Clinical Forensic Psychiatry: Settings and Practices

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1.1 Forensic Psychiatry in the UK

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Clinical forensic psychiatry is the evidence-based assessment, treatment and rehabilitation of mentally disordered offenders. In practice, however, 'the forensic patient' is a term which encompasses a broader range of individuals, including those who have not committed an offence but have a mental disorder and are presenting with behaviour considered to be dangerous (relative to their environment) and are at risk of offending (Mullen 2000). Typically, forensic patients are those with chronic and complex mental disorders whose actions, having been wholly or in part influenced by their psychopathology, ultimately pose a serious risk to others. At times, this risk of harm is also extended towards themselves. Specialist forensic settings and services provide a greater degree of security and more intensive interventions in order to manage these risks and support the individual towards recovery and rehabilitation.

Detaching from the labels which link 'mad' behaviour with being 'bad' or 'evil' is arguably the biggest battle of modern-day psychiatry and perhaps the most challenging one in forensic psychiatry, given the dual stigmatisation of being an offender and having mental health problems (Adshead 2012). Criminology cannot be simply characterised as pathological, nor are all mentally disordered individuals assumed to lack capacity regarding decisions they make to break the law. One key aspect of

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forensic psychiatry is to seek to reconcile when offending behaviour may be linked with mental disorder, with the aim of subsequently both optimising the person's mental health and reducing their risk of further offending, thereby protecting the public.

The laws in the UK appreciate that there can be a relationship between mental disorder and offending behaviour. However, the resulting interplay between criminal responsibility, mental health and the justice system is highly complex. Working in forensic psychiatry requires a comprehensive understanding of the application of the law in that jurisdiction not only from a clinical perspective but also within the context of the criminal justice process itself.

This chapter provides an overview of forensic psychiatry in the UK from a general clinical perspective. With regard to the relevant mental health law, three distinct jurisdictions (England and Wales, Northern Ireland and Scotland) exist, each with their own legislation governing the treatment of people with mental disorders.

Historically, in the UK, it has been the presence of mental disorder and risk which has dictated involuntary detention and treatment for mental disorder. In England and Wales, the Richardson review (1999) acknowledged the impossible reconciliation of the conflict between upholding values of autonomy for those with mental health problems and avoiding potential, albeit rare, risks posed to the public. Richardson's proposal in short sought to justify the detention and treatment of competent patients against their will, providing the caveat was followed that these patients needed to be assessed as presenting with a *higher* degree of risk, compared to patients who lacked capacity (Zigmond 2017). This was rejected by the government who ultimately upheld the maxim that detention and treatment decisions were made according to necessity, not capacity.

However, Scotland's review of its mental health legislation (Millan 2001) concluded that it was necessary to distinguish between incapacity arising from cognitive or physical health problems (including that termed brain disease) and 'significantly impaired decision-making ability' (SIDMA) occurring as a result of mental disorder. The Mental Health Care and Treatment (Scotland) Act manual (2003) explains that SIDMA occurs 'when a mental disorder affects the person's ability to believe, understand and retain information, and to make and communicate decisions. It is consequently a manifestation of a disorder of mind'. SIDMA is a criterion for determining compulsion in the Mental Health Care and Treatment (Scotland) Act.

More recently, Northern Ireland has advanced a new approach by enacting the Mental Capacity Act of 2016 which when fully implemented will repeal the country's separate Mental Health (Northern Ireland) Order of 1986. Described as a piece of 'fusion' legislation, the Mental Capacity Act of 2016 takes a non-discriminatory approach by standardising assessment regardless of whether the illness is of physical or mental origin: 'Impairment of decision-making capacity and best interests are the only criteria to be used when making decisions across health and social care' (Lynch et al. 2017).

The functional component of this legislation's capacity test is more than just a cognitive exercise and seeks to address the interplay between capacity and insight.

At a basic level, insight has been defined as how well the patient accepts that they are ill (Owens et al. 2010). However, clinical assessments of insight extend to include many factors such as insight with regard to treatment. The Northern Ireland Mental Capacity Act requires that the person must be able to 'appreciate' the relevance of the information they have been given as part of their decision-making process. It is therefore this part of the test which may not be met if a person's thinking is affected by psychiatric symptoms that impair their insight into their condition or the treatments available.

Each of the jurisdictions legislates within their respective Acts for patients in contact with the criminal justice system. With regard to the forensic setting in Northern Ireland, although involuntary admission to hospital *can* take place (with necessary safeguards), the individual still *cannot* be treated against their wishes providing they are deemed to have capacity in this regard, making this legislation more progressive with regard to meeting the requirements of the UN Convention on the Rights of Persons with Disabilities (Centre for Mental Health and Capacity Law 2014).

Part III of the Mental Health Act of 1983 (as amended in 2007) in England and Wales outlines provisions for psychiatric assessment and treatment at various points as an offender moves through the criminal justice pathway. With approval from the Ministry of Justice, remanded and sentenced prisoners can be moved between the prison estate and secure hospitals. At the point of sentencing, psychiatric disposal options include treatment in hospital leading to discharge back into the community (the hospital order), as well as the hybrid order. In the latter, where the sentence is not already fixed by law, higher courts can direct the prisoner to hospital in conjunction with passing a prison sentence. For a psychiatrist recommending the hybrid order, this arguably introduces additional ethical considerations regarding potentially offering an opinion on the offender's culpability. In effect, the offender is treated in hospital until which point no further treatment is required resulting in their return to prison to complete their sentence (Delmage et al. 2015). If a prisoner who has been transferred to hospital completes their sentence there, ongoing hospital detention may take place in the form of a hospital order (without any restriction) termed as a 'notional Section 37' in England and Wales. For transferred prisoners with life sentences or indeterminate sentences for public protection (discontinued in 2012), discharge via the inpatient pathway involves both the First-Tier Tribunal and Parole Board.

British psychiatry during the twentieth century was concerned with liberalisation, deinstitutionalisation and building upon community care (Gunn 2004). Forensic mental health services as we know them today began developing after the 1959 Mental Health Act ratified that a mentally unwell person, who was convicted of an offence, could be admitted to hospital for treatment. In 1975, the Butler Report led to the development of 'regional secure units', now referred to as medium secure services (Committee on Mentally Abnormal Offenders 1975), and the Reed Report went on to outline the core principles of secure care (Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services 1992). Recommendations made by the Bradley Report in 2009 noted the unmet

needs of offenders with mental disorders and addressed the importance of integrating liaison and diversion systems between specialist mental health services and the criminal justice system, in order to make sure mentally unwell offenders received parity of care with those in the community (Department of Health 2009).

