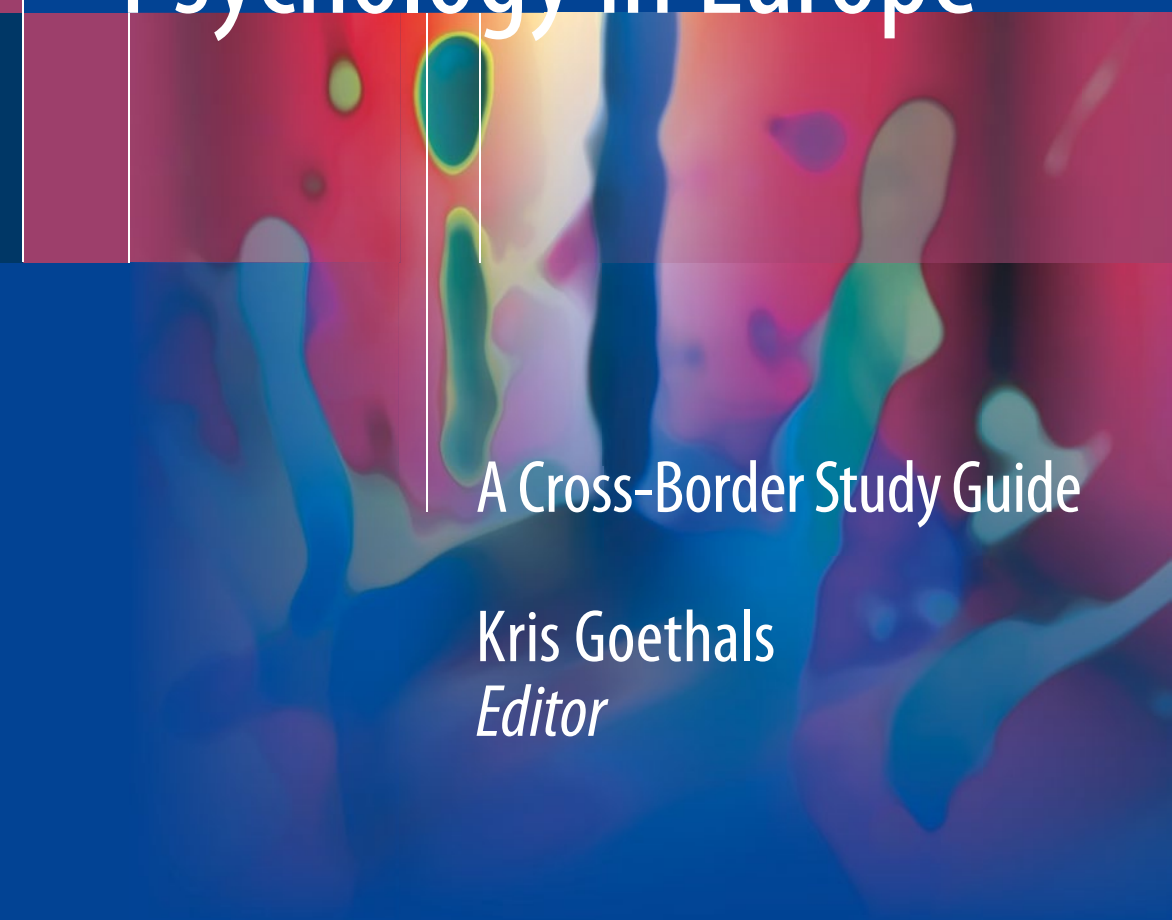
Forensic Psychiatry and Psychology in Europe



A Cross-Border Study Guide

Kris Goethals
Editor

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Why I See the Necessity for Such a Study Guide

It is a pleasure for me to see the publication of the new book *Forensic Psychiatry and Psychology in Europe: A Cross-Border Study Guide*, which has been edited by Prof. Kris Goethals from the University of Antwerp. In this book, the editor brings together authors from different countries and also from different disciplines that discuss important issues affecting the sphere of forensic psychiatry regarding their importance for the field and their consecutive relevance for the education and training of forensic psychiatrists. As the field of forensic psychiatry is characterized by a blend of different professions that are involved in and cooperate during the legal procedures, the treatment, and the rehabilitation of the patients, it is important that young psychiatrists and psychologists in training are aware of the importance of this interprofessional interactions and their presence in different countries. Furthermore, it is dependent on the legislative and judiciary culture of a country in which way it deals with psychiatrically ill offenders. The interaction of different agencies involved in the process of dealing with psychiatrically ill offenders (multiagency working) differs considerably between the European countries. To describe these different cultures and their manifestations in the systems of forensic psychiatry in different European countries provides an important basement for the discussion of advantages and disadvantages of different approaches.

The concept of the book subdivides the contributions into five main categories or areas that are legal frameworks, forensic services, mandatory skills, education, and diverse issues.

The legal frameworks relevant to forensic psychiatry are discussed with respect to the importance that the knowledge of different legal aspects has in the training of forensic psychiatrists and psychologists in order to be able to exert their profession in the field of forensic psychiatry. Here, the international aspect gains an ever increasing importance as, specifically in Europe, legal institutions tend to converge. Judgements from local courts in exempli gratia the countries of the European Union (EU) are subject to evaluation by the European superior courts (European Court of Human Rights). Furthermore, placement/hospitalization and treatment in psychiatric hospitals and prisons are subject to review by the Committee for the Prevention of Torture (CPT), which is an institution of the Council of Europe that is dedicated to the surveillance of the regulations that have been fixed in the European Convention for the Prevention of Torture. Furthermore, the study guide outlines the provision of forensic services in different countries. From the differences and commonalities of

these implementations and their differential effects on criminological outcomes interesting conclusions can be drawn that are very illustrative for trainees in forensic psychiatry. Also important is the reflection of skills that are crucial for the work as forensic psychiatrists. Here, not only language skills are necessary but also a deep understanding of transcultural problems in psychiatry as well as in transcultural differences in moral norms. These latter transcultural aspects gain an increasing importance not only due to the challenge of the European societies by migration from poorer countries but also because of the increasing professional migration of physicians that also affects forensic psychiatrists. Aside from such specific questions, it has also to be discussed what professional requirements are present in different countries for professionals working in forensic psychiatry.

Training in a medical specialty such as forensic psychiatry on the one hand relies on theoretical knowledge, which can be obtained from the study of literature and books such as this study guide. On the other hand medical training also requires real-life interaction and discussion of the contents that have been theoretically studied. Naturally, the discussion of these aspects of different systems of forensic psychiatry in different countries cannot succeed sufficiently when discussants from only one country are present. Rather, such a discussion requires the participation of discussants from these different cultural backgrounds and forensic psychiatric systems. In order to provide a training opportunity for young psychiatrists from different European countries, the Ghent group has established an international European summer school for forensic psychiatry. This summer school brings together senior experts and junior professionals as well as trainees in forensic psychiatry from a range of European countries. Therefore it is a perfect real-life counterpart of the present study guide in order to further explore and differentiate the concepts of forensic psychiatry and the approaches taken in different European countries.

This study guide is a very important contribution to the education of young psychiatrists interested in forensic psychiatry. It provides a collection of important insights and descriptions of how forensic psychiatry is carried out in several different European societies. Moreover, it compares different aspects and allows for a consideration and evaluation of the effects of the different approaches. This may in the future contribute to a possible European convergence of systems while fostering beneficial elements and attenuating more problematic elements.

Kolja Schiltz

Recommendations to the Practice of Teaching, Training, and Research in Italy

The reform in Italy of treatment for mentally ill offenders led to the closure of Forensic Hospitals, mainly hospital prisons, at the end of 2016: new facilities, residences for security measures (REMS), run totally by Mental Health Services, have since been built. Furthermore, community services are currently taking charge of the less dangerous patients not guilty by reason of insanity.

Psychiatrists, psychologists, nurses, and rehabilitation workers need to increase their knowledge of juridical and forensic issues and should receive better training due to the fact that therapeutic plans for forensic patients are currently very common in the network of Community Mental Health Services.

At the same time, health workers in prison have the responsibility of identifying detainees suffering from mental illness as quickly as possible and must not only take care of them but also involve the community services in their future treatment.

This complex change in Italy will transform the organization of the mental health network without changing the "non-institutional" principle that led to the closure of the psychiatric hospitals in 1978 (Law 180/78).

The personnel working in mental health, and in the juridical system, including forensic psychiatrists and psychologists, judges, and any other parties who are involved in the pathways of treatment and security needs, will be trained therefore to have an active participation in the reform.

An initial training of health workers is currently underway, but it must be reinforced and become permanent. The main items to stress with the aim of improving or introducing skills regarding treatment and assessment are, in my opinion:

- knowledge of the legal framework
- knowledge of the mental health network of facilities
- a common language between juridical and medical systems for defining the actions to be carried out
- to introduce the methodology of risk assessment of violence
- rehabilitation and recovery interventions inside REMS and in community facilities
- therapeutic techniques for patients with violent behaviour

It is necessary to develop a systematic and national work of research that would be able to follow the changes inside the system.

REMS and the network of the mental health services currently look very different and this can radically change the care pathways of the people who are sentenced to security measures. The judges can adopt different decisions according to the level of security that the REMS, or the community facilities, can guarantee.

University faculties, the National Health System, and the judicial system should therefore promote a common plan of research that includes monitoring of the number of patients on security measures, their relapse or recidivism, the quality of the treatment they receive, and any other item involved in this field.

The book by Goethals, and the co-authors, is a helpful instrument that describes methodology and the entire process aimed at carrying out a survey of the system and the implementation of a teaching and training programme. In the book there is a contribution of an Italian colleague, who is working in a REMS of the Veneto Region, and who shared with me his experience in the COST (Cooperation in Science and Technology) Action IS1302 “Towards an European research framework on forensic psychiatric care”. The Italian Reform is undoubtedly a courageous experience that can demonstrate that it is possible to create a care pathway for mentally ill offenders within the network of a community health system.

I sincerely recommend reading it and paying attention to the suggestions in the book and the network of European experts.

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Kris Goethals (1969) is a forensic psychiatrist/psychotherapist and director of the University Forensic Centre (UFC) at the Antwerp University Hospital. Besides this position, he is a professor of forensic psychiatry at the Faculty of Medicine and Health Sciences, Collaborative Antwerp Psychiatric Research Institute (CAPRI) of the University of Antwerp, Belgium. He also works in a private practice. He has a wide clinical experience in forensic psychiatry and psychology in Belgium and the Netherland.

Part I

Legal Frameworks

Adversarial Versus Inquisitorial Systems of Trial and Investigation in Criminal Procedure

1

John Gunn and Paul Mevis

1.1 Fundamental Differences in Approach to Protect the Same Values

Common law and civil law are terms used to distinguish two distinct legal systems and approaches to law. The use of the term 'common law' in this context refers to all those legal systems which have adopted the historic English legal system. Foremost among these is the United States, but many other British Commonwealth and former Commonwealth countries retain a common law system. The term 'civil law' refers to those other jurisdictions which have adopted the European inquisitorial system of law derived essentially from ancient Roman law, but owing much to the Germanic tradition and the French tradition of codification of systemised, written (substantial and procedural) law is based on the ideals of the French Revolution. Under the inquisitorial system or civil law approach, (we use the terms interchangeably), there are many differences between jurisdictions, for instance, in whether laymen are involved or not. There are also differences in the possibilities for and conditions under which a trial in absentia is possible. The trial judge may allow hearsay evidence in some jurisdictions. There is not 'a' civil law system, but the approach differs from the common law.

