to examine the treatment of these patients. First, it is important to consider where the fear of the mentally ill within the public stems from- often, from the perceived dangerousness of those afflicted by mental disorders. Indeed, this belief is the foundation of much of the current legislation and ethical decisions within psychiatry, with the principle “risk to self and/or others” being the grounding concept (6).

### **Public perception of Mental Illness**

A huge contributor to the perception of people with mental illness is the coverage given by the media where people with mental health problems have been both currently and historically treated as dangerous. A study from 1969 in Edinburgh revealed that a third of people thought that mentally ill persons were dangerous (24). This is most commonly explained by the perceived association between mental illness and violence. Despite the actual rarity of violence linked with mental illness, there is often massive sensationalising of such events by the media, creating the impression that violence is more prevalent than statistics would indicate. For example, a Health Education Authority examined media coverage concerning people with mental health problems and discovered that 46% involved violence, clearly fuelling a raft of misguided conceptions surrounding mental illness (25). The media are fascinated by, and convinced of the selling power of, the exciting, terrifying prospect of the violent, deranged misfit, and often do so by creating stereotypes of mental illness; exaggerating symptoms and the fear surrounding the event. These stereotypes over time lead to great, almost irrevocable stigmatisation of those with a mental disorder, as many people have no real personal experience to challenge media coverage. As previously discussed, the significance of public opinion in mental health is partly through its resultant legislative agenda, but Monahan and Arnold describe the wider, and more abstract impact of such perceptions in the “informal responses and modes of interacting” (26) with those perceived as having a mental illness.

The story-telling aspect of media coverage surrounding mental health does not only concern the individual with mental illness, but also health professionals involved in their care. The typical story that is portrayed in the media often describes a scenario that implicates the health care professionals or law-makers for inadequate controls to prevent the violence perpetrated by those with mental health conditions. This is often the result of “a commonly held belief that mental health professionals have an expertise in predicating and managing dangerousness contrary to the empirical studies” (27). This may create an environment where health care professionals and politicians are overly restrictive and cautious in their management of persons at risk of violence in their care.

Despite this, it would be a mistake to place sole blame on the media for the knowledge of mental illness in society, as often, the media is simply reflecting current public opinion within their narratives. Holding the media solely accountable for the current understanding of mental health and violence also suggests that we as individuals and members of society are not responsible for changing such attitudes. One of the difficulties faced within forensic psychiatry is that the risks of violence that health care professionals find acceptable in their patients’ may be different to the level of risk that the general public find acceptable. There is no correct objective level of risk, therefore, the difference in opinions between the public and professionals may simply be a difference in

values. However, if those values are based on misguided information, then it should be a responsibility for professionals to change those perceptions so that society can make informed decisions about the care of the mentally ill (28). This responsibility is brought to the fore by asking if it is ethical that patients are treated based on the stigma found within the general populace rather than the ethical principles of medicine, a discipline founded by great philosophical debate? Furthermore, does every person, regardless of their crime, not deserve treatment that is protected from the scientifically and ethically disinterested personal ambitions of politicians?

In addition to the ethical questions that are posed by political control of psychiatric patients, the risks that the political control of psychiatry poses have been horrifically played out throughout history, through politicians abusing those powers for political gain.