A reduction in the number of high secure beds and a corresponding increase in medium secure provisions occurred. Data from commissioner guidance in 2013 identified in England that approximately 680 beds were occupied in high secure services, 2800 in medium security and 2500 in low security (Guidance for Commissioners of Forensic Mental Health Services 2013).

Earlier this decade, approximately a third of beds were estimated as being provided by the independent sector in England (Centre for Mental Health 2011a, b). In 2012–2013, England saw 1788 people admitted into hospital using part III of the Mental Health Act of 1983 (amended in 2007) (Annual Report 2013). Whilst forensic units expanded, inpatient provisions overall in psychiatry have reduced in the UK (Galappathie et al. 2017).[1] This trend of increasing forensic beds perhaps indicates a shift back towards focusing upon detention as means of public protection by the reinstitutionalisation of forensic patients (Priebe et al. 2005).

The team in forensic psychiatry is multidisciplinary:

- Specialist nurses with experience in forensic settings.
- Healthcare assistants.
- Consultant forensic psychiatrists.
- Junior doctors—core trainees and higher trainees.
- Clinical psychologists and psychology assistants.
- Psychotherapists.
- Drama and art therapists.
- Occupational therapists and assistants.
- Educational specialists for therapeutic settings.
- Social workers.
- Pharmacists.
- Members of the security department (for inpatient care).

Forensic psychiatry takes place in a variety of settings which can be largely separated into the criminal justice system (primarily prisons), secure inpatient services and outpatient care.

The basic pathway of forensic care is often dictated by the ease of access to psychiatric services in these settings. For instance, a person may come to the attention of healthcare professionals whilst in prison which leads to them being assessed by a forensic psychiatrist and ultimately transferred into a secure hospital. At a later date, following successful rehabilitation back into society, the individual may remain supported by a forensic community team.

[1] Figures depicting the use of the Act in England in 2016–2017 are not mentioned here as they have been acknowledged as unreliably low due to incomplete data submission from healthcare services (NHS Digital Mental Health Act Statistics 2017).

1.1.1 Criminal Justice System

Forensic psychiatry aims to identify, assess and treat individuals who are mentally unwell at any point that they come into contact with the criminal justice system. Where appropriate, this includes organising the diversion of those individuals into other suitable treatment settings such as secure hospitals or liaising with relevant community services.

1.1.1.1 Police and Court Diversion

At police stations, police officers on site or attending health professionals may raise concerns about an arrested individual presenting with symptoms of mental disorder. The types of concerns could range from questioning unusual behaviour associated with the alleged offence to general agitation or distress with expressions of suicidality in custody. By alerting psychiatric and approved mental health professionals on duty to complete further assessments under the auspices of mental health law, in England and Wales, this can result in the individual's transfer into psychiatric hospital. In practice, only prisoners with lower level offences will be bailed into standard locked wards or psychiatric intensive care units (PICU) within general adult inpatient services. Where the degree of the alleged offence is more serious and indicative of a need for a greater level of security to contain the individual, there is often difficulty in admitting 'out of hours' to secure units. Consequently, it is more common for the offender to be transferred to a prison on remand, with the recommendation that an urgent forensic psychiatric opinion be sought.

Mentally unwell offenders may also come to the attention of local Criminal Justice Mental Health Teams or Court Diversion Services. Typically, formal assessment of the prisoner by a mental health professional and representation of matters by a psychiatrist at the magistrates' court can lead to the prisoner's redirection into hospital via detention under the Act should this be deemed necessary and appropriate.

Forensic psychiatrists may be called to act as an expert witness in court. This is an aspect of forensic psychiatry which may be part of a clinician's usual employment or independent medicolegal work. Although mindful of their duties and ethics as a psychiatrist, the expert witness' primary duty is to assist the court on matters of his/her expertise in order to advance the administration of justice (Rix 2011). The expert may be instructed by the judge, prosecution or defence team's legal representative or associated agencies such as the probation service. These assessments can be required to address specific matters including the defendant's fitness to plead, psychiatric defences, for example, in relation to establishing their mental state at the material time and their capacity to form intent, and other mitigating factors on making sentencing recommendations. In this role, the interaction between the forensic psychiatrist and the prisoner is fundamentally different. Discussions are therefore not bound by usual doctor-patient confidentiality, and the prisoner needs to be made fully aware that disclosures could end up as evidence in court.

1.1.1.2 Prisons and Young Offender Institutions

Estimates are that 23% of the prison population has a need for secondary mental health services (Centre for Mental Health 2011a, b). The prison environment itself is understandably a psychological stressor, with those already known to have a mental disorder being at risk of deteriorating, as well as those who have no known history being at risk of decompensating and becoming mentally unwell. Although there has been some argument that the complex needs of some offenders would not have been met in the community either, 'once an offender is in the full-time care of the state, different standards apply' (Peay 2011), and determining whether prisoners may need inpatient (i.e. hospital) psychiatric care, and where this threshold lies, is a complex process that has to take into account the individuals' needs as well as available service provision.

In the same way that a competent prisoner can understand and consent to treatment for his or her physical health problems, so too can a prisoner for their mental disorder. The problem arises when either the necessary intervention cannot be supported in the prison environment or the prisoner does not hold insight into the need for an intervention and consequently does not accept treatment.

For patients not consenting to treatment for their mental health problems in England and Wales, although very limited interventions could potentially occur under the direction of statute minded to act in the best interests of those lacking capacity (should they be deemed to lack capacity), it is mental health law that provides the most appropriate safeguards and due process for these situations. However, compulsory treatment for mental disorder cannot be carried out in prison. As already outlined, legal provisions do, however, facilitate transfer of prisoners meeting the necessary criteria to hospital for assessment and/or treatment at each stage of contact with the criminal justice system.

Within prisons, psychiatric in-reach services follow a care delivery model akin to community mental health teams. Multidisciplinary teams including specialist psychiatric nurses, forensic psychologists and psychiatrists assess and treat referred prisoners and consider whether they can continue to be managed appropriately in the prison environment, either on the 'ordinary location' (prison wings) or in the hospital wing (when there is one). At one level, in-reach services could include ensuring maintenance of depot antipsychotic medication administration for a prisoner with a diagnosis of schizophrenia, for example, or initiation of antidepressant medication and focused psychotherapy for a prisoner with low mood. Managing dual diagnosis of mental disorder and harmful alcohol and/or substance misuse is also an important issue for mental health services in prisons often working in conjunction with specialist addiction services. The prison in-reach services also provide liaison with community psychiatric services for patients under Care Programme Approach (CPA) to try and support their transition and mental health follow-up on being released.