In this essay we will concentrate upon criminal law.

Both systems aim to find 'the truth' (i.e. an acceptable and reliable truth) (Brants [1], p. 1074) about a criminal offence in a 'fair' trial, leading to the conviction of those who committed a crime and the implementation of a 'just' and 'fair' sanction.

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Moreover, both systems aim to avoid convicting the innocent. That makes a comparative study relevant.

In Europe, almost all countries in both systems have signed the European Convention on Human Rights, a treaty signed within the framework of the Council of Europe. Both systems acknowledge the right of every citizen to a fair trial. We are not trying to discern whether one system is fairer or better than the other. But we recognise that both systems are imperfect. For example, in Great Britain, there have been some notorious miscarriages of justice such as the wrongful conviction of alleged Irish terrorists which led to the setting up of the Royal Commission on Criminal Justice [2]. The Netherlands has also identified similar severe miscarriages of justice. In one recent case, the initial trial relied on the confession of the accused, but in retrospect it was decided that his mental situation made him confess (see Hoge Raad 2014, 2015).

1.2 Three Key Issues: Responsibility of the Judge, the Position of the Accused and the Influence of the Pre-trial Investigation

An illuminating description of the difference between the adversarial system and the inquisitorial system is given in *The Judge* by Patrick Devlin [3], a distinguished English academic jurist. He says that:

> the essential difference between the adversarial system and the inquisitorial system … is apparent from their names. The one is a trial of strength and the other is an enquiry. The question in the first is: are the shoulders of the party upon which is laid the burden of proof, the plaintiff or the prosecution as the case may be, strong enough to carry and discharge it? In the second the question is: what is the truth of the matter? In the first the judge or jury arbiters; they do not pose questions and seek answers: they weigh such material as is put before them, but they have no responsibility for seeing that it is complete. In the second the judge is in charge of the enquiry from the start: he will of course permit the parties to make out their cases and may rely on them to do so, but it is for him to say what it is that he wants to know.

A further description was given by the British Royal Commission on Criminal Justice which defined the adversarial system as a system which has the judge as an umpire who leaves the presentation of the case to the parties (prosecution and defence) on each side. They separately prepare their case and call, examine and cross-examine their witnesses and experts. In contrast to inquisitorial systems, the judge plays a major role in the presentation of the evidence at trial. Here the judge calls and examines the defendant and the witnesses and experts, while the lawyers for the prosecution and defence ask supplementary questions. It is the judge's responsibility to arrive at the 'correct' outcome of the case. It is his or her responsibility to examine the case laid out by the prosecution. Codified rules of procedure may say that the judge has to allow parties to hear witnesses, rather than allowing the accused to question the witness. The 'judge' has to guarantee the integrity of the decision, the procedure and the pre-trial inquiry of a criminal case at trial. So, in the inquisitorial system, the court is not only responsible for the right decision but also

for the investigation leading to the decision. The 'judge' may be a professional judge or layman (or a combination) or a jury.

In a common law system, 'truth' is believed to be found by a '*choc des opinions*' (battle of opinions) between equal parties before an independent umpire, i.e. a jury or a magistrate. The 'battle' concentrates on the facts and the opinions presented by the 'parties', unlike the judicial enquiry of the inquisitorial system where the accused and the prosecution don't bear any 'burden of proof' as such. They are only invited to make a contribution by the trial judge. They are not in a battle with each other.

The influence and structural position of the pre-trial investigation and its influence on the character of the trial differ significantly between the systems. Under the civil law, state authorities have many intrusive powers of investigation. These powers are based on written, democratically decided laws. In some jurisdictions, the judge takes part in the pre-trial investigation and can determine that, for instance, illegally obtained or unreliable evidence is not admissible,[1] and the state authorities responsible for the investigation also have to protect the rights of the accused. This double duty imposed on the state is probably why Packer's dichotomy due process-crime control[2] never seems to work very well in inquisitorial systems (see Brants [1], p. 1075); the decision to prosecute (and for what) is left to a public law official, usually the public prosecutor, sometimes a judge. The accusation is presented as a case that is to be tested by the judge, with the results of the pre-trial investigation in a dossier. The role of the trial procedure is not, therefore, as in the adversarial system, to produce all the evidence at the trial; the trial is a test, by the judge, of the accuracy of the prosecutor's case. The role of the defence is limited to casting doubt on the prosecutor's case, for example, persuading the judge of the necessity to call a witness to the trial, instead of relying *de auditu* on his or her statement during the pre-trial investigation.[3] 'De auditu' (hearsay) evidence is not forbidden in the civil law system. It is allowed as long as the judge sees no reason to hear the witness as part as his or her task to find the truth.

If the accused is extra vulnerable, for instance, in cases of mental disturbance, it is for the judge – and for the other authorities during the pre-trial investigation – to 'compensate' for this in the way the trial or the investigation is organised. There are very few cases in the inquisitorial system in which the prosecution is stopped because of 'unfitness to stand trial'. This is because it is the task of the judge to protect the accused from his or her weaknesses. For example, the judge may represent the accused against the prosecutor. Also, she/he has to be extra careful in evaluating evidence when the accused is not able to give his or her view on the facts. In a comparative study between Canada and the Netherlands, the 'umbrella-protection' of the judge was found to produce greater fairness and effectiveness in the prosecution of a mentally disordered defendant than in the adversarial system [4].

[1] Exclusion of illegally obtained evidence is, in the view of the European Court on Human Rights, not under all circumstances part of Article 6 (fair trial) guarantee of the convention.

[2] Packer constructed two models, the crime control model and the due process model, to represent the two competing systems of values operating within criminal justice [17].

[3] *De auditu* is the testimony of a witness obtained from third parties.

1.3 Convergence of Systems

The usual distinction made between the two systems is that the common law system tends to be case centred and hence judge centred, allowing scope for a discretionary, pragmatic approach, whereas the civil law system tends to be a codified body of general abstract principles which controls the exercise of judicial discretion. In reality, both of these views are extremes with the former overemphasising the extent to which the common law judge has discretion and the latter underestimating the extent to which continental judges have the power to exercise judicial discretion.

It is worth noting that the European Court of Human Rights, based on the European Convention on Human Rights, was established, initially, on civil law principles, but is increasingly recognising the benefits of establishing a body of case law. The court wants to see the rights of an accused being effectively protected in every system of criminal procedure and in every separate case. There is a clear 'common law' approach, for example, when the court underlines the right of the accused to question witnesses himself, preferably during the trial, as the best way to challenge the evidence, instead of relying on the professional opinion of the judge on the reliability of the statement of the witness. Another example is the recent jurisprudence on police interrogation. Instead of trusting the police to uphold the rights of the suspected citizen and to make a 'true' report of the interrogation, the Strasburg Court has underlined the right of the suspected person to have his or her lawyer present during police interrogation as a better means of preventing miscarriages of justice. The court went so far as to rule that 'the rights of the accused will in principle be irretrievably prejudiced when incriminating statements made during police interrogation without access to a lawyer are used for a conviction (ECHR 2008).' (for an analysis see Schwikkard [5]). The Dutch inquisitorial oriented police were rather upset by this ruling.

Separate from the Council of Europe, the EU recommendation on procedural safeguards for vulnerable persons[4] calls for several instruments to protect the accused in a criminal procedure, without any distinction between or differentiation in systems of (Common or Civil) law. This and other EU documents are discussed in Chap. 5 of this book.

1.4 Historical Roots

1.4.1 History of Roots of the Common Law: Adversarial System

A good guide to the history of the development of the adversarial system is the book by Potter [6], and this can usefully be supplemented by the biography of Sir William Garrow by Hostetler and Braby [7].

[4] Commission recommendation of 27 November 2013 on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings (2013/C 378/02).

How have two different systems developed within one continent which has much common history? After all, 1000 years ago, Britain and France were united, and one might have expected that their systems of justice would reflect this close connection. Well they do to some extent; both systems have some roots in Roman law. After the collapse of the Roman Empire, the written law seems to have disappeared in Britain for several centuries; grievances, feuds and other disputes were settled privately, often by armed conflict. The Anglo-Saxons reverted to codification, akin to Roman codification, at the end of the sixth century. The code set out a list of grievances and the compensation which they merited. Not only did everybody and everything have financial worth in this code, but every part of the anatomy did also, e.g. the loss of a big toe costs 10 shillings.

The disputes were administered by the courts of the hundreds[5] unless the alleged offences were quite serious when they were referred up to the county or shire courts. The shire courts were overseen by a representative of the king or a shire reeve (sheriff). The basis of the trial was the oath. To declare his or her innocence, the accused had to swear an oath and get people to come and testify to his or her honesty. Serious cases required more people to testify to his or her honesty, for example, a complaint of arson required 36 people to testify to the accused's honesty. This was potentially open to abuse, but most people were religious, and it was believed that if one made a false oath then one was liable to eternal damnation. At first there was no distinction between civil and criminal laws.

By the tenth century, the codes were more complex and also prescribed physical punishments including death for some offences. For example, anyone caught forging the common currency of England was to have his hand struck off. This was the beginning of the doctrine that any serious offence is an offence against the Crown. In common with the rest of Europe, the later Anglo-Saxons devised a new system of proof in the trial, the so-called ordeal. This was a way of inviting God into the trial. The ordeal was dangerous and painful but was not a punishment; it was a mode of proof. The idea was that God would come to the aid of the innocent, so if you failed the ordeal, you were then punished. The ordeals were supervised by the clergy. There were two main kinds of ordeal at the time, the first was being made to hold a red-hot poker; the hand was then bandaged, and after 3 days it was inspected to see if it had healed. If it had festered, you were guilty. The second kind of ordeal was by water; you were lowered into a pool of sanctified holy water; if you sank you were innocent, and if you floated it implied that the pure holy water had rejected you, and you were therefore guilty. Trial by ordeal was used for some centuries, although it was only used in cases which could not be settled in other ways, i.e. if there was no factual proof, for example, recovered stolen goods or appropriate marks on a person's body. These methods of trial were used throughout Europe. About half of those who subjected to trial by ordeal were found to be innocent.

When the Normans invaded England in 1066, they decided to keep the courts of the hundreds and shires, but they added a new system of ordeal; this was ordeal by combat. The winner is being declared the innocent. Most of the offences being tried

[5] Probably an area of land containing a 100 dwellings.

this way were capital offences, so the victor might as well finish off the loser at the end of a battle. If he didn't, the loser would be brought before the bishop or the sheriff to be sentenced to, for example, death or blinding or castration.

All was well with the Norman system until Stephen usurped the English throne, and civil war ensued, and the law broke down. Henry II came to the throne in 1154 aged 21. He sorted out the anarchy by strict imposition of the king's law and indeed is sometimes regarded as the father of the English common law. In 1166 he established a system of travelling justices who were significant friends or appointees of the king personally. These justices found that there were wide discrepancies in the efficiency with which the laws were administered in different counties (shires), and so the king sets standards which had to be followed, and he invoked the support of ordinary people by establishing juries of presentment. The jurors of presentment were to present to the courts all the suspected offenders in an area; they did this under oath.

