Any discussion of contemporary child and adolescent forensic psychiatry will eventually encompass considerations of the ethical underpinnings of this work. Ethical issues arise inevitably in clinical work with children and adolescents and are even more likely to surface in forensic settings.

The term ethics refers both to a "series of moral principles that govern a person's or group's behavior" and to "the branch of knowledge that deals with these principles." Codes of personal ethics are at least as old as the Ten Commandments, and codes of medical ethics have been a part of civilization since at least the Oath of Hippocrates. Contemporary medical and psychiatric practices are grounded in ethical codes of the major membership organizations corresponding to these areas of practice.

Medical and Psychiatric Ethics

The overarching ethical code for clinical medical practice in this country is embodied in the American Medical Association's Principles of Medical Ethics (2001). As a reflection of the fact that the fundamental ethics concepts under which we operate do not much change but periodically require supplementation to cope with changing circumstances, the 2001 revision consisted of certain additions to the original seven principles as well as two new ones. One of these--that a physician caring for a patient shall "regard responsibility to the patient as paramount"--may have
some particular ramifications for forensic psychiatrists.

For years, the American Psychiatric Association's ethics approach piggybacked on the AMA's principles (APA, 2001). It incorporated the AMA's Principles and coupled them with numerous judgments, posed in Q&A format, about ethical issues commonly encountered by psychiatrists in practice or in research. Both the AMA and the APA supplement these documents with ethical judgments on issues that arise as a result of changes in society, such as the ethical use of e-mail by a physician. These opinions are available on the Web sites of the respective organizations.

**Child and Adolescent Psychiatric Ethics**

The Code of Ethics of the American Academy of Child and Adolescent Psychiatry (AACAP) is the third pillar on which the ethical practice of clinical child and adolescent psychiatry rests (AACAP, 2005). As physicians and psychiatrists, members are bound by both the AMA and APA guidelines. The AACAP Code attempts to refine and clarify these principles because of the uniqueness of the child as patient. Enzer (1985) delineated three aspects of this uniqueness: first, children are dependent but become more independent over time; second, children are uniquely vulnerable both because of their dependency and because of the "potential for intimidation and coercion" by parents and others; and third, despite their vulnerabilities, children and adolescents remain "individual human beings" and, as such, are "entitled to be taken seriously and respected."

In common among all of these codes are the principles of beneficence and non-malificence (to do no harm), from which exhortations to practice competently, show compassion and respect, be honest, safeguard confidentiality, and respect the law all derive. Clinical medicine and psychiatry are almost exclusively patient-centered, so that the patient's needs must be paramount in the thoughts and actions of the ethical physician. Even more care must be taken when dealing with a child or adolescent, because they are in varying degrees dependent and incapable of taking full responsibility for themselves. This leads to the inevitability of the presence of a third party, whether the parents or the state, which complicates issues such as consent and confidentiality.

**Ethics Applied to Forensic Psychiatry**

Forensic work has always occupied a somewhat different space from clinical psychiatry. It is defined in the current ethical
guidelines of the American Academy of Psychiatry and the Law (AAPL) (2005) as a "subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment." Because forensic psychiatrists practice at the interface of law and psychiatry, they may be "called upon to practice in a manner that balances competing duties to the individual and to society."

In other words, forensic psychiatry exists in order to provide expertise to assist courts and related agencies in making decisions. The expertise consists of a great degree of clinical skills, including interviewing and analyzing individuals, which are used to formulate an opinion about an individual. These opinions can encompass issues as disparate as whether a person is competent for trial, fit to be a parent, able to work, or damaged by a particular physical or emotional trauma. Thus, the aim of a forensic evaluation differs from the clinician's job of helping or curing the patient. Furthermore, the forensic evaluator's primary allegiance is generally to third party, whether it is the courts or an attorney involved in an adversarial process. As propounded by the AAPL guidelines (2005), the four overarching categories of ethical concern are confidentiality, consent, honesty and striving for objectivity, and qualifications.

One major ethical issue of forensic psychiatry that is not present in clinical practice arises when there is confusion of the forensic and clinical roles. This can happen either when a clinical psychiatrist decides to take on an added forensic role for the patient or when a forensic evaluator allows a patient to slip into a virtual doctor-patient relationship. The former situation may obligate the psychiatrist to violate confidentiality and harm the patient's interests by revealing damaging personal material. If the psychiatrist chooses not to do so, they are violating their ethical obligation as a forensic psychiatrist to tell the truth. In the latter situation, the forensic clinician may violate their obligation to secure truly informed consent by using their skills, even inadvertently, to lull the patient into a false belief that confidentiality will be preserved when it will not be. Again, information could be revealed that a fully informed individual might wish not to divulge.

Strasburger et al. (1997) characterized these and other moral dilemmas as arising from a situation where the psychiatrist is wearing "two hats": that of physician, where the primary allegiance is to the patient and, at the same time, that of objective
evaluator with a primary allegiance to another party. Because of the incompatibility of these two roles, the authors strongly encouraged the psychiatrist to avoid the situation if at all possible. For a fuller explication of these themes with some historical background, see also Ratner (2002).

**Forensic Child and Adolescent Psychiatry**

As is the case with adult forensic psychiatry, forensic practice with children and adolescents revolves around various kinds of evaluation and testimony. However, the types of evaluation generally performed are unique to this age group. Custody and related matters, including relocation, termination of parental rights, parent evaluations in cases of abuse and neglect, and foster care and adoption, are the most common focus of involvement with younger children. Evaluations of suspected sexual abuse also fall within the forensic sphere. Evaluations related to juvenile justice are more common with older youth. These include evaluations for competency to stand trial, criminal responsibility, waiver or transfer to adult court, and evaluations of sexual offenders. Perhaps the most common is the post-adjudicational hearing, which focuses on the best disposition for the youthful offender.