### **Political Abuse of Psychiatry**

The Global Initiative on Psychiatry states that “political abuse of psychiatry refers to the misuse of psychiatric diagnosis, treatment and detention for the purposes of obstructing the fundamental human rights of certain individuals and groups in a given society” (29). It is often difficult to elucidate the division between political abuse of psychiatry and simple misuse of psychiatry, particularly in recent times, as cases are often complex and government involvement is less obvious than previously. Political abuse of psychiatry appears to be a simple matter; the use of medical practice for the intention of the oppression of citizens. In a clear scenario of political abuse, it is fairly simple and indeed, is universally deplored, along with other human rights atrocities explaining why regimes often attempt to hide their abuses (30). However, the definition of political abuse is difficult particularly due to the place that culture plays in the specialty. There is no universally accepted classification for psychiatric illness and understanding of illness differs across different societies. This is evident currently in the differences between the two main classification systems of psychiatric disease found in Europe and the United States despite much shared intercontinental culture and understanding. In an even wider setting, there are those, such as Szasz, who describe mental illnesses as “human problems”, broadly denying their very existence (15). The presence of psychiatric illness is the keystone upholding mental health legislation, maintaining the narrow bridge between psychiatric treatment and wrongful incarceration. For example, although incarceration for religious or political beliefs is illegal in many countries, if a mental illness manifests itself through the expression of religious or political beliefs, treatment may be justified. This is a relatively common but complicated picture, and if there is difficulty in assessing what constitutes a mental illness and therefore the foundation of our mental health acts, the assumption of beneficence can no longer be guaranteed. Therefore, there is the potential for well-meaning psychiatrists to perpetrate political abuse using their understanding of psychiatric illness within oppressive societies.

### **The History of Political Abuse of Psychiatry**

Political abuse of psychiatry became an increasingly important issue in the 20<sup>th</sup> century, mainly due to the actions of the Soviet Union in dealing with political dissidents. The ability of the state to manipulate the diagnostic criteria of psychiatric illness is exemplified during this period with the advent of “sluggish schizophrenia”. This diagnosis was created by the Moscow School of Psychiatry, in collaboration with the KGB, to be used for individuals unhappy with the political regime. However, the abuse of psychiatry is not confined to the Soviet Union, and is seen across other authoritarian regimes, particularly the socialist-oriented. This may be explained by the disparity between the

perceived utopian society created under Socialism and unhappiness in their citizens. Unhappiness in such a utopia, therefore, could only be due to mental illness. Although the creation of sluggish schizophrenia was most likely by the Soviet government, the disease is thought to have been accepted by most psychiatrists in Russia at the time, as it explained the seemingly illogical actions of political dissidents. Sluggish schizophrenia incorporated even persons with mild symptoms and normal social functioning into its confines. Political ideas of societal reform were refashioned into paranoid symptoms and grandiose delusions. This enabled potential trouble-makers to be incarcerated in psychiatric hospitals before festivals in Communist Russia and Romania to avoid political embarrassment (30), perhaps akin to the removal of the homeless in Windsor before a royal wedding (31).

More recently in Russia there has been much debate surrounding homosexuality, with resultant legislation being enacted to criminalise support for such relationships. This legislation is supported by much of the Russian population; a poll in 2014 by the Pew Research Centre discovered that almost 75% of the populace supported the ostracization of homosexuality (32). In fact, homosexuality remained classified as a mental disorder until 1999 in Russia and the removal of its medical status reflected changing societal attitudes, further cementing the position of culture in psychiatric diagnosis. Recent political action against homosexuality by Putin suggests an attempt to reclassify it as such, reminiscent of Soviet Russia's use of psychiatry to demonise non-traditional behaviours and dissident attitudes (33).

Although Soviet Russia is often taken as the prime example of political abuse of psychiatry and certainly gained the greatest attention, political abuse of the speciality began with the birth of psychiatry itself. Asylums were originally a method of relocating and incarcerating those deemed "deviant" for their behaviour or morality, such that prostitutes or orphans were almost as likely to be shoved away there as someone truly suffering in a contemporary sense (34). Slaves who escaped from plantations were thought to possess "drapetomania", a condition which neatly accounted for why an "inferior" black individual would abandon the "civilising" effects of Western society (35). The government of the Third Reich employed scientists to scientifically prove the mental inferiority of Jewish citizens, thereby justifying eugenic policies (36). Medicalisation of deviance has been used throughout the ages by the ruling classes to perpetrate injustices (30). It is therefore imperative that psychiatric illness and treatment is rooted in a clear evidence base without interference of political ideas.