The juries of presentment were 11 or 12 men from the hundreds and perhaps three or four selected more locally who had the responsibility of bringing anyone who was suspected of an offence to trial. If someone was suspected of stealing cattle, for example, they would be reported to the jury of presentment who would then try to ascertain the facts of the case as best they could and decide whether to progress the case further or not. If they decided that the accused person was likely to be guilty, they would pass them on to be submitted to one of the ordeals. They had considerable power however to filter out people for whom they thought the case was weak. This is a forerunner to the grand jury which is still used in the United States. A good account, using historical records, of the jury of presentment before 1215 is given by Groot [8] who points out that not only did the jurors investigate the facts of the actus reus (whether the early alleged sequence of events took place and the accused was implicated), but also they enquired into mens rea, i.e. they decided whether or not an action was deliberate.

A central court was established in Westminster; it was not an appeal court or a higher court, but it was the court from which the justices would set out on their journeys around the country and where the king could make his wishes known. It was a place where judges could meet and discuss cases and establish general principles which they could then take out into the shires. They wrote down some of their cases, and the first books of English law began to appear. This meant that the judges were establishing the basis of common law which is 'precedent', i.e. law is consistent and based on previous judgements.

The year 1215 was a landmark year in English law. Henry's son John embarked on disastrous military adventures in France and lost the nation its wealth. He demanded taxes from a nobility who hated him, and he seized lands arbitrarily. The barons rose against him and forced him to sign a Great Charter (*Magna Carta*) which outlawed arbitrary imprisonment and decreed that no one should be victimised except by lawful judgement of his peers or by the law of the land. It was a ground-breaking recognition that the English people had rights. The Charter was used in the English Civil War to curb the power of King Charles I. Later it formed the basis of the Constitution of the United States.

Trials by ordeal were eventually banned by Pope Innocent III who decreed that the judgement of God could not be manipulated by the judgement of men. This meant that the church withdrew from trial by ordeal, and the continent of Europe reverted to methods of proof that had been established by the Romans. Confessions were extracted from those accused, by torture if necessary. England chose to introduce instead trial by jury. The first known English jury trial took place in 1220. Juries in the thirteenth century were a development from the juries of presentment who were now expected to decide the verdict. They did not come to their verdict by weighing evidence but by using their own local knowledge. Trial by jury became one of the defining characteristics of English common law.

In Tudor England the common law became corrupted; juries were bribed, and local nobleman largely ran the judges in the courts. To counteract this corruption, the king developed a separate system of law which was held in the Star Chamber (literally a chamber with stars on the ceiling) without juries and thus not subject to bribery. The aristocracy in particular could be tried in the Star Chamber. Mythology tells us that the Star Chamber was tyrannical and frequently resorted to torture. In practice the Chamber was an inquisitorial system without a jury, used on the one hand to express the king's mercy, but on the other hand to deal with direct threats to the king, for example, the gunpowder plot to blow up Parliament. Torture was used, however, in unusual circumstances by virtue of powers deriving from the doctrine of sovereign immunity from legal action. This doctrine was totally repudiated by the common law and thus provided a long-running source of tension between the Crown and Parliamentary lawyers. Things came to a head in the reign of Charles I. The high-handed king forced disastrous wars and asked Parliament to raise the necessary funds. When this was refused, he disbanded Parliament and raised money by extortion from wealthy landowners. If a nobleman refused to pay up, he was arraigned before the Star Chamber. Arrested knights appealed to the common law for release from prison, but the king said he had unlimited powers because he ruled by divine right, and he dismissed Parliament.

However he had to recall Parliament to demand more money. Edward Coke devised a scheme whereby money was to be granted to the king so long as he signed a document giving full rights to the common people. The document is called the Petition of Right and may be second only in importance in English law to *Magna Carta*. Nobody could be compelled to pay taxes without parliamentary authority, and nobody could be imprisoned without cause. The latter is the principle of habeas corpus.

As soon as he had secured sufficient cash, King Charles I closed down Parliament again. He ruled without Parliament for over a decade until he fought an unsuccessful war against the Scots. In 1640 he was again forced to recall Parliament for more money. Parliament immediately made torture warrants, which the king had been using, illegally. In 1641 Parliament forced the king to disband the Star Chamber and its inquisitorial system. Neither torture nor the Star Chamber system has ever been re-enacted.

The English Civil War between King Charles I and Parliament broke out in 1642. The king was beaten but refused to submit to the will of Parliament in the slightest degree, and so he was executed. The ruler of the victorious Parliamentary army Oliver Cromwell also dismissed Parliament and in some ways behaved like his predecessor, for example, locking up people without due cause. Parliament regained the upper hand when Cromwell died, and the monarchy was restored.

Barristers have existed in England since the thirteenth century, yet for five centuries, prisoners on indictment for treason and felony were not permitted to have counsel appear for them, even though the sentence for these offences was death. The reason for this was that in English criminal law, indictments of felony were always taken in the name of the monarch, and it was considered to be lèse-majesté for those indicted to be allowed to counsel against the monarch. Instead, in the trial the accused was allowed, indeed encouraged, to speak to the charges and to the evidence adduced against him, a system of trial they called 'the accused speaks'. The logic of the rule was to pressure the accused to speak in his/her own defence. The accused was regarded as an important source of information, and the jury was expected to judge the defendant's veracity and character by his/her performance in court. As Langbein points out, the judges believed that allowing the defendant to instruct counsel to speak for him/her would impair the jury's ability to weigh up the defendant for themselves.

The first breach in this barrier occurred after King James II had been ousted by the Dutch invasion of 1688 in the 'Glorious Revolution'. The new regime gave Parliament more power, and it introduced a Bill of Rights in 1689. The Bill established the principles of frequent parliaments, free elections and freedom of speech within Parliament (parliamentary privilege). It also included no right of taxation without Parliament's agreement, freedom from government interference and the right of petition and just treatment of people by courts. This provided for the right to trial by jury, the outlawing of excessive bail surety and excessive fines, as well as cruel and unusual punishments.

However, prisoners were still at a great disadvantage because the government sponsored a bounty system giving rewards to citizens who reported thieves. In some cases, when several thieves were caught, they would give evidence against each other in order to receive rewards and save their own necks. Judges thus came to believe that the scales were weighted too heavily against prisoners charged with the multitude of capital offences. As a consequence, from the 1730s, and without legislation, a few of them allowed counsel to appear for defendants and cross-examine prosecution witnesses: but barristers were still not permitted to examine their clients in court and were largely limited to cross examination. In theory this allowed the 'accused speaks' principle to continue. Nevertheless, in spite of this limitation, by skilled cross-examination lawyers could capture the courtroom and reduce the previously active role of the judge and jury who, respectively, became umpire and fact-finders. In this development a crucial role was played by William Garrow who appeared in over 1000 cases at the Old Bailey and established an aggressive and personal style of questioning prosecutors and their witnesses. This secured an

adversarial trial and also helped lead to the introduction of rules of evidence, such as the presumption of innocence, the 'best evidence rule' and a complex hearsay rule all of which were designed to give new rights to prisoners.

With counsel available to cross-examine prosecution witnesses, to examine defence witnesses, to raise evidentiary objections and to insist on the prosecution burden of production of proof, an effective defence no longer require the participation of the accused, so by the 1780s, the counsel had effectively silenced their clients. Trial became what it has remained, a proceeding whose primary purpose is to provide defence counsel with an opportunity to test the prosecution case. Adversarial procedure presupposed that truth would somehow emerge when no one was in charge of seeking it. Truth was a by-product [9].

1.4.2 History and Roots of the Civil Law: Inquisitorial System

The roots of the continental civil law system date back to the twelfth century. Before that, as in the common law countries, there was no distinction between civil and criminal law cases. Accusation of another person in a more or less formal procedure was possible. The accusation and the evidence were presented there. The accused (not a suspect) could purify himself from the indictment. The judge's main function was to guard the procedure and to apply the law. But from the twelfth century, the p*rocédure extraordinaire* (originally for treason trials), which was secret and could include torture, was developed. More and more of this procedure was used to try those alleged to have offended the sovereign, partly because of problems with the ordinary process which was liable to abuse and corruption and used severe and unjust punishments as well as the ordeal as a mode of proof. Although the latter, as we have seen above, was forbidden by the Catholic Church, the influence of this Church by prosecuting heretics contributed to the further development of the inquisitorial system in criminal law. The criminal process began not with an accusation but with a suspicion; the authorities had to prove a case against the citizen in a procedure before a judge. That meant an important shift in the burden of proof [10]. Thus civil law has its roots in a public policy approach relating to the rising power of the government.

The inquisitorial system kept its main characteristics as a criminal law procedure after the Enlightenment and the French Revolution, but it was adjusted. Public law notions to protect the citizen against the powers of government and against arbitrariness were added. The systematic codification of the law emerged, fundamental rights to protect privacy were introduced, home and physical integrity were made constitutional rights (e.g. by banning the use of torture) that could only be breached by democratic written law, for instance, in the law on criminal procedure. These adjustments added a constitutional framework around the criminal procedure.[6] But not all civil law jurisdictions accept that criminal process should protect against

[6] The presumption of innocence in criminal cases is part of the French 'Déclaration des droits de l'homme' et du citoyen' from 1789.

breaches of constitutional provisions. In fact, the right to a fair trial, with its sub-rights, such as the presumption of innocence, in criminal cases is not codified in all civil law written constitutions. However, the situation changed after the fall of the Iron Curtain. Countries in Middle and Eastern Europe became member states of the Council of Europe and thus signed the European Convention on Human Rights, with its right to a fair trial in Article 6. They started to build up systems of constitutional rights and procedures on that basis. This has been difficult for countries using a more traditional, inquisitorial system of criminal procedure in which the right to a fair trial is supposed to be protected by the professional authorities behaving properly. It is not surprising that the European Court of Human Rights (ECHR) does often find breaches of the Convention. This is another example of two types of criminal procedure converging.

1.4.2.1 The Confession as a Gold Standard

One common factor in both the adversarial system and the inquisitorial systems is that the confession is still the gold standard for most prosecutors. At one level it is easy to see why if someone says 'yes I took the bottle of whiskey from the supermarket and deliberately left without paying for it', the procedure for dealing with such a person is simple and relatively inexpensive. However, most confessions are not like this, and criminals may deny responsibility in many ingenious ways. In a modern world, this means that the prosecuting investigation has to find corroborative evidence which places the criminal at the scene of the crime and is perhaps backed up by witnesses. All are very expensive and difficult to provide. It is very tempting therefore to resort, not to the physical torture of the past, but to psychological duress to try and get someone who is strongly believed to be guilty to say so. As with torture confessions in the past, this is a flawed process and produces the wrong answer quite frequently. A pioneering Icelandic/British psychologist Gisli Gudjonsson has developed techniques for showing how unreliable a confession obtained under duress can be [11]. Many countries have now determined that police interviews should be conducted formally and transparently recorded. Even then confessional evidence is probably not good enough in some cases; in many inquisitorial systems, it is forbidden to declare an accusation proved by a confession alone.