At the other end of the spectrum are the 'nontreatment' interventions in custody. Although led by the prison itself (as opposed to by healthcare resources), these services may overlap with the forensic pathway for some patients, such as probation services which provide behavioural programmes for offenders. Another example is

the development of psychologically informed planned environments (PIPEs) which were introduced for prisoners who were deemed likely to meet the eligibility criteria for the personality disorder pathway. They were 'designed to have a particular focus on developing an enabling environment, which emphasises the importance and quality of relationships and interactions' (Turley et al. 2013) for prisoners who had already completed high-intensity offending behaviour and treatment programmes.

1.1.2 Healthcare System

1.1.2.1 Inpatient Care

Patients in secure forensic hospitals in England and Wales are detained under the Mental Health Act of 1983 (as amended in 2007) and so have the opportunity to be engaged with the legal process regarding challenging their ongoing detention in this regard, including participating in First-Tier Tribunals and Hospital Managers' Hearings. Some patients will have added 'restriction orders' in place associated with being sentenced to a hospital order or transferred as a sentenced prisoner, which are imposed by the court or the Ministry of Justice. They add in controls which are applicable for patients taking leave or being discharged into the community.

In secure hospitals, the multidisciplinary team works across several areas:

- Assessment, diagnosis and treatment of mental disorders.
- Optimising physical health.
- Specialist and structured risk assessment.
- Psychological interventions (via group programmes and individual work):
  - Psychoeducation in mental disorder; building insight; anger control; stress management; relationships; relapse prevention work.
  - Substance misuse work.
  - Sexual offending work.
  - Victim empathy work.
  - Engagement in occupational therapy to build up life skills and personal development.
- Rehabilitation pathway planning.
- Liaison with other relevant agencies.
- Supporting patient's carers, family and friends.

Hospitals with different levels of security, high, medium and low, exist to accommodate forensic patients, accordingly reflecting the degree of risk they are assessed to pose. This kind of assessment is multidisciplinary and multifactorial, taking into account the patient's current presentation, their past offending history and any extenuating circumstances such as whether they are considered a high-profile offender. *The Dundrum Quartet* is one example of a structured professional judgement tool which seeks to address in detail all the relevant risk information and principles that need to be considered in order to suitably determine the level of

security for a patient being admitted or transferred within a forensic service (Kennedy et al. 2012). Determining which services undertake gatekeeping assessments into secure services is dictated by local policies with some regions entering into 'partnerships' to distribute referrals.

How secure a hospital is deemed to be is directed by three areas: physical security, procedural security and relational security. Physical security refers to the building restrictions with guidance set for heights of surrounding fences, for example, the use of locks and alarms, etc. Procedural security sets in place the necessary operational policies such as protocols on restrictive practice, needed for an individual unit to follow in order to maintain their level of safety and security across all domains. Finally, relational security has been defined as 'the knowledge and understanding we have of a patient and of the environment and the translation of that information into appropriate responses and care' (see Think Act 2015). Examples of procedures that support good relational security might include standardising a handover process and setting minimum staff-to-patient ratios.

High secure hospitals (historically termed the 'special hospitals') most closely resemble the higher category prisons and are reserved for the few deemed to be in need of significant security to prevent them absconding from psychiatric care. The NHS Act (2006) states they require treatment under these conditions 'on account of their dangerous, violent or criminal propensities' (Guidance for Commissioners of Forensic Mental Health Services 2013). In practice, these hospitals also admit individuals where the risk they pose must also be considered in the context of the notoriety of their crime, if there has been a significant degree of media interest, for example.

Medium secure services must also follow standards with regard to security procedures; however, the nature of these units is to be adaptable according to the needs of the patients. Medium secure services may have a range of intensive care areas including seclusion suites, acute admission and rehabilitation wards. This is in order to safely manage their patient group which can include transferred prisoners who are on remand for serious offences, as well as hospital order sentenced patients, who, following progressing with their rehabilitation, may be independently accessing the community ('unescorted community leave') in preparation for resettlement and discharge. Within the latter group, the rate of progress following a recovery-based model is also variable, with some patients needing a slower paced reintroduction to society than others.

Commonly, low secure services are used as step-down transfer for patients from medium security who no longer require the level of physical restrictions in place there. Locked rehabilitation units may also liaise closely with forensic services and provide a longer period of rehabilitation for slower-stream patients who are not yet suited for community-based rehabilitative care.

Forensic supported accommodation (ranging from 'floating support' to 24 h staffed) in the community often provides a further step-down interim placement for forensic patients moving from hospital to the community.

In the UK, bespoke female secure services for women including Women's Enhanced Medium Secure Services (WEMSS) were developed in recognition of

the need for gender-sensitive environments with enhanced procedural and relational security as opposed to high levels of physical security measures (Eastman et al. 2012). There are additional specialist rehabilitation services for specific groups of offenders such as adolescents; those with severe personality disorders, neuropsychiatric conditions and a history of sex offending; deaf or hard of hearing patients; and those with intellectual disabilities and autism spectrum disorders.

As already outlined, a patient may have entered into a secure hospital through the criminal justice system at one of several different points. A patient may also move into secure services as a consequence of stepping up to a higher level of security, for example, into a medium secure service from a general adult inpatient service, or conversely by stepping down as part of a rehabilitative process moving from medium security into a low secure hospital.

1.1.2.2 Outpatient Care

Community Forensic Teams in England have developed roles in two key areas:

1. Assessing new referrals: this is to provide specialist risk assessment and advice on management in liaison with the healthcare professionals who are already involved in the individual's care. Assessments may take place in hospital or outpatient clinic settings.
2. 'Outreach' for community forensic patients: providing monitoring and formal supervision for patients that have been discharged from forensic settings into the community, some of whom remain liable to conditions imposed by the Ministry of Justice in England and Wales (conditional discharge). Where appropriate, this includes liaison with other criminal justice system agencies (police, probation and prisons) via Multi-Agency Public Protection Arrangement (MAPPA). Some patients may also be managed under joint care with general adult community mental health teams.