### **Current Abuse of Psychiatry**

It is easy, in the Western world to pretend that the political abuses of psychiatry that have taken place in recent years in the People's Republic of China and in Russia, play no part in the current superficially ethical practice in the UK or the US. For example, in the United States, a much sharper scrutiny has been placed at the role that detainees' health information has played in interrogation practices at the infamous Guantanamo Bay (GTMO). There are suggestions it is used by interrogators to carry out what has been described by the International Committee of the Red Cross as "cruel and inhuman treatment, even torture". The US Military had consistently denied that health information was used in Guantanamo Bay, and indeed a 2005 inquiry concluded that "access to medical information was carefully controlled at GTMO" (37). However, further inquiries deduced that health information was routinely accessible to personnel responsible for inventing and implementing interrogations at GTMO. Indeed, health information was not only used by interrogators to manipulate detainees but health professionals such as psychiatrists were also involved in creating

conditions of extreme stress for detainees to extract intelligence. A US policy statement confirmed these findings by stating that communications from “enemy persons under US control...are not confidential” (38). The statement illustrates the perceived responsibilities of medical professionals to disclose all information about detainees to United States personnel, with the only limit on their role in intelligence being that they cannot act as interrogators. It requires that medical personnel provide information, not only on request, but actively provide any that may be perceived to be relevant. This results in doctors becoming responsible for reporting sensitive information, breaching confidentiality, to an unlimited number of non-essential third parties (39).

As demonstrated in the case of Guantanamo Bay, the idealised role of the Western medical professional as healer appears much changed by its inclusion into the network of military and intelligence structures. Rather than providing treatment to an incarcerated patient, the physician assists and improves the methods of interrogation and torture, disregarding all of the ethical principles a doctor is required to uphold. Further to the disregard to the ethical and legal responsibilities of medical professionals in the United States itself, this is in complete disregard to the Geneva Convention, the core of international humanitarian law. The Geneva Convention states that medical professionals “shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics” (40). Although confidentiality is not an absolute within any area of medicine, it forms the bedrock of all medical practice and as such, should not be violated except by great need. Systemic abandon of confidentiality for the development of interrogation methods, which are themselves, illegal and atrocious human rights violations, does not qualify as great need. Furthermore, the contempt shown by the US Military for the human rights of its detainees as well as the medical profession may pose a much greater danger to the United States and its citizens than the potential intelligence gathered by such methods (39).

The horrors that occurred during the Soviet Union’s political abuse of psychiatry resulted in psychiatrists across the globe examining their current understanding of medical ethics and how that applied to their specialty. The first evidence of such a movement was in the creation of the Declaration of Hawaii which defined the responsibilities of all physicians and an ethical code of practice (41). However, this is an ongoing process and forensic psychiatry in particular remains what has been described as a “moral minefield” (16). It is a speciality that is unique in its public attention and particularly emotive subject matter. We need to continue to be aware of political abuse of psychiatry as it becomes increasingly guised and hidden behind cloaks of bureaucracy to ensure that the treatment we give to the mentally ill is without bias and upholds the ethical principles of medicine. The ultimate roots of psychiatric abuse, with the repression of political and religious dissidents being the most obvious mark of distorted psychiatric care, reflect an understanding of psychiatric illness which encompasses all nonconformist thinking. Political abuse of psychiatry is at its base, a use of social power to dampen thinking at odds with societal norms. However, the impossible intricacies of separating mental illness from societal influence is evident currently even within relatively uncontroversial psychiatric treatment, such as in the management of suicidal thoughts, which is regarded in the majority of cases as a result of mental illness. However, suicidal thoughts are seen by some as the ultimate expression of personal liberty (15). Therefore, if suicide becomes not a symptom of illness, as considered by societal norms, but an expression of personal liberty, psychiatric treatment of such thoughts becomes difficult to justify.



## Conclusion

Psychiatric illness remains difficult to define, ultimately leaving the speciality open to interpretation and abuse. As research continues to develop within the field, and a widening, more holistic discourse emerges around the specialty, it seems possible that a more in-depth understanding of mental health will occur- one with clearer definitions of illness and a smaller scope for manipulation. Whilst this body of knowledge grows, psychiatrists themselves should ensure that their work is not coloured by cultural or ideological beliefs, or dictated by political demands, and is instead fully backed by defined ethical principles and a system of well-rounded empirical evidence.

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