Britain had a spate of wrongful convictions following a series appalling atrocities carried out by the Irish Republican Army, a terrorist organisation, in the 1970s. The convictions were based on flawed confessions and flawed forensic science evidence. A Royal Commission recommended changes to the ways in which the police collect evidence, but an attitudinal sea change in the English legal system is needed if it is to get away from the notion that the police know best. The Netherlands has stuck to the notion that it is best to trust in the professional integrity of the police officer. Even so some cases have led to a rule that the interrogation should be audiotaped. The ECHR has introduced the right of the accused to have a lawyer present during police interrogation, and the European Union has said that this must be implemented by 2017 (see Ogorodova and Spronken [12] and Mevis and Verbaan [13]). This is another example of the trend towards the harmonisation of procedural law across Europe.

1.4.2.2 Psychiatric Evidence and Exclusion from Criminal Liability

Fortunately for psychiatrists, psychiatric evidence is rarely called to attest to the facts of a case. It can be, in strange situations where, for example, a defendant fabricates a story, but usually the facts are determined by other means. The facts may be a burglary, an assault even a murder. The psychiatrist is then asked for an opinion on the mental capacity of the offender.

The general public and therefore lawyers put a great deal of emphasis on the question of blameworthiness or 'responsibility' in any court setting. People wish to know whether a damaging act was deliberate i.e. intended, or accidental. An apparently deliberate act can be excused to some extent by immaturity, lack of comprehension or mental disorder. These excuses are ancient, vague and capricious. Psychiatrists may have something to say about these matters, and indeed they can describe, to some extent, an individual's mental functioning. In Britain and in the Netherlands, however, it is clear that the psychiatrist cannot usurp the function of the court and decide whether someone is 'responsible' for a criminal act or not. Judges may ask them for an opinion on this central issue from time to time, but the jury or the judge (GB and the Netherlands, respectively) has the last word.

When the issue is 'insanity', a legal concept which doesn't map very easily on to medical concepts the adversarial system, by and large, sticks with the McNaughton rules which were developed in the first half of the nineteenth century to explain to an outraged public how it was that a man who tried to kill the Prime Minister was found not guilty because of his mental health (see West and Walk [14]). Politicians demanded that the judges explain themselves and come up with an acceptable definition of insanity. They decided that:

> Every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.

Thus delusions are no excuse if the accused knew, at the time of committing the crime, that she/he was acting contrary to the law.

In Britain, it is so difficult for an accused to convince the jury of this misfortune that the defence is rarely used. A more usual plea is 'diminished responsibility' in murder trials where the defence argues that the charge should be reduced to manslaughter because of an abnormal mental state at the time of the killing. But this also rarely succeeds, as psychiatric mitigation is not popular with juries. The bald truth is that most mentally abnormal offenders who commit serious crimes go to prison with its inadequate psychiatric services rather than to a secure hospital.

The difficulty of the plea in the Netherlands is reflected in the question as to whether there might be a lack of evidence to prove that the accused acted with intent. 'Intent' is a substantial part of the definition of almost all serious crimes. The

plea of lack of evidence of intent[7] based on a lack of mental capacity is, in the ruling of the Dutch Supreme (Criminal) Court, only acceptable if the accused at the time of the crime lacked any sense or notion of the range and possible consequences of his/her act.

McCauley [15] and Simon and Ahn-Redding [16] give a comparative analysis of the different means of different concepts of insanity in the civil law systems. McCauley begins with what he calls the psychopathological approach which he says exists in Finland, Norway, Greece and Spain. Such an approach reduces the issue of insanity to a diagnosis of mental illness or mental deficiency. The guiding question is: does the accused suffer from a clinically diagnosed mental illness or from mental deficiency when he did the act that forms the basis of the charge against him? McCauley says that the principal criticism of this system is that it trades on the essentially fluid concept of mental illness which is too vague to satisfy the constitutional requirements of legality yet too wide to secure the preventive aims of the criminal law. Looking at Spain, he says that in practice, the Spanish courts have all but abandoned the psychopathological approach in favour of a mixed approach, combining the psychiatric diagnosis with an assessment of the impact of the mental disorder on the accused's reasoning powers.

The psychological approach is practised in France, Belgium and the Netherlands. The approach is in two stages. The first stage is concerned with the question of whether or not the accused is suffering from a serious mental illness, mental illness being defined by codified criteria and not by psychiatric classifications, so insanity is not equated with psychiatric diagnosis. The second stage is to decide whether the mental disorder prevented the accused from understanding the significance of his or her actions or from acting in accordance with such understanding. Stage two was designed to take account of the fact that serious physical psychiatric illness can profoundly alter the accused's capacity to act rationally without impairing his or her freedom of choice. These countries import the concept of *démence*[8] from the code Napoleon, for example, the Belgian penal code allows the insanity defence to anyone who was in a state of *démence* at the time of the act or who committed the act under the influence of an impulse she/he was unable to resist. To reiterate *démence* does not denote a particular psychiatric illness or diagnosis the central issue may be whether the mental condition has undermined his or her autonomy as a moral agent. As McCauley says 'not surprisingly, this formula has not been easy to apply, as its effect has been to replace one set of contentious ideas (the categories of clinical psychiatry) with another (the philosophical concepts of personal autonomy and moral agency)'. The principal difficulty has been to give concrete legal form to the abstract notion of personal autonomy. The French and Belgian penal codes do not require proof of a causal link between the accused's state of mind and the alleged offence; it is enough that he or she was in a condition that qualifies as 'a state D-' at the time of the act.

[7] In distinction to 'lack of criminal responsibility' based on a lack in mental capacity.

[8] Dementia, impaired mental capacity.

A striking feature of the psychological approach is that a successful insanity defence leads in some jurisdictions to an unconditional acquittal. In some jurisdictions, like the Netherlands and Germany, safety measures are nevertheless possible against the former accused if and in so far they can be seen as a threat to public safety, a ground for compulsory measures in (Dutch) mental health law.

1.4.2.3 Sentencing

When it comes to sentencing, there is little difference between the two systems. The trial judge decides what sentence should be applied. The decision is based on an analysis of all the relevant information, mostly gathered during the pre-trial investigation including an examination of the mental capacity of the accused in the civil law system. In the British system, there is very little advocacy from the prosecution, which leaves the judge to decide on the sentence using the facts of the case and the formal sentencing guidelines which are established within the justice system as well as listening to any mitigation that the defence counsel puts forward. The sentencing phase in both can be regarded as inquisitorial; the criminal court has some discretion to tailor the sanction to the evidence available in order to decide on a 'proper' or 'just' sanction.

Conclusion

The inquisitorial system tends to rely on the results of the pre-trial investigation; its advantage is the possibility of a debate at the trial. A possible threat to the inquisitorial system is a trend to forgo the debate at the trial. Adequate psychiatric reports can enhance the debate in both systems. The adversarial system depends upon scrupulous honesty including both the defence and the prosecution revealing their weak points as well as the strong ones. Sometimes the competitive urge to win can compromise this honesty. Judges have to be very alert to ensure that all the rules of the trial kept and fairness are maintained.

Our general conclusion is that, in the end it is not the system of criminal procedure that decides whether the outcome is fair and just, but the way in which the lawyers and others including, sometimes, psychiatrists work adequately together. If a lawyer and doctor in a psychiatric case don't understand each other, then both systems can result in an unfair result.

Take-Home Messages

- A take-home message from this debate is that the two main legal systems even with differences in historical developments have had confessions as the gold standard of proof. These days confessions have to be treated with circumspection and should be supported by scientific evidence. Where in the present times legal systems interact within Europe, convergence of rules, type of procedures and standards will be approached.

- A further point, which follows from this, is that all practitioners should recognise that no one system has achieved perfection or has all the answers; discussion, especially international discussion will be beneficial.
- Psychiatrists should remember that a courtroom in any legal system, be it more inquisitorial or more adversarial oriented, is not a clinic room. But nevertheless, it is perfectly possible to satisfy both medical ethics and the demands of the legal oath provided the limitations and biases of medical evidence are fully acknowledged where psychiatrists are involved in criminal pre-trial and trial investigations and procedures concerning questions of criminal liability, evidence and sentencing.
- It is not the system of criminal procedure that decides whether the outcome of a trial is fair and just, but the way in which the lawyers, the psychiatrists and others work together within the given system.

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National Laws and Their History

2

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2.1 Introduction

The scope of this chapter is to give an idea about national laws and legal systems in some of the European countries, given the great diversity of national laws and health systems in Europe.

The lack of criminal responsibility has been described since Greek and Roman times and later in the Middle Ages (for instance, in Romania and Spain) [1, 2]. It wasn't until the eighteenth century that mentally ill offenders started to be placed together with the non-criminal mentally ill in asylums to get more appropriate psychiatric care. The reforms during the second half of the nineteenth century gradually permitted the compulsory admission of mentally ill offenders to psychiatric hospitals. As a part of the expansion of mental hospitals during the nineteenth century all over Europe, some places offered early examples of what could be characterized as specialized services for mentally ill or disordered offenders.

Influential contributions came from Italy and were made by Beccaria (1738–1794) and Lombrosso (1836–1909). Beccaria, the founder of the classical school of criminology, considered criminal acts to be the result of free will and thus to require punishment or penal sanction [3]. In contrast, Lombroso (1876), as a representative of the positivist school of criminology, identified physical features assumed to be characteristic of criminal males and discussed criminal behavior as deterministic.

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As a consequence of crimes resulting from genetic predisposition, offenders should be treated rather than punished. However, Lombroso's prognosis for achieving remission of criminal behavior was not optimistic.

Early in the nineteenth century, after a mentally ill person had tried to assassinate King George III, Parliament passed a statute aiming at the safe custody of insane persons charged with offenses. In 1815, a hospital opened that provided specialized wards for "criminal lunatics" [4]. Even today, it is still a matter of debate among experts as to whether forensic psychiatric services should be integrated into general psychiatric hospitals or separated into secure facilities of their own. Whereas large secure hospitals may be advantageous in that they can provide a variety of specialized treatment programs and in that they probably offer better safety for the public, they also may serve as an example of what Erving Goffman has labeled the "total institution" [5]. According to this concept, a total institution is characterized by a basic split between large managed groups, conveniently known as "inmates", and a small supervisory staff. Inmates typically live in the institution, and their contacts with the world outside the walls are severely restricted [6].

During the 1950s and 1960s, as a consequence of psychiatric treatment approaches, the development of psychopharmacology and new opportunities for treating the mentally ill, community-based mental health care developed, and the number of psychiatric hospital beds declined substantially.

The McNaughton Rules from 1843 are considered to be a cornerstone of the further development of the concept of criminal responsibility. When during the trial it became evident that McNaughton was mentally disturbed, the jury—rather unusually for that time—ordered him committed to a mental asylum rather than deciding to hang an obviously ill person. The uproar over McNaughton's acquittal prompted the creation of McNaughton's Rules by the House of Lords: to establish a defense on the grounds of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong.