Ongoing debate exists as to the relationship between general adult services and forensic services, and consequently three main models for Community Forensic Teams have been described: parallel, integrated and hybrid models. Historically, the parallel model has been more common being based upon a structure where forensic specialists work in a separate specialist team with a large part of their caseload often comprised of managing patients who have been discharged from medium secure services directly into the community. The integrated model refers discharged forensic patients back into general community mental health teams for follow-up. The hybrid model combines the integrated model approach with shared care with forensic services during the patient's initial post-discharge period from a secure hospital setting (Mohan et al. 2004). In practice, different forensic liaison schemes offer consultatory and assessment services for Community Mental Health Teams. Community Forensic Teams are designed considering features from all these models according to local area and patient needs as well as available resources (Natarajan et al. 2012).

Community Forensic Teams work intensively with their patients to monitor their mental health, medication compliance, social engagement and work in the community as well as physical health monitoring and dealing with any comorbid difficulties such as substance misuse or challenging behaviours. Research has suggested that patients conditionally discharged into the community from forensic mental health services have a lower recidivism rate in comparison to release following imprisonment (Fazel et al. 2016). Provisions under the Mental Health Act of 1983 (as amended in 2007) allow patients who have been discharged into the community under restrictions imposed by the Ministry of Justice to be 'recalled' and readmitted into hospital should there be concerns about a deterioration in their mental state or increase in their risk in association with transgressions from their conditions of discharge.

1.1.3 Conclusion

Establishing what 'forensic psychiatry' represents, beyond the boundaries of the specialists who work in its field, can be quite misleading. Public opinions, the media and political views seemingly oscillate between wanting services to instigate more restrictions (usually following a publicised incident or inquiry) and being disapproving of restrictive practices because they oppose fundamental human rights. To patients, forensic psychiatry may represent many different things at different times, including being the system that holds them captive, as well as the system that provides opportunities for achieving an improved quality of life in the community. Practising with due professionalism in this specialty requires employing an inquisitive and ethically reflective mind. Forensic psychiatry poses challenging questions for the clinician and society itself, with conflicts arising with regard to determining culpability, the need for detention, treatment compulsion and autonomy, to name a few.

1.2 Forensic Psychiatry in Europe Outside the UK

Katharina Seewald

Along with all the differences in legal and administrative procedures across the European countries come several differences in the provision and organisation of forensic mental health services as well as in the training of medical professionals. Reasons for these dissimilarities can be found in historical background of legal systems and judicial understanding in the different nations (Nedopil et al. 2015). The work of the 'Ghent Group', a European network for forensic psychiatrists, is the best resource to explore the practical differences and also potential similarities between the European medicolegal systems, professions and service provision.

The group recently stated that Germany, Ireland, Sweden, Switzerland and the UK are those European countries that have established certificates of completion of

forensic training for medical professionals and Croatia as a new EU member has not yet established a certification but a substantive training programme (Nedopil et al. 2015). Other countries, such as Austria, Belgium, Denmark, Finland, the Netherlands, Norway and Spain, are more reserved when it comes to supporting a forensic specialisation, fearing that this would increase the likelihood to become separated from general psychiatry. Instead, diploma courses in forensic psychiatry to train their staff are offered in these states (Nedopil et al. 2015).

There are some countries in Mainland Europe (Europe outside the UK) that have not developed specific forensic psychiatric hospitals or services such as France, Italy, Greece and Cyprus (Nedopil 2009; Roesch and Cook 2017).

In most of the countries, the question of criminal responsibility plays a crucial role regarding the adequate diversion of offenders to either prison or forensic psychiatric services (Gordon and Lindqvist 2007). In the following, the variety of forensic systems in Mainland Europe will be exemplified focusing on a few selected countries.

1.2.1 Germany

1.2.1.1 Legal Framework

In Germany, mentally disordered offenders can be placed in a forensic psychiatric hospital if their criminal responsibility is either absent or diminished at the time of their index offense and if they pose a risk to commit further crimes (Edworthy et al. 2016; Roesch and Cook 2017).

1.2.1.2 Inpatient Care

The offender is then admitted as a psychiatric patient into forensic psychiatric facilities indefinitely. The offender will be discharged when the risk to commit further offenses is considered low enough to justify the release. Psychiatrists and psychotherapists as well as nurses, social workers, art therapists and occupational therapists work together to treat mental health conditions on the one hand and manage the recidivism risk on the other hand. An external forensic expert assesses the offender's risk in an evaluation statement every year to assist case managers (which can be psychiatrists or psychotherapists) in the hospital to come to informed decisions on stepwise reduction of security measures with the final goal to release the offender back into the community. If the offender's criminal responsibility is assessed not fully absent but partly absent (diminished), the individual can be given an additional prison sentence by the court.

Offenders who suffer from substance use disorders at the time of the offense (with fully or partly absent criminal responsibility and a high risk to commit future crimes) are referred to a specialised form of forensic hospitals targeting alcohol and drug addiction. The length of stay there is a maximum of 2 years with mostly additional prison sentence to follow.

1.2.1.3 Prison Psychiatry

Offenders who have been assessed as fully responsible for their offenses and are serving a prison sentence have access to psychiatric care whilst in prison. Psychiatric treatment has to be provided in every prison facility, and there are usually several psychiatric beds in prison inpatient healthcare wings for acute patients who need inpatient treatment during their stay in prison.

1.2.1.4 Outpatient Care

The number of facilities providing outpatient care for high-risk offenders either released from prison or from forensic psychiatric facilities in Germany is rising (Sauter et al. 2017). They are part of a risk management network consisting of probation services, court supervision, electronic monitoring if necessary and numerous community-based services including aftercare residencies to support offenders who have been discharged from prisons or forensic psychiatry hospitals.

1.2.2 Netherlands

1.2.2.1 Legal Framework

In the Netherlands, offenders with mental disorders can be referred to specific forensic psychiatric hospitals. Comparable to Germany, the diversion depends on criminal accountability which has five stages of responsibility from total absence to complete responsibility (Edworthy et al. 2016).

1.2.2.2 Inpatient Care and Outpatient Care

Offenders with personality disorders are referred to internationally known TBS hospitals (TBS is for TerBeschikkingStelling) based on a so-called TBS law (de Boer and Gerrits 2007). Offenders with other psychiatric disorders are treated in forensic units of general psychiatric hospitals or in one of three forensic psychiatric hospitals (Roesch and Cook 2017). In TBS hospitals, after the initial 2 years, an offender's detention will be reviewed every second year and can last for as long as necessary to protect society. An external expert opinion is needed to justify detention every sixth year (Edworthy et al. 2016).