What makes these types of evaluations unique is the fact that the individual at the center of them is not yet an adult. The entire notion of custody is based upon the fact that a child is dependent and of an age when they are unable to care for themselves. Juvenile justice is also unique in that its aim, at least officially, is the rehabilitation of the youthful offender rather than punishment. Because a child or adolescent is presumed by society to be less than fully responsible for their actions, they are seen both as needful of the support of competent parenting figures and, if having offended, the substitute parenting of the state.

Custody issues are often hotly contested and, depending upon how they are involved, psychiatrists must be careful about their ethical obligations. The outcome of such a hearing is likely to be that the child is placed under the control of one or another adult parent or parent surrogate. It is thus crucially important for any psychiatrist involved in the evaluation to act in a fully ethical way. For example, if a psychiatrist is attempting to perform a custody evaluation, good clinical practice requires that they interview all parties before attempting to make a decision (Weintrob and Nye, 2003). If this is not possible, they are required by the ethical precepts of honesty and objectivity to make clear that one or more individuals could not be evaluated.
Generally, it is unethical to opine about the fitness of parents that one has not seen. If one is performing an evaluation under the auspices of one or another parent as opposed to being employed by the court, the danger of coloring one's opinion in the direction of the hiring parent is heightened. Ethical considerations prohibit tilting toward one parent or another for any reason other than the child's best interests.

Regarding the evaluation of youthful offenders, to the degree that juvenile court has remained non-adversarial, the ethical pressures on forensic evaluators might seem to be less than in adult court. The representatives of the state in juvenile court have at least a nominal commitment to the rehabilitation of the offender along with its duty to the public. As a result there may not be as vigorous an adversarial engagement around adjudicative issues, such as competency and criminal responsibility, as one finds in criminal court. Yet the notion of juvenile court as more reminiscent of a benign case conference that an adult court, with all the players putting their heads together to figure out the best disposition for the youthful offender, is rarely realized. The dichotomy of prosecution and defense is present in juvenile court as well, except that it is more likely to crystallize around the dispositional issues.

Unfortunately, too often the only dispositions available to the courts are the so-called state schools, which are little better than adult prisons in many jurisdictions. In situations where this is the case, the real adversarial conflicts take place at disposition rather than at trial. Here, the defense attorney will be attempting to arrange for their client to be released either to home or to an outpatient setting, as opposed to incarceration. The ethical issue for the forensic psychiatrist testifying about disposition involves weighing what is best for the youth against what is good for society. While a potentially violent youth will not be helped and may well be harmed by incarceration in a juvenile facility, the likelihood that they could become violent in the community must also be considered. It would be a violation of the precepts of honesty and striving for objectivity to present unbalanced testimony by withholding information that could change the court's decision.

For juveniles who commit more serious crimes, in states that still mandate transfer hearings, the prosecution will likely make a case for the teen-ager to be waived into adult court (Ratner, 2004). Conviction in adult court leads to a permanent criminal record and, often, incarceration in adult correctional settings. Youthful sex offenders tried as adults will be listed in the
national data bank of such offenders. Worst of all, perhaps, is that nothing worthwhile is gained by sending youth to adult court. Although research in this area is difficult to do, the evidence indicates that transfer increases recidivism, compared to youth retained in juvenile court (Ratner, 2004).

The U.S. Supreme Court has recently relieved child and adolescent forensic psychiatrists of one major ethical concern regarding transfer to adult court: that a juvenile who commits a capital crime while still under 18 might be executed. Prior to their ruling in the case of Roper v Simmons (2005), 19 states had laws allowing the execution of minors of 16 years or older. True, one had to be transferred (or waived) to adult court in order to be eligible for the death penalty in these states; however, it had been getting systematically easier for a juvenile to end up there. At one time, the law required that a juvenile be given a hearing at which a juvenile court judge would decide whether to retain or transfer. However, over the years, some jurisdictions have passed laws allowing transfer to be automatic based on age and the seriousness of the crime or at the discretion of a prosecutor. In states with these procedures, many more juveniles could face adult justice.

Once a youth of 16 or 17 had been transferred to adult court in one of these states, conviction for a capital offense could lead to the death penalty. At the time of Roper, there were 73 such individuals on death row (Davies, 2004).

Roper, however, took the death penalty off the table for anyone, regardless of the seriousness of the crime, who committed it before their 18th birthday. Thus, while juvenile offenders may still get transferred to adult court, they cannot be put to death there. This has proven a great relief to psychiatrists who are ethically opposed to the death penalty in general or for minors in particular. Those who participate in transfer hearings had great difficulty doing so with the realization that transfer to adult court could be tantamount to a death sentence. Those working for the government, and expected to recommend transfer when warranted, were in an impossible position, knowing that their recommendation could lead to death. Defense psychiatrists could be haunted if their efforts to retain a juvenile, later condemned to death, failed or alternatively cause them to withdraw their appearances if their evaluation led them to find little chance for rehabilitation.

These observations can do little more than suggest the contexts in which ethical dilemmas that face the forensic child and adolescent psychiatrist arise. In fact, while ethical principles
remain relatively immutable, specific situations in which ethical problems arise are multitudinous and unique enough that one must be prepared to think through the application of those principles in new and different ways. Practicing forensic child and adolescent psychiatrists must thus remain ever vigilant by keeping a critical eye on their own practices as well as those of others in the field.

Dr. Ratner is clinical professor in the department of psychiatry and behavioral sciences at George Washington University. He is also adjunct professor of law (psychiatry) at Georgetown University Law Center.

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