Furthermore, the McNaughton Rules defined insanity as intellectual incapacity, and emotional and volitional aspects were excluded. In 1953, a report by the British Royal Commission on Capital Punishment therefore proposed an amendment to McNaughton's Rules, adding to them an "irresistible impulse test." The Royal Commission also specified the term "wrongfulness," under which the persons concerned are not held responsible for their actions, to include:

- *Illegality standards* (applicable to defendants lacking the capacity to know or appreciate that their acts violated the law)
- *Subjective moral standards* (applicable to persons suffering from a disease of the mind that results in their belief that they were morally justified in carrying out their actions)
- *Objective moral standards* (applicable to persons lacking the capacity to understand that society considers their actions to be morally wrong)

In the event, the law was changed by the Homicide Act of 1957, which introduced the concept of diminished responsibility into English law, the standard for which is very low within the Act. This enabled the substitution of a manslaughter conviction for a murder conviction in cases of mental illness (nonpsychotic as well as psychotic), thereby allowing a range of possible disposal options.

The Old Germanic law as well as the ancient laws of Ireland and ancient Dutch law are reported to already have included certain features of the concept of reduced criminal responsibility for criminal acts and thus reduced punishment [7].

At the end of the nineteenth century, German psychiatrist Kraepelin criticized the use of punishment as the sole available sanction since it neglects the individual disposition of an offender and the chance to treat certain kinds of misbehavior [8]. Thus, acquittal from imprisonment should depend on psychopathological status. As a consequence, the responsibility for a discharge decision should be shifted from judges or courts to the psychiatrist. Convinced that recidivism or repeated delinquency was closely linked to a mental disorder, Kraepelin favored the integration of the concept of diminished criminal responsibility into the penal code.

In the Netherlands, the first statute referring to criminal responsibility of varying degrees appeared in 1809, to be applied to cases of insanity, varying madness, and organic diseases affecting the mental state, as well as to severe mental retardation. Punishment or acquittal would be decided on the basis of the degree of criminal responsibility. However, this progressive law was never applied in practice due to the French annexation of the Netherlands in 1810, after which French penal law stayed in effect until Dutch penal law was initiated in 1886. Although the Dutch penal law does not explicitly mention the diminished criminal responsibility, the concept was implicitly introduced into the Dutch judicial context in 1928. From this time on, punishment for mentally disordered offenders has been able to be combined with specific restrictive measures (the Dutch Entrustment Act "terbeschikkingstelling" abbreviated as "tbs") in the Netherlands [7].

In most European countries, in the 1990s, following changes in European and international laws (human rights, prison, mental health, etc.), there was a review of the penal codes and mental health acts regarding criminal responsibility and placement of mentally ill offenders.

Also in the former communist countries (Romania, Hungary, etc.), there were important changes in legislation regarding forensic patients (including prisoners) as they joined the main international conventions about human rights.

2.2 Legal Systems

History and identity of the countries had a great influence on the principles and practices of each national legal system. In Europe there are two main systems upon which most countries' systems are based. These are Roman law and common law.

2.2.1 Roman Law

This law underpins most legal systems in continental Europe. From its origins in ancient Roman and Greco-Roman tradition, its current forms reflect the evolution it experienced during the Middle Ages in Central Europe under the Holy Roman Empire and at the beginning of the modern era with the French Revolution.

Penal codes state what is an offense and what is not and lay down procedures and punishments which must be applied by magistrates and judges with little discretionary power. Interpretation is limited, codes and doctrines are the sources of judgment, and jurisprudence plays a minor role. A consequence of such systems is that processes of change in specific areas are very slow and that there is little flexibility in adapting legal outcomes to circumstances and individual situations. Roman law systems can be quite different. German laws may be considered the prototype of Roman law, while Mediterranean countries seem to have simpler systems, with fewer options and wider discretionary powers accorded to judges in difficult cases. France, Belgium, and Holland (nations with many legal aspects in common) seem to have more detailed laws, in which many exceptions are regulated, as do Scandinavian countries, in which civil law seems to regulate more matters [5].

With regard to mentally disordered offenders, Roman law tends to emphasize the psychological element of an offense: the basic concept is responsibility, which in cases of insanity at the time of an offense is considered to be diminished or lacking. Usually, for reasons of public safety, a security measure can be applied in case of persistent dangerousness [5]. For instance in Spain, a security measure is applied, following the Spanish penal code, when there is an offense and there is a likelihood of an offense being repeated. This measure could be implemented both in a psychiatric hospital and in mental health community resources.

2.2.2 Common Law

This is practiced and observed in all countries whose legal systems developed from the Anglo-Saxon. Its roots lie in the more informal way of managing justice adopted in the early Anglo-Saxon kingdoms, and it is much less prescriptive in nature. It has a pragmatic approach and emphasizes behavior rather than psychological elements. The judge has wider discretionary powers, and the trial is aimed at ascertaining whether the offense was committed or not. Once the verdict has been reached, a decision is taken as regards the sentence or disposal of the case, which in cases of mental illness entails a placement in hospital for treatment. This disposal is a pragmatic decision arising from issues of justice, equality, effectiveness, and the right to psychiatric treatment. There is no concept of responsibility but rather a series of empirical acts and decisions which are taken in the best interests of the individual and of society.

The implications of this system are that each case can be flexibly managed as to procedures and to placement, and that changes are much more rapid, allowing for

radical reforms and different practice, based simply on the decisions of one or more judges, when new needs are felt. The forensic psychiatry system can undergo more rapid development and change. It is readily understandable, given the above, that procedures and practices may be very different in these systems and that concepts and terminology may vary.

Most of the EU members' laws regarding forensic patients are traditionally based on Roman law (Austria, France, Germany, Spain, etc.), while some have Roman law and certain common law features (Denmark, Sweden, and Finland), and others have common law (England and Wales, Ireland). In those cases where the common law is implemented, it is easier to adapt legislation to new changes, while in those with Roman law, changes in approach to mentally ill offenders take more time to be modified.

2.3 Health-Care and Welfare Systems

As with their legal systems, European countries have adopted very different welfare and health-care systems, in which variations are particularly great where mental health care is concerned.

Italy, the UK, and most Scandinavian countries have adopted a radical public health approach and run National Health Services (NHS) with an objective of universal and comprehensive coverage. Under this approach, the UK has promoted a major reform, integrating within the NHS all forensic psychiatric treatment facilities, leaving to the judicial system only the role of reaching a verdict and of disposing of mentally ill cases by transferring them to the health-care system [5].

Most European countries run mixed systems, where some basic services are provided by the state and most services are provided on private or public insurance schemes. The development of the forensic psychiatric system is always a state task, but it can be accomplished either by the Ministry of Justice or the Ministry of Health. It is clear that, in these countries, integration with general psychiatric services can be more difficult given the different administrative arrangements governing different sectors.

A broad consensus to move toward deinstitutionalization has emerged across most of Western Europe in the past 20 years. This change is still underway in Central and Eastern Europe. Despite this, the rate of change has varied markedly, and support service models vary substantially. Many countries which have already chosen to switch to a community-based mental health system or have incorporated substantial community services in a hospital-based system still provide a high number of psychiatric beds.

Mental health legislation focused the interests of most countries during the 1990s. Two recent comparisons of the legal frameworks in European Union member states have delineated models for regulating this complex issue; these may also influence legislation and care routines for mentally disordered offenders [9, 10].

2.4 Cultural Attitudes

Cultural attitudes have a strong influence in determining the shape of regulations, practices, and innovations, both in judicial and health-care systems. These cultural attitudes vary perceptibly and result from multiple social sources.

Detention is practiced only in the case of major offenses, and alternative measures are often proposed. This may contribute to the low figures for detained mentally disordered people in prisons and forensic care in Latin countries. But attitudes toward care may also help explain the low figures. In Latin countries, informal support from family, community, and nonprofessional agencies is traditionally stronger than in Central European-, Scandinavian-, and English-speaking countries. Only recently, with rapid and dramatic demographic changes (low birth rate, increasing immigration, the aging population), do these traditional informal supports seem to be becoming weaker, with more requests for public assistance from the health or social services becoming apparent. In general, in Latin countries, it is still perceived as the responsibility of the family to take care of a person with a mental disorder, and this might explain the lower rates of institutionalization [5].

2.5 The European and International Policy

Mentally ill offenders are an issue that does not fall within a single policy area but cuts across a number of fields such as health, legal affairs, and human rights in a variety of ways and to differing degrees. The fact that a mentally ill person who has committed a crime must be viewed as both a patient and as an offender encapsulates the complexity of the issue. Consequently, for the European Community, the issue of the placement and treatment of mentally ill offenders incorporates concerns both from the field of public health and from those of legal affairs and human rights.

With the development of public health as an area of competence for the community, mental health issues were integrated step-by-step into this new competence. The Council Resolution of June 2, 1994 on the framework for community action in the field of public health called for the issue of mental illness to be explored and actions at community level to be identified in order to assist member states in this area. The commission communication of April 16, 1998 on the development of a public health policy also identified mental health as a field that has to be taken into account in future community action.

The Council Resolution of 18 November 1999 on the promotion of mental health called for member states to give attention to mental health, to promote the exchange of good practice and joint projects, as well as to support research activities, including using the support of the fifth and sixth framework programs of the European Community for research, technological development, and demonstration activities. These developments have been accompanied by an intense process in the recent years to promote a European mental health agenda so as to provide a visible platform of mental health issues in a European context. One of the first steps toward

realizing this goal was the founding of the European Network on Mental Health Policy in 1995.

The next step taken was a research project in 1997 on the development of Key Concepts for European Mental Health Promotion. In April 1999, a joint WHO and European Commission meeting on Balancing Mental Health Promotion and Mental Health Care was held in Brussels, Belgium, followed by a European Conference on Promotion of Mental Health and Social Inclusion in October 1999, in Tampere, Finland.

The issue of mentally ill offenders is also of concern with regard to the community's policy area of legal affairs. Here, the community is pursuing a policy to encourage legal cooperation in criminal matters and to slowly harmonize substantive and procedural criminal law with regard to those crimes that are of a cross-border nature. Although the Treaty of Maastricht identified various areas of the Directorate-General (DG) of justice and home affairs as matters of common interest, there was still no legal basis for a convergence of substantive criminal law. The Treaty of Amsterdam laid the groundwork for a convergence of substantive but not procedural criminal law. The 1998 Vienna Action Plan laid down provisions as to how best to implement the Amsterdam Treaty with regard to the areas of freedom, security, and justice. In 1999, the Tampere European Council sets further goals: the convergence of criminal law in specific sectors identified as areas of common interest, the coordination and the mutual recognition of judicial proceedings, and the protection of individual human rights. Certain cross-border crimes that were identified by the Tampere European Council as a primary field of action, such as the sexual exploitation of children, touch upon the issue of the placement, and treatment of mentally ill offenders. Community-wide activity also includes mentally ill offenders as a target group [5].

2.6 Mentally Ill Offenders and Human Rights

The placement and treatment of mentally ill people who have committed criminal offenses must be considered in the context of human rights. Human rights are inseparably linked to mental health as both are complementary approaches to the improvement of the human condition. Human rights also are the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country [11].