TBS hospitals have their own outpatient services and residencies after discharge. Generally, the Netherlands has a highly developed system of aftercare services (Roesch and Cook 2017).

1.2.3 Scandinavian Countries: Sweden and Denmark

1.2.3.1 Sweden: Legal Framework and Inpatient Care

The forensic mental health service in Sweden is separated into two systems. One is the National Board of Forensic Medicine which is in charge of assessments for courts. Different to Germany, the term 'responsibility' is not known in the Swedish system. Nevertheless, the handling is quite similar. If the offender suffered from a

severe mental disorder at the time of the offense stated by a psychiatrist, the court can order forensic psychiatric treatment and/or reduction in sentence. The forensic treatment order is based on the mental health state and the lack of insight on the one hand and on the risk for future violence on the other hand, and the duration of hospitalisation depends on both criteria, as in Germany (Gunn and Taylor 2014; Roesch and Cook 2017).

The second system is represented by 20 regional healthcare providers which provide forensic treatment and care (Gunn and Taylor 2014). In five forensic psychiatric hospitals, there are only a few high security beds. Offenders with low risk can be referred to low secure forensic units or are likely to be managed in general psychiatric settings (Gunn and Taylor 2014).

1.2.3.2 Denmark: Legal Framework and Inpatient Care

The legal framework in Denmark is similar to the Swedish one. However, in Denmark, mentally ill offenders will locally be managed mostly in general psychiatric units according to their security needs or in forensic units within general psychiatric hospitals (Gunn and Taylor 2014; Roesch and Cook 2017). Additionally, prisoners do have the same right and access to medical care as individuals not in prison. If necessary, they will be referred to public hospitals or private practitioners accompanied by security personnel (Gunn and Taylor 2014).

1.3 Forensic Psychiatry in Australia

Katharina Seewald

1.3.1 Legal Framework

In Australia, each state has separate mental health legislation (Gunn and Taylor 2014). However, criminal responsibility is tested in each of those concerning whether the potentially mentally disordered offender could have had insight into the criminal act or into the fact that the doing was wrong. In case this has to be denied, the offender is to be detained in a secure hospital (Gunn and Taylor 2014).

1.3.2 Inpatient and Outpatient Care

The location of provision of forensic psychiatric care also varies from state to state. However, regardless of whether the service is provided in psychiatric hospitals, correctional facilities and inpatient or outpatient community settings, it is always offered by specialised forensic mental health service organisations (Roesch and Cook 2017). Community forensic mental health services are particularly important in the management of acquitted offenders or in the transition of discharged offenders with mental disorders (Every-Palmer et al. 2014).

1.3.3 Prison Mental Health

All prisoners have access to specialised mental health services within correctional departments and can be relocated into an inpatient psychiatric setting if necessary (Every-Palmer et al. 2014).

1.4 Forensic Psychiatry in Asia

Katharina Seewald

In Asia, the situation of forensic psychiatry varies widely. In China and Japan, mentally disordered offenders can receive a reduction in their sentence length or a treatment order (Roesch and Cook 2017).

There are (administrative) regions such as Hong Kong, where forensic care is provided on forensic wards and where there are community services in place to ensure a successful reintegration, and Bangalore, for example, where forensic inpatient treatment is delivered in general psychiatric facilities. In China, mentally ill offenders are treated in secure hospitals for offenders and non-offenders who pose a risk to themselves or others ('Ankang Hospitals'). In Singapore, a recent development (2010–2011) now provides treatment for mentally disordered offenders after release from prison and established a mandatory treatment order for offenders whose psychiatric disorder is linked to criminal behaviour. On the other hand, there are countries such as India with no noteworthy specialised forensic service for mentally ill offenders who will mostly be detained in prison facilities (Every-Palmer et al. 2014; Roesch and Cook 2017).

1.4.1 Japan

The most elaborated forensic psychiatric system can be found in Japan. There, specialised forensic mental health services recently (2005) developed in form of a 'Medical Treatment and Supervision Act' (MTSA; Fujii et al. 2014; Roesch and Cook 2017). It applies to offenders with no or diminished criminal responsibility, whose serious offense was caused by a mental disorder and was assessed so by forensic experts. The MTSA process replaces prison sentences for eligible offenders (Fujii et al. 2014).

The treatment order can refer to in- or outpatient treatment. There are specialised forensic psychiatric hospitals where inpatient treatment is delivered. Outpatient treatment and rehabilitation during the first 3 years after discharge is provided by probation services, outpatient psychiatric practices or community services and is centrally coordinated (Fujii et al. 2014; Roesch and Cook 2017).

1.5 Forensic Psychiatry in America

Hasanen Al-Taiar

As Benjamin Rush is considered to be the father of American psychiatry, so Isaac Ray is known as the father of forensic psychiatry in the USA. His contributions, as noted by historian forensic psychiatrist, Dr. Kenneth Weiss, are progressive and timeless. However, there could be a gap in professional recognition from the time of Isaac Ray in the late nineteenth century to the mid-twentieth century when people such as Gregory Zilboorg, the great psychiatric historian, took centre stage. Doctors Andrew Watson, Richard Lonsdorf, Jonas Robitscher, Jay Katz and Alan Stone began teaching not only in medical schools but also in law schools. Dr. Jonas Rappeport, considered the father of modern forensic psychiatry, developed his clinic in psychiatry and law in Baltimore and taught both at the University of Maryland and at Johns Hopkins. It was Dr. Rappeport, with several others, who initiated the modern era of rapid growth and proliferation of the field of forensic psychiatry by beginning the American Academy of Psychiatry and the Law (AAPL) in 1969.

Dr. Rappeport called together several teachers of forensic psychiatry in order to organise them as a scholarly group, to promote the field of forensic psychiatry and to aid in the teaching of this growing subspecialty. Three of the original group comprised the membership committee, Drs. Seymour Halleck, Ames Robey and Robert Sadoff, meeting in 1969, which listed 100 potential candidates for membership in the AAPL. Not surprisingly, all 100 agreed, and the organisation grew exponentially from that point to the present time, at which there are now well over 2500 members worldwide. The newsletter of the AAPL was developed as well as the bulletin of the AAPL, which later became the journal (JAAPL). Other journals, such as *The Journal of Psychiatry and Law*, *The Journal of Forensic Psychiatry* and *The International Journal of Law and Mental Health*, began to publish articles from contributors from around the world. There have been at least two other organisations of medical/legal interest that preceded the AAPL. One was the American College of Legal Medicine (ACLM) in which the fellows had to be dually qualified both in medicine and law and consisted primarily of pathologists and other nonpsychiatric physicians who had law degrees.