The fundamental document in the protection of human rights in Europe is the *European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR*) of the Council of Europe, which was signed in 1950 and took effect in 1953. The European Convention is not statutory. As a tool of the Convention, the European Court of Human Rights (ECHR) investigates alleged violations of the Conventions' human rights standards, involving interstate cases as well as individual claims. However, the court is only able to consider those cases that have already exhausted all domestic remedies. There have been several judgements by the court concerning national mental health laws and practices. The resulting case law has

dealt mainly with issues of compulsory detention, conditions of confinement, and civil rights. Additional articles of importance to people with mental illness, including those who have committed an offense, concern the obligation to respect human rights (Article 1), the right to life (Article 2), the prohibition of torture (Article 3), the right to a fair trial (Article 6), the prohibition of punishment without law (Article 7), and the prohibition of discrimination (Article 14).

Conclusions about the impact of this act differ. It was initially suggested that the Human Rights Act would be likely to result in "a flood of legal cases," particularly those of patients admitted on a compulsory basis under the Mental Health Act. In 1983, the Committee of Ministers of the Council of Europe adopted a *Recommendation Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients*. The 1994 Parliamentary Assembly *Recommendation 1235 on Psychiatry and Human Rights* refers to compulsory admission in general, and no special distinction is made between mentally ill persons admitted under civil law and those admitted following criminal proceedings. Nevertheless, the *recommendation* gives special attention to the situation of detained persons, stating that the recommendations set out should also apply to them. In 2000, the Council of Europe published a *white paper on the protection of human rights and dignity of people suffering from mental disorder especially those placed as involuntary patients in a psychiatric establishment*, and the scope of which encompassed civil detention as well as detention in the context of offending. The white paper defines the roles and certain standards regarding the various agencies involved in the placement and treatment of mentally ill offenders, such as the police, courts, prisons, and medical experts. It further emphasizes that member states should ensure sufficient provision of a range of hospital accommodation with the appropriate levels of security and community-based forensic psychiatric services. The European Prison Rules (1987) also stipulate an obligation to treat mentally ill detainees not in prison but in appropriate establishments.

In December 2000, the EU proclaimed the *Charter of Fundamental Rights of the European Union*. The Charter itself provides standards of health care in Article 35, stating that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national law and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities." The principles set out in this article are based on Article 152 of the EC Treaty and on Article 11 of the European Social Charter (the right to protection of health). Chapter VI on justice includes the right to an effective remedy and fair trial (Article 47), the presumption of innocence and right to defense (Art. 48), the principles of legality and proportionality of criminal offenses and penalties (Article 49), and the right not be tried or punished twice in criminal proceedings for the same offense (Article 50). Despite its nominalized legal status, it is argued that the *Charter* represents a step forward in the protection of human rights and articulates a new normative basis and a new ethic for the European Union.

The *Universal Declaration of Human Rights* attempts to achieve common standards of human rights. It contains several articles that protect human rights

concerning the placement and treatment of mentally ill persons, including those who are placed on the basis of criminal proceedings. Article 5 states that "…no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." Article 12 of the *Declaration* states that "…no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation," an article which is put forward by critics against the granting of wider access to the medical data of mentally ill offenders or the introduction of offender registration laws. The *Declaration* is not legally binding. In the early 1970s, the United Nations began intense debates on issues of mental health, and the years 1983–1992 were designated as the "Decade for Disabled Persons." In 1989, the General Assembly adopted the *Principles for The Protection of Persons with Mental Illnesses and The Improvement of Mental Health Care*, which formulate detailed statements on the rights of people with mental illness. The *Principles* state that all people have the right to the best available mental health care and that treatment should be undertaken with humanity and respect (Principle 1). Specific reference is made to the fact that these principles shall also apply to criminal offenders suspected of suffering from a mental illness (Principle 20). The principles also determine standards of surgical procedures, stating that sterilization should never be carried out as a treatment for mental illness. Any major surgical procedure should only be carried out on the basis of a formal domestic law and with the patient's informed consent. No irreversible treatment should be carried out on an involuntary patient. In addition, the principles determine that clinical trials and experimental treatment should never be carried out on a patient without the patient's consent. If a patient is unable to give this consent, an independent body has to give its approval (Principle 11). *The Standard Minimum Rules for the Treatment of Prisoners* states that persons found to be insane are not to be detained in prisons. It also states that prisoners suffering from other mental abnormalities shall be observed and treated in specialized institutions under medical management, and steps shall be taken to ensure the continuation of care after release.

The United Nations Standard Minimum Rules for Non-Custodial Measures ("the Tokyo Rules") aim for the rehabilitation of offenders as well as their integration into the community and call for the development of noncustodial measures. The *Rules* reject the controversial practice of community access to the personal data of an offender, stating that the offender's personal records should be kept strictly confidential with access limited to persons directly concerned with the case. Furthermore, the *Rules* call for the avoidance of pretrial detention as a means of last resort only for investigation or protection of society and for post-sentencing alternatives to assist the offender with his/her reintegration into society. UN resolutions as such are not legally binding documents. However, they are of practical importance as they help to establish international human rights norms by creating a baseline for fair treatment of mentally ill persons and therefore also enable objective monitoring of psychiatric abuses.

The Convention on the Rights of Persons with Disabilities is an international human rights treaty of the United Nations intended to protect the rights and dignity of persons with disabilities. Parties to the *Convention* are required to promote,

protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law. The *Convention* has served as the major catalyst in the global movement from viewing persons with disabilities as objects of charity, medical treatment, and social protection toward viewing them as full and equal members of society, with human rights. It is also the only UN human rights instrument with an explicit sustainable development dimension. The *Convention* was the first human rights treaty of the third millennium. The text was adopted by the United Nations General Assembly on 13 December 2006 and opened for signature on 30 March 2007. Following ratification by the twentieth party, it came into force on 3 May 2008. As of October 2016, it has 160 signatories and 168 parties, including 167 states and the European Union. *The Optional Protocol to the Convention on the Rights of Persons with Disabilities* is a side-agreement to the *Convention on the Rights of Persons with Disabilities*. It was adopted on 13 December 2006 and entered into force at the same time as its parent *Convention* on 3 May 2008 [12]. As of October 2016, it has 92 signatories and 92 state parties. The *Optional Protocol* establishes an individual complaint mechanism for the *Convention*.

The United Nations Standard Minimum Rules for the Treatment of Prisoners ("the Mandela Rules") are accepted as being good principles and practice in the treatment of prisoners and prison management. Some of the rules describe how prisoners with mental health conditions should be treated and state that prisoners should enjoy the same standards of health care as is available in the community [13].

A thorough knowledge of human rights issues as well as of the respective international and national legal instruments is essential for both researchers and forensic practitioners in view of their implications in the managing of mentally ill patients, including those admitted under criminal law.

2.7 Recommendations and Conclusion

- The great diversity of legal systems regarding mentally ill offenders as well the mental health system of each country makes it difficult to reach some sound conclusions when assessing, detaining, trying, and sentencing mentally ill offenders, as well managing their placement. In most of European states, these laws are relatively new or were revised during the last two decades. On the one hand, such change contributes to the complexity of the problem, but on the other it offers opportunities for the revision, improvement, and harmonization of legal frameworks.
- Court procedures are variable and provide numerous differing pathways pre- and post-trial in the mental health-care systems, the specialized forensic systems, and the prisons and other penal systems. There are different discharge procedures for forensic patients, and in some member states discharge procedures include obligatory conditions or release on recognizance.
- The legal definition of mental illness or the absence of it in different countries means that some offenses could be treated in forensic psychiatry or prison

settings (for instance, sexual offenses or personality disorders). There are no uniform concepts as to which mental disorders are covered by forensic legislation across the member states. The legal terms are vague and have little relation to medical concepts or to modern international classification systems for mental disorders, thus providing no practical guidelines for assessment or decision procedures. However, routine practices in the majority of the states show a common pattern, at least in including within the scope of the relevant legislation the major mental disorders such as schizophrenia (most often termed "psychotic state"), affective disorders, and organic mental disorders. Even more variable is the handling of alcohol-related disorders. The wide range of mental states connected to these syndromes—from simple intoxicated states to severe addiction or even psychotic states—prevents the elucidation of common approaches or typical judicial procedures for offenses committed under the influence of alcohol. The variable or non-specific inclusion of alcohol-related and addiction-related personality disorders marks a clear shortcoming in the forensic legislation of the European states and prevents the harmonization of legal frameworks and routine practices within or across these states.

- There are no clearly defined national or European indicators as to the effectiveness of legal concepts or of current practices for detaining or treating mentally disordered offenders. Reoffending rates among people discharged from forensic detention would probably provide the most useful information, along with psychiatric estimates for treatment success. Generally, a set of European indicators should be developed, covering and standardizing the most basic data in the field (service provision, outcomes, prevalence, incidence, length of stay, disorders, types of crimes, and reoffending rates).
- There are divergent ideas concerning the inclusion of forensic care and the detention of mentally ill offenders in the general mental health-care system, ranging from strict separation to full inclusion. Outpatient forensic care and forensic aftercare seem to be particularly underdeveloped.
- The role and responsibility of psychiatrists in the process are complex and variably defined. It often exceeds basic medical expertise (in assessing the mental state and applying psychiatric treatments) and may extend to predicting the criminal prognosis and guaranteeing the safety of detainees and of the public.
- European Union countries differ widely in the extent to which they recognize forensic psychiatry as a specialty and thus also in the amount of training clinicians receive before they present themselves as expert witnesses in court, or develop or run services, or manage and treat individual offender patients [14]. This training should, always, include legal and ethical aspects.
- Basic human rights principles seem be fulfilled in the most of the countries, although the delay between the new international conventions and the approval by national parliaments means implementation in the daily attention to mentally ill offenders could take several years. There are variable definitions of the role of mentally disordered suspects or defendants during court procedures, for instance, regarding attendance and legal representation.

- Furthermore, the financial situation of each country could also limit some forensic psychiatric developments.
- International research and networking on the issue should be encouraged. This would be likely to focus the development of adequate interdisciplinary working and could contribute basic evidence to the field of a type which is currently lacking.

Take-Home Messages

- Wide variability of legal framework is found around Europe.
- There are different forensic health systems to treat mentally ill offenders.
- Human rights (Council of Europe, United Nations) conventions should be implemented in all countries around Europe.
- International research and networking is of paramount importance in order to have reliable data to improve legislation and services.
- Training has to include legislation (both local and international) and ethical issues. Networking among forensic mental health professionals has to be encouraged.

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3 Legal Approaches to Criminal Responsibility of Mentally Disordered Offenders in Europe

Michiel van der Wolf and Hjalmar van Marle

And when he's not himself does wrong Laertes,
Then Hamlet does it not, Hamlet denies it.
Who does it, then? His madness…

Shakespeare [1]

3.1 Introduction

3.1.1 A Moral Tradition

In these times of political and monetary turmoil in Europe, when mutual cultural differences are being highlighted, binding statements about our joint history and traditions are often heard in response. When explaining how different European jurisdictions approach the criminal responsibility of mentally disordered offenders, it may be a similar wisdom to start off with our common ground. In this case in the famous words of the—nota bene—American judge Bazelon in *Durham v. United States* [2]:

> The legal and moral traditions of the western world require that those who, of their own free will and with evil intent, commit acts which violate the law, shall be criminally responsible for those acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein, moral blame shall not attach, and hence there will not be criminal responsibility.