The other organisation was the American Academy of Forensic Sciences (AAFS), which included members from various medical, legal and scientific disciplines: forensic odontology, forensic pathology, and a small group of psychiatrists led by Drs. Meier Tuchler, Seymour Pollack and Bernard Diamond. Through the leadership of Dr. Richard Rosner, of New York University, came the development of fellowship training in forensic psychiatry at various university medical centres. Dr. Rosner, through the AAFS and AAPL, coordinated the efforts and initiated the accrediting committee that visited various programmes to ensure high quality of training and compliance with required curriculum. Dr. Rosner also led the way to

formal examinations of forensic psychiatrists with the inauguration of the American Board of Forensic Psychiatry (ABFP) in the late 1970s. That board certified several scores of forensic psychiatrists until 1994, when its sun set in favour of board certification through the American Board of Psychiatry and Neurology (ABPN). Subspecialty board examinations had been resisted by the American Psychiatric Association until the mid-1990s, when several subspecialty board examinations arose, including that for forensic psychiatry, which became a 10-year certification rather than lifelong as is the certification for general psychiatry. Scholarly programmes that were developed in various institutions became more formalised under the guidance of the Accreditation Council for Graduate Medical Education (ACGME). Currently, there are about 40 accredited fellowship training programmes in forensic psychiatry throughout the USA. The number of fellows in each programme ranges from one to four, and about 75 individuals are trained each year in forensic psychiatry and thus become eligible to take the board certification examination.

Many of the fellowship programmes have attorneys on the faculty and are affiliated with law schools in which mental health law or mental disability law is taught. The fellows are expected to know the landmark cases that are developed through the Supreme Court of the United States and other major courts where policy is determined. For example, historically, the concept of the right to treatment, initiated by Dr. Morton Birnbaum in his seminal article, 'The Right to Treatment', led to cases such Donaldson v. O'Connor (1968) that mandated the right to adequate treatment for those individuals who were involuntarily committed for psychiatric treatment. Other cases followed, including Washington v. Harper (1990) and Sell v U.S. (2003), which authorised treatment for those criminal defendants who were deemed incompetent to stand trial and who were believed to be able to become competent with appropriate treatment.

There are major differences between UK and USA with regard to the laws that govern psychiatric practice (both general and forensic) and the organisation of forensic mental health services, but also the training and practice of forensic psychiatrists. As in other countries, forensic psychiatrists provide expert opinion in criminal and civil court proceedings (e.g. competency to stand trial, opinion on criminal responsibility and 'legal insanity' as well as mental state opinion, risk assessment and sentencing), but also work in forensic mental health services providing assessment and treatment to mentally disordered offenders. Such services include inpatient forensic psychiatry clinics (dedicated forensic facilities such as maximum security units, and in some states special hospitals for sentenced prisoners, but also clinics within general psychiatry hospitals either dedicated forensic or ordinary units), outpatient services and correctional facilities (remand and sentenced such as maximum secure correctional settings). Services available and practice vary among the different states, however most states provide evaluations in the community and inpatient services that promote competency restoration in order to minimise length of stay in hospitals. Twenty states also have specific laws about the civil commitment of sex offenders who present with mental illness/disorder or personality disorder that puts them at risk of offending (even if they are not in need of

treatment). Canadian forensic psychiatry, after efforts over many decades, became a recognised psychiatry sub-specialty in 2009. As with USA, forensic psychiatry practice here is also focusing on the provision of expert opinion in criminal and civil courts, and secondarily providing care for mentally disordered offenders in forensic psychiatry hospitals and correctional facilities. Forensic psychiatry in Latin America is also governed by different laws in each country including criminal, civil but also mental health legislation. The Declaration of Caracas resulted in reforms in mental health in all countries (some more than others), especially focusing on community-based rather than hospital centered care, however this did not include forensic psychiatry. Forensic psychiatrists in Latin America also provide expertise in courts (albeit the concept of fitness to stand trial is not applicable here), but also clinical input in forensic hospital settings and correctional facilities.

Experienced forensic psychiatrists are seen almost daily in news articles about prominent criminal cases in which they testify about the mental state of the defendant at the time of the commission of the charged offense. Forensic psychiatrists have commented on a number of issues facing the community at large, including gun control, torture of terrorist suspects and death penalty cases. The development of biomedical ethics within forensic psychiatry has also become a major field in which the practice has been regulated through ethical considerations. Issues such as confidentiality, privileged communications, privacy and informed consent are important, as is the concept of 'wearing two hats', in which the treating psychiatrist, in most cases, should not testify as the expert witness for his or her patient. Various textbooks have emerged from both law professors and professors of psychiatry and from practising psychiatrists and are listed in the references of this chapter.

1.6 Status of Psychiatric Services and Forensic Psychiatry Services in the Middle East

Hasanen Al-Taiar

The Arab world has witnessed the cradle of civilisations since ancient years, and many Arab and Middle Eastern countries have established psychiatric services many centuries ago. The first recorded usage of the insanity defence can be found in Hammurabi's code which dates back to around 1772 BC. It used some sort of insanity defence.

It is enlightening to learn about the medieval Islamic hospitals, called *märistäns*, which were once designed to provide therapeutic care. These *märistäns* were known to be safe, aesthetic and pleasing environments, in the aim of encouraging recovery. Arab countries were the first in the world to establish psychiatric hospitals, at a time when Western civilisation dealt with those suffering from mental illness by condemnation and punishment (705 in Baghdad, 820 in Cairo and 1270 in Damascus).

However, current psychiatric services in the Middle East remain underdeveloped in comparison to their counterparts in developed countries. Several factors play a role in that, including poor governmental planning underestimating the role of

mental health and well-being and stigma around psychiatric disorders caused by poor public awareness.

In many Arab countries, many people (especially those of low socioeconomic and educational backgrounds) with psychiatric conditions tend to consult traditional and faith healers before seeking professional help from psychiatrists or approved professionals (Al-Adawi 2002).

This chapter will allude to three different examples of healthcare systems in the Middle East, namely, Iraq, Oman and Egypt.