A first nuancing to be made is that this tradition is not exclusively Western, as also in the Eastern world, similar ancient traditions are known [3]. The tradition

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may not even be exclusively human, as it can also be seen in action in other primates. For example, it is observed that a Rhesus monkey with a condition that resembled human Down's syndrome would as an exception not be punished by the group for violating the rules of their strict society, like threatening the alpha male. 'It was as if everyone realized that nothing they did would ever change her ineptness' [4].

3.1.2 Aim, Scope and Approach

More importantly however in this context is the nuancing that a shared moral tradition waters down into different legal systems in a wider variety of forms and substances than Bazelon's quote suggests. The aim of this chapter is to explain a few major distinctions in the legal approaches to criminal responsibility of mentally disordered offenders in European jurisdictions.

By 'European' we do not mean to limit the continent to the members of the European Union but rather to a broad scope like the members of the Council of Europe, best known for its European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR). Even though both 'Brussels' and 'Strasbourg' may produce binding legal obligations in the realms of criminal law and mental health law, so far the national approach to criminal responsibility of mentally disordered offenders has generally been left to the members' discretion. However, the nonbinding United Nations Convention on the Rights of Persons with Disabilities (2006) states that also psychiatric patients should be treated (in laws) as full participating members of society able to make their own choices, which would mean that legal insanity is in itself discriminatory and thus unlawful.

With regard to deprivation of liberty, Article 5 (1, e) of ECHR mentions the lawful detention of 'persons of unsound mind' and of course that of a person after (criminal) conviction by a competent court (1, a). In some cases of (preventive) detention of mentally disordered offenders, the European Court of Human Rights in Strasbourg has considered both provisions applicable, allowing for detention of longer duration than the maximum penalty on the committed offence and an obligation to provide treatment [5]. With regard to this population, the European Union's legislating efforts have mainly focused on procedural safeguards for 'vulnerable persons suspected or accused in criminal proceedings'. Vulnerability should be presumed in cases of 'persons with serious psychological, intellectual, physical or sensory impairments, or mental illness or cognitive disorders, hindering them to understand and effectively participate in the proceedings' [6]. These directives touch upon the subject of competency or fitness to stand trial, a concept which can generally be distinguished from criminal responsibility as derived from procedural instead of substantive criminal law and focusing on the time of the trial (or earlier stages in the procedure) instead of the time of the offence. In this chapter the discussion on legal insanity will be limited to the latter, thereby also excluding all kinds of doctrines of incompetence and unaccountability known in civil or administrative law.

Our intention is not to present a complete overview of provisions in all applicable jurisdictions as, for example, Salize and Dressing [7] have done for placement and treatment of mentally disordered of the EU members, but to describe a few major distinctions. Therefore, first of all some common historical roots will be explored. Just as Aristotle has argued that matter is made into a substance by the form that it has, the matter of criminal responsibility will then be addressed first in its form—the legal context—and second as substance—the contents of the legal doctrine. Finally, the implications for the behavioural scientific disciplines that are generally asked to assess criminal responsibility will be discussed, as well as recent debates about the doctrine.

3.2 Common Historical Roots

3.2.1 Hebrew, Greek and Roman Roots

As the Western world is said to have a Judeo-Christian tradition, then so has the moral tradition of legal insanity. Our knowledge of this tradition dates back to the earliest recordings of Hebrew law. The Babylonian Talmud (written around 500 AD) mentions:

> Idiots, lunatics and children below a certain age ought not to be held criminally responsible because they could not distinguish good from evil, right from wrong and were thus blameless in the eyes of God and man. It is an ill thing to knock against a deaf mute, an imbecile or a minor. He that wounds them is culpable, but if they wound others they are not culpable… for with them only the act is a consequence while the intention is of no consequence. (cited in [3, p. 4])

In Hebrew law, criminal acts were dealt with in a civil law manner. Similarly, many mediaeval Western European legal traditions—for example, both the English and the Germanic—reacted to crimes through compensation or restitution. Kinsmen of the insane offender were held liable for compensating the victim and were also held responsible for preventing future harm by the offender [8, 9].

A similar moral tradition can be found in the other ancestor of Christian, Western law, both the mythological and philosophical thought of classical Greece and Rome. As a starting point, usually the Greek Philosopher Plato's (427-347 BC) draft of Utopian laws is mentioned:

> Someone may commit an act when mad or afflicted with disease… [and if so,] let him pay simply for the damage; and let him be exempt from other punishment. Except that if he has killed someone and his hands are polluted by murder, he must depart to a place in another country and live there in exile for a year [10].

The idea of a 'moral excuse' can actually be traced back to that other great Greek philosopher Aristotle [11]. Even though there is no historical evidence that these laws were in fact ever practiced in any part of ancient Greece, connections can be shown with the main source of Roman law, The Justinian Digest—a collection of

texts from legal scholars (100 BC-300 AD, compiled in 533 AD) [8]. A certain Modestinus states that someone falling in the category of 'lunatics' (*furiosi*, *mente capti* and *dementes*) who had committed an offence could not be punished, because he was 'excused by the misfortune of his fate', stemming from the belief that a madman was already punished by virtue of his mental condition (Justinian Digest 48, 9, 2 Modestinus, cited in translation in Parlopiano [12, p. 186]). The rationale is perhaps a reference to the classical notion that madness was a divine punishment—just as Juno had jealously punished Hercules with madness. In other parts of the Digest, damage done by the insane is compared to that done by an animal or a tile falling from the roof (9, 2, 5.2 Ulpian), 'as if it happened by some chance… and not as if done by a person' (26, 7, 61 Pomponius).

3.2.2 Church Influences

Even though the Justinian Digest dates already from after the fall of the Western Roman Empire, Roman law would heavily influence legal scholarship across Europe in the ages thereafter. It would pragmatically be used to be referred to when local legal customs were lacking in a particular area. It has therefore been argued that many jurisdictions today have an insanity defence that can be traced back specifically to the earliest to survive insanity defence case in Roman law; that of Aelius Priscus [8]. For example, in the famous English case of James Hadfield who in 1800 attempted to kill King George III, the Latin phrase 'furiosus solo furore punitur'—a madman is only punished by his madness—was quoted at the trial by Sir Edward Coke [9, p. 39].

Nevertheless, even though the Catholic Church was in a way a custodian of Roman law, theology and criminal law as divine and earthly justice influenced each other from Medieval Times with the idea of the sin tribunal as expressed in the Last Judgment as mediator [13]. Punishment as penance, for example, led the Church Synod of Worms (868 AD) to a ruling suggesting that an individual who killed someone while insane and later returned to sanity would still be in need of, however less, penance. This was interpreted as referring to a situation of an individual whose earlier actions had brought about their insanity—a concept which is widely adopted in modern legal doctrine as a correction to the moral tradition and is called vicarious responsibility, culpa/dolus in causa or prior fault, mainly related to prior substance use [12].

An exceptional interruption of the moral tradition in the Late Middle Ages was also the result of the Church influence that turned heresy into an offence. Some mentally disordered offenders were given harsher punishment than ordinary offenders but only because they were mistaken for persons possessed by demons, even by doctors [14]. It underlines the importance of the medical state of the art in assessing insanity and assisting criminal justice. The Dutch doctor Johannes Wier is known to be the first to separate the mentally ill from the possessed in the sixteenth century, as a predecessor of French doctor Philippe Pinel who is said to have freed the mentally ill from criminal chains in the dungeons of Bicêtre in the late eighteenth century [15].

Even though in the era of the Reformation, through the two kingdoms doctrine, criminal law becomes less theocratic, it becomes even further influenced by religious thought and separated from civil and police law sanctioning in which punishment was merely a reaction to crimes which could not be compensated. 'Principles of modern criminal law, as central as the guilt principle and the personality of punishment, are, from a historical point of view nothing but derivatives of the idea of divine justice' [13, p. 169]. This idea of personal ethical blame explains how guilt, intent and voluntariness—free will—of the perpetrator became central concepts in the criminal law of today, thereby 'colouring' the concept of criminal responsibility. Walker [9] describes how in England certain crimes which were punishable—even by death—because they could not be wiped out by compensation, could at first not entirely be excused, but through Church influence later could, by absence of intention and/or voluntariness, 'not out of own free will'.

3.3 Differences in Form of the Responsibility Doctrine

3.3.1 Context Within Criminal Law and Procedure

Despite many regional differences, similar historical commonalities as described for legal insanity have led to some sort of doctrinal consensus that criminal liability generally requires both 'harm and fault'. Derived from the Latin phrase '*actus non facit reum nisi mens sit rea*'—loosely translated as 'an act does not make a man guilty unless his mind is (also) guilty'—a criminal offence is the combination of a bad act ('actus reus') and 'a guilty mind' ('mens rea'). Of course there are exceptions to the basic rule, for example, some jurisdictions know 'strict liability offences' which do not require an assessment of 'mens rea'. Mens rea is acknowledged to have both a descriptive meaning—the fault element of an offence—and a normative meaning—blameworthiness. In most (Continental) European jurisdictions, this second distinction leads to the following system of assessing criminal liability: first, the elements of the statutory offence definition, both relating to actus reus and mens rea; second, the wrongfulness of the conduct; and third, the blameworthiness of the offender. The latter two generally correspond with the liability-negating circumstances of 'justifications' and 'excuses' [16]. It explains that the concept of criminal responsibility is not exclusively related to mental disorder. Criminal non-responsibility may, for example, also refer to the legally underaged or be related to other excuses or justifications. In this system 'insanity'—or the lack of criminal responsibility due to a mental disorder—is seen as an excuse negating the blameworthiness of the offence. Through this system it can easily be explained that insanity does not generally lead to a complete lack of mens rea, as, for example, the element of 'intent' can usually still be fulfilled: mentally disordered can act intentional and yet not be blameworthy.

In jurisdictions stemming from the English common law tradition, in which some offences—like murder—are not regulated in statutes but in case law, especially the presence of an adversarial justice system, leads to a different criminal

procedure, also concerning insanity. In inquisitorial justice systems, common on the continent, judges play an active investigative role in establishing the three requirements for liability, while in adversarial systems, they are mainly the referee in the contest between equivalent rivals: the prosecution and the defence [17]. From the perspective of forensic psychiatry, this difference has relevant consequences. In adversarial justice systems, for example, the emphasis on equality of arms and an active defence by the accused evokes a more prominent position of the unfitness to stand trial doctrine [18]. In addition, in an adversarial system, expert witnesses—including in forensic psychiatry—are usually appointed by the parties, which could lead to a battle of the experts, while in an inquisitorial system, they are generally appointed by the court. For example, in England, as one of the mentioned solutions for the battle of the experts, a Law Commission [19] advised to have a third expert appointed by the court.