1.6.1 The State of Mental Health in Iraq

Iraq is a country that has suffered through 30 years of an oppressive regime and an ensuing war since 2003, which has devastated its society and left a public mental health crisis in its wake. Half of the Iraqi population is under 18 years of age, all of whom have lived their entire lives in conflict. The adult population is reported to have witnessed an array of reprehensible horror from kidnappings to ear amputations (Abed 2005). These conflicts have adversely affected the country's healthcare infrastructure, causing various mental health problems. The infrastructure was destroyed following the 2003 invasion that led to further destabilisation of available services (Crawford 2013), and whilst initial international response was supportive, the need for ongoing mental health services requires a stable, permanent solution in Iraq. There is enough evidence to suggest high levels of emotional distress among people who have been exposed to long periods of violent conflict (Abed 2005). According to the WHO, mental health disorders are the fourth leading cause of ill health in Iraqis over the age of five (Médecines sans Frontières 2009). Data collected on Iraqi children reveals a prevalence of an astounding 37% who suffer from mental health disorders, 10% of which was unsurprisingly in the form of post-traumatic stress disorder (PTSD) (Kutcher et al. 2015). The Iraqi government is currently neglecting the critical situation of the lack of adequate mental healthcare within the country. Paediatric and adolescent mental health must become a priority for Iraq as they are not only the bearers of displacement, malnutrition, lack of education and physical suffering, but they are also the future of the country.

1.6.1.1 Culture of Psychiatry and the Stigma in Iraq

For many decades, psychiatry in Iraq has held a stigma and has been a subject of great taboo, which has consequentially restricted people from seeking professional help when needed. These restrictions are derived from social, political and religious origins. People with psychiatric disorders have always been associated with an undertone of negativity, especially in low- and middle-income countries (Sadik et al. 2010).

Culturally, however, mental health carries a huge stigma not only for the patient but also for the associated family, where they are known to be very discreet in disclosing that they have members with mental health conditions. The problem is even bigger with women. If a woman wishes to seek treatment despite the risk of

besmirchment, she faces the additional burden of needing a male chaperone to leave the home, where he himself may refuse due to the associated stigma. It is reported that women with mental health problems and their siblings are less likely to have chances of getting married due to the stigma attached to the illness. In fact, in a study conducted in Baghdad to assess public attitudes, more than half of the respondents said they would be ashamed if a family member had a mental illness. The stigma attached to mental illness in Iraq is pervasive and forms an irrefutable barrier to mental healthcare. Advocating mental health and integrating it as part of overall healthcare are two important recommendations to improve access for patients to get help (Sadik et al. 2010).

1.6.1.2 Mental Health Workforce in Iraq

Skilled workforce is the basis for developing a healthcare system; without it, the healthcare system cannot function efficiently. In particularly low- and middle-income countries across the globe, recruitment and retention into psychiatry and other mental health professions remain a challenge (Kakuma et al. 2011). This shortage in the mental health workforce is one of the main barriers upon treating mental health conditions (Bruckner et al. 2011). Like most regions of conflict, Iraq's medical workforce is facing severe shortages. The International Committee of the Red Cross estimated that by the end of 2006, nearly half of the doctors in Iraq had left the country (18,000 doctors remained from the 34,000 previously practising) (The International Committee of the Red Cross 2006).

In 2014, records show that there were 0.37 psychiatrists and 1.64 nurses who worked in mental health, 0.22 social workers and 0.09 psychologists per population of 100,000 (Cetorelli and Shabila 2014; WHO 2016). An audit requested from the Health Directorates of both Basra and Nasiriyah in March 2016 showed similar figures. In Basra, the Director of Health, Riyadh Al-Halfi, reported that there are 0.36 psychiatrists per population of 100,000, 0.36 for psychiatric nurses and 0.11 for social workers. The figures presented for Nasiriyah showed even lower ratios of 0.15, 0.1 and 0 per population of 100,000 for psychiatrists, psychiatric nurses and social workers, respectively. These figures demonstrate the scarcity of health professionals within mental health, especially in smaller cities, showing that Iraq trails far behind the international averages of 7.7 specialist nurses in mental health per 100,000 people (WHO 2016).

Furthermore, there is a noticeable discrepancy among the various governorates across the country, as well as large disparities between urban and rural areas where some have no psychiatrists at all (Cetorelli and Shabila 2014). Moreover, psychiatry in Iraq lacks specialty training, where, for example, there are no child psychiatrists or mental health services that provide help to children and adolescents. The non-existence of child psychiatry poses a serious concern. Children and adolescents account for nearly half of the population in Iraq (Kutcher et al. 2015), and with years of war and large numbers of internally displaced refugees, the prevalence of mental disorders among this age group has risen (Al-Obaidi et al. 2010). Not only does this emphasise the burden of mental health, but it also adds the additional challenge of addressing the psychosocial needs in primary healthcare.

1.6.1.3 Forensic Psychiatry in Iraq

The Al-Rashad Psychiatric Hospital is the biggest inpatient psychiatric unit in Iraq and is located in the north of Baghdad. It was built as an asylum in 1952 and has the capacity of 1200 beds. There are four wards dedicated for forensic patients, one of which is for remanded prisoners awaiting a panel's decision about their culpability, mental health and any relevant disposals. Four general adult consultant psychiatrists and a similar number of specialist psychiatrists provide medical input to the forensic wards in addition to a small number of psychiatric nurses and psychologists. A panel of three psychiatrists is allocated for each patient to assess their mental health, any relationship with the offence and potential disposals.

The Ministry of Health (MOH) is currently considering the Iraqi mental health law, which derives some similarities with the British Mental Health Act.

1.6.2 Mental Health Provision in Oman

The percentage of expenditures on mental health is unknown. In Oman, the financing system in the MOH does not separate the mental health budget from other health sector budget (as there is no programmed budgeting). All medical services including access to the mental health services and essential psychotropic medications are 100% free to Omani citizens (WHO 2008).

1.6.2.1 Inpatient and Outpatient Services

There are 26 outpatient mental health facilities available in the country, of which two are for children and adolescents. In 2006, these facilities treated 386 users per 100,000 general population. Female users make up over 40% of the population in all mental health facilities in the country. The proportion of female users is highest in inpatient and outpatient facilities in general hospitals and lowest in mental hospitals. The vast majority of beds in mental health facilities in the country are provided by the mental hospital (2.88 beds per 100,000 population), followed by six general hospital-based inpatient psychiatric units (1.01 beds per 100,000 population) and forensic units (0.19 beds per 100,000 population). There has been a 23% increase in the number of the psychiatric hospital beds in the last 5 years. The majority of the service users are treated in outpatient facilities of the mental hospital. The percentage of child and adolescent attendees is comparatively low across all mental health facilities.

The distribution of diagnoses varies across facilities; in outpatient facilities, neurotic and mood disorders are most common, whereas, in inpatient facilities and the mental hospital, schizophrenia has the highest prevalence. Psychotropic drugs are most widely available in the mental hospital, followed by outpatient units and then inpatient mental health facilities in general hospitals.

Most of the mental health facilities are present in or near large cities. To promote equity of access to mental health services, Oman is encouraging the development of outpatient psychiatric units and facilities in catchment areas across the country.

Nine percent of the training for medical doctors is devoted to mental health, in comparison to 7% for nurses. Six percent of primary care doctors and 3% of nurses received at least 2 days of refresher training in mental health in 2006. Only doctors can prescribe psychotropic medications in primary care settings (WHO 2008).

1.6.3 Psychiatric Services in Egypt

The Al-Abbasiyah Hospital in Cairo is the teaching hospital in Ain Shams University in Cairo. There is a specialised forensic department which deals with mentally ill offenders in this hospital. There are around 30 beds for the patients who are remanded pending court disposals or trials. After sentencing, female patients are disposed to around 20 beds in the Al-Abbasiyah Hospital, and male patients are disposed to the El Khanka Central Hospital which has 40 beds for forensic patients.

Ain Shams University in Cairo used to grant a diploma in forensic psychiatry after a year of training in that hospital, but this qualification has recently stopped and the university is trying to reinstate it (Al-Taiar 2014).

1.6.3.1 Specialist Psychiatric Facilities

Evaluation of the status of mental health services in the country by the MOH in collaboration with the Egymen project confirmed that the country's healthcare system operates under extremely resource-restricted conditions, in terms of infrastructure, manpower and finances. Mental health specialist care is largely delivered at national level (national referral hospitals in Cairo and Alexandria) and at governorate level (one to two psychiatrists attached to each governorate hospital for around 3 million catchment population).

The total number of hospital beds for a population of over 75 million is 6156 (including the 680 forensic psychiatric patients at Khanka, 95 forensic beds at Abbassia and 13 forensic beds at Ma'amoura). This is an average of less than 1 bed per 12,000 population across the country as a whole, compared with a WHO recommendation of 5–8 beds per 10,000 population (WHO 1996 World Health Organisation Recommendations for Mental Health Services, WHO, Geneva). In practice, when the national hospitals are excluded from the calculation, since it is not good practice to use them to admit people from a long way away from their communities, in most governorates, there are only 20 beds per 3 M, i.e. 1 bed per 150,000 population. With the prevalence of probable psychosis running at least 0.2% (Kakuma et al. 2011), it would be helpful to have psychiatric services available in every district as well as every governorate and for every district hospital to have a 10–20-bed inpatient unit for brief admissions to assess and stabilise complex cases, as well as outpatient clinics. This would still leave the vast majority of psychosis cases to be managed at the health centre and dispensary levels.

There were 979 registered psychiatrists in 2009, including 285 consultant psychiatrists, the remainder classed as specialist psychiatrists. These figures have been increasing by around 6–9% a year (these statistics are not entirely accurate because

of emigration, temporary working in the Gulf countries and also some university professors who do not register themselves as having consultant status but rather only use their professorial title). Egypt has lost a high proportion of psychiatrists to rich countries. Of all medical graduates, 5% go into psychiatry training and 10% into nursing training. There were 1902 mental health nurses in 2006, 201 social workers and 77 psychologists. Specialists are mostly concentrated in the major urban centres, and so the specialist service for the other 30 governorates is largely delivered by one or two psychiatrists and a handful of psychiatric nurses for 3 million population. This lack of human resource and continued limited funding of mental health services severely curtail access to specialist care. Nonetheless, 25,443 outpatients were seen in 2006.

The mental hospitals are institutional in design (e.g. Al Abbassia has about 2000 beds) with large wards and little provision for personal possessions; patients are not allowed to wear their own clothes, and there are no ward-based activities and little opportunity for active rehabilitation. There are a striking lack of meaningful ward-based activities and a lack of multiaxial assessments, care planning and regular case reviews, and there are many long stay patients who could be rehabilitated (Al-Taiar 2014).

The Egymen project recruited expert assistance to capacity build specialist expertise and develop services for forensic psychiatry, rehabilitation and child psychiatry, and continued support was given by the Finnish government from 2000 to 2009, the WHO Collaborating Centre of the Institute of Psychiatry in London from 2000 to 2009 and the British Royal College of Psychiatrists from 2006 to 2009. This comprised visits to Egypt by Finnish and UK experts; Egyptian study tours to Finland, England and other European countries; and specific tailored placements in the UK. Funding for service development from the Finnish government and the MOHP has continued to access expert assistance from the UK for forensic psychiatry and legislation (Jenkins and Loza 2010).

1.7 Conclusion

This chapter is an introduction to forensic psychiatry and provides information on forensic psychiatry practices mainly in the UK but also briefly in different countries worldwide. It is not meant to be a narrative of how to conduct forensic psychiatry but rather an illustration of current practice alongside a historical development of the growth and evolution of the field within psychiatry and medicine and how it has been influenced by other subspecialties in psychiatry and other disciplines of scholarly endeavours, such as law, psychology, criminology, nursing, social work and bioethics. The past half-century has witnessed the burgeoning of forensic psychiatry from the status of ‘alienism’ to that of multidisciplinary science, in which, increasingly, scientific techniques such as neuroimaging and psychological testing have influenced juries in a number of cases. To illustrate not only the growth of forensic psychiatry within medicine and law but the breadth of its influence spreading to various other fields, this book has authors of chapters from subspecialties in

medicine and psychiatry to nonphysician specialists who work with forensic psychiatrists in various cases. Perhaps the most common discipline working with the forensic psychiatrist is the forensic psychologist, who often complements the opinions given in particular cases through his or her work conducting interviews as well as a battery of appropriate psychological tests, which are regularly updated and modernised. Within the psychiatric profession, there are subspecialties that are both paramount to forensic psychiatry and also dovetail and intersect with this growing subspecialty. These include child psychiatry, geriatric psychiatry, social and community psychiatry, correctional psychiatry, addiction psychiatry, consultation and liaison psychiatry, psychosomatic medicine, psychopharmacology, sleep medicine and, most recently, neuroimaging (Felthous and Saab 2007).

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