The contest between parties in adversarial justice also entails positioning through the use of formal pleas and defences. The defendant can plead guilty or not guilty but also use an insanity plea or an insanity defence. Similar to the described liability system common in inquisitorial systems, the offence itself is not contested, but the moral responsibility (or agency) is, placing the insanity defence amongst the 'supervening' defences [20]. Compared to inquisitorial systems, raising this defence has more procedural consequences, as, for example, it generally entails the 'burden of proof' to persuade the decision-makers—usually juries—of your plea [21]. Even though the insanity defence can be viewed as the functional equivalent of the excuse of non-responsibility in other jurisdictions, it is probably because of this different procedural embedding that some argue that, for example, in England and Wales the issue of criminal responsibility is absent ([7]; the issue of diminished responsibility is discussed in §3.4.3).

However there are jurisdictions in which the issue is truly absent, but this has to be understood against a different background. For example, the fact that Sweden has abolished its responsibility doctrine in 1965 is ultimately rooted in the debate between classical criminal law theorists—emphasizing free will and rational choice as the cause of crime—and modern theorists, adopting determinism and biopsychosocial causes of crime. While this debate was prevalent all over Europe (and beyond), in most other countries, modernists did not manage such a grand victory.

3.3.2 Context Within Sentencing Law and Mental Health Law

Abolishing the criminal responsibility doctrine poses new problems, amongst which the question of how mentally disordered offenders will then be led to the appropriate place for protection of society and/or treatment. As establishing non-responsibility generally leads to a kind of 'not guilty' verdict, some sort of acquittal generally follows. This has always been unsatisfactory for persons that were considered dangerous because of their mental disorder. Plato already stressed that it was the duty of the family to keep the acquitted under control: 'if anyone be insane, let him not be seen openly in the town, but let his kinsfolk watch over him as best they may,

under penalty of a fine'. As described in §3.2.1, similar laws existed in many regions throughout Europe, until prisons began to be provided not only for punishment but also for protection of the public. Around the turning of the twentieth century, this distinction between detention as punishment—proportionate to the extent of guilt—and as a safety measure, of indeterminate duration as dependent on dangerousness, became the compromise between classical and modern theorists [22]. As for non-responsible mentally disordered offenders, punishment is impossible; in many jurisdictions—which have adopted this twin track system of sanctioning—safety measures are provided nonetheless for this group to ensure public protection. French philosopher Foucault has convincingly argued that around the same time the developing functioning of Western medicine as a public hygiene—often equalling dangerousness with disorder or degeneracy—ensured that safety measures could be used as a 'social defence' against 'nonsocial' groups in society [23]. Especially the concept of diminished responsibility was used to widen the scope of such measures. In the century that followed, when psychiatric hospitals with sufficient security began to be provided along with mental health law which allowed for (civil or criminal) commitment of mentally disordered, that became the royal way for disposing of the acquitted that were deemed dangerous. In many jurisdictions the responsibility doctrine plays an important role in selecting cases for either safety or hospital (treatment) measures.

This was also the case in Sweden up until abolishing the responsibility doctrine. As an alternative, not the mental state at the time of the crime but the time of the criminal proceedings (trial) is indicative for placement in a psychiatric hospital and thus for not receiving punishment. Especially in jurisdictions that have not adopted this twin track system of penal sanctioning, placement in a psychiatric hospital is not necessarily dependent on establishing diminished or non-responsibility. For example, the (civil) hospital order in England and Wales can be imposed by a criminal court as well, without an acquittal on the basis of the insanity defence. As the moral tradition then has no instrumental function with regard to the desired outcome, it is no wonder that the insanity defence is highly seldom successfully raised. For forensic psychiatrists, not connecting the responsibility criterion to hospital placement has the advantage that assessment is not concerned with the time of the crime (retrospective diagnosis) and, when there are a separate trial of fact and a sentencing trial, nor with proof of the offence. Such two-phase trials exist, for example, in Sweden and England and Wales.

3.4 Differences in Substance of the Responsibility Doctrine

3.4.1 The Definition of Insanity: Legal Versus Medical Competence

As the doctrine of criminal responsibility in relation to a mental disorder can be regulated in specific provisions in many different ways, nevertheless one common element can be observed: insanity has to be defined. The applicable mental states

are either summed up in the provision itself or explained in other provisions or supplements. The Austrian provisions are a random example of the former, as 'Geisteskrankheit', 'geistigen Behinderung', 'tiefgreifenden Bewußtseinsstörung' and 'dieser Zustände gleichwertigen seelischen Störung' are mentioned.

For the members of the European Union in 2005 Salize and Dressing conclude: 'Most terms as used in codes or acts are non-specific, descriptive in nature and to a large extend outdated. The legal terms have little relation to modern international classification systems for mental disorders' (334). References in this chapter to legislation in the respective countries are predominantly from their book. As they are both psychiatrists, that last remark seems to reveal disappointment. However, it is important to note that in many jurisdictions, the legal definition of mental disorder is intentionally not related to the psychiatric terminology. The argument may be of course that psychiatric classifications are often altered, but more important is the broadness of the criterion and question of who is competent to establish legal insanity. Legal terminology is usually related to a competence of the court to, either with or without psychiatric advice, establish legal insanity. Competence commonly entails discretion to ignore the behavioural scientific advice and make another decision. This discretion is much less logical when the terminology used in legislation is narrow and similar to that of psychiatry.

This is, for example, the case in Norway, which became clear to the world as this was at the heart of the debate in the infamous case of terrorist Anders Breivik. The District Court of Oslo [24] issued an English translation of their verdict, including a translation of their provision for 'criminal capacity': 'A person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty. The same applies to a person who at the time of committing the act was mentally retarded to a high degree'. Especially the term 'psychotic' is medical language. It not only led to a discussion about whether his extremist right-wing worldview was delusional but also to a strange interaction between psychiatry and law. As a first set of behavioural scientists had assessed him as psychotic, the court—apparently not convinced—asked a second set which concluded to the contrary. The court followed the second opinion, but in motivating their verdict made use of medical reasoning beyond its competence [25].

In the Danish provision, the term 'mental illness' is used as an equivalent to 'psychotic'. However after a medical finding of psychosis, it is interestingly still for the court to decide on the responsibility. Using legal terminology not only underlines legal competence but enables the court to include other legal or societal elements in its decision. For example, in Germany and the Netherlands, the term 'attribution' is used, which has a broader meaning within criminal law in light of the question whether offence behaviour can be attributed to the accused. Nevertheless, in these countries there has been enough discussion about medical competence, as the common term 'Zurechnungsfähigkeit' or 'toerekeningsvatbaarheid' seems to suggest a rather fixed capacity of the personality. Of course, non-responsibility is strictly related to the particular offence and not a permanent trait.

Even though the terminology in the different provisions across Europe varies widely, in practice generally major mental disorders such as a 'psychotic state',

affective disorders and organic mental disorders seem to fall within their scope [7]. The variation is more extreme when it comes to personality disorders, paraphilia or substance abuse disorders. For example, in Hungary, personality disorder is explicitly mentioned as a condition, which could lead to non-responsibility [3]. When criminal responsibility is not regarded a dichotomous concept but one of degree (see §3.4.3), there is more leeway to include such disorders in the doctrine. That is similar when the question of disposal or commitment to a hospital is not related to responsibility. For example, in England and Wales, immoral conduct, paraphilia and substance abuse disorders are explicitly excluded, while personality disordered offenders are in theory eligible for a hospital order but in practice often excluded on the basis of the criterion that there is no 'appropriate treatment'—which replaced the former 'treatability' criterion. Opinions about the treatability of personality disordered offenders seem to differ, however, as, for example, in the Dutch TBS (entrustment) order they are overrepresented and treated with a high success rate.

The legal necessity of forensic (psychiatric) assessment also differs if the question of responsibility and disposal are not connected. Most jurisdictions legally require forensic assessment when a defendant is presumed to be mentally disordered. The ECHR, for example, in *Winterwerp v the Netherlands* [26], requires a medical assessment for (criminal) or civil commitment. As the moral tradition of criminal responsibility has more ancient roots than modern psychiatry, medical assessment has not always been a requirement of course. The concept of madness has moved over the ages from a 'religio-astrologic' to a 'scientific-organic' perspective [27]. What madness is has long been in the realm of common knowledge and was therefore also assessed by layman. The development of legal standards of proof and the scientific revolution—including the rise of modern society—have coincided to a system in which legal decision-making, for example, concerning insanity requires expert evidence [28]. As psychiatric diagnosis has become more subtle and the term insanity is no longer reserved for the overtly irrational, the medical competence has been strengthened resulting sometimes in more tension with its legal counterpart. In some jurisdictions, for example—especially Denmark is really strict—it is out of the question that behavioural scientists also advise on anything other than disorder (and disposal), like the (causal) relation between the disorder and the offence and the degree of guilt or responsibility. In most countries, the system is such that they can advise on these medicolegal concepts but that the court can substitute its own view on the matter. In practice, the advice is generally followed. In Portugal, however, a court cannot substitute its own view, but only ask additional questions or order a new assessment, extending even further the competence of medical experts (questionably beyond their expertise).

3.4.2 The Test of Insanity: A General Versus a Specific Relation Between Disorder and Offence

A second element which may appear in provisions of the responsibility doctrine is a specification of the (functional) capacities that the disorder should have

impaired at the time of the offence in order to establish legal insanity. This is often called a 'test'. While most European jurisdictions have such tests in place, two other approaches exist. As mentioned above, the Norwegian criminal code, for example, only requires psychosis and no further relation to the offence. In assessment of legal insanity, this is called the 'medical principle'. It becomes more medicolegal when a relationship between disorder and offence is required. The Dutch provision (art. 39 of the Criminal Code) is an example of requiring a general (not specified) relation between the disorder and the offence: 'A person who commits an offense for which he cannot be held responsible due to defective development or diseased disturbance of his mental faculties shall not be punishable'. As there was no consensus in parliament (at the end of the nineteenth century and ever since) as to which specific abilities should be impaired, the law allows for all sorts of causal relations between the disorder and the offence which have been formed in legal doctrine, case law and assessment practice. Such a general relation can also be observed in the citation from judge Bazelon at the beginning of this article, who speaks of acts as the product of a mental disease, also referred to as the 'product test'.

Aristotle already postulated such a test, implying that acts done in the midst of madness should be considered involuntary and that 'a fool and a madman' would have 'impaired ability to deliberate' [29]. In the Digest criteria like 'not capable of wrongful intent', 'not consisting in the will of the culprit' and 'without knowing what he is doing' have been formulated (56). Especially in English case law, the development of tests of insanity can be traced. In a case from the year 1313, the disordered offender was compared to a child or a 'nonperson', not able to distinguish good from evil because the moral implications of the act were not understood: it was later referred to as the 'good and evil test' [30]. In the case of *Rex v. Arnold* (1724), a mentally disordered offender was compared to a 'wild beast' that has no sense of 'its' own conduct. This 'wild beast test' was more about cognitive than moral capacity. Acceptance of mere moral defects for the insanity defence, such as the nineteenth century concept of 'moral insanity', has mostly been avoided throughout history. However, in the famous case of Edward Oxford who shot at Queen Victoria (1840), the used 'right and wrong test' seemed to stress mere moral capacity, even though the offender was officially acquitted for a 'lesion of the will'. It could not prevent the newly found psychiatric diagnosis of 'homicidal mania' to be grounds for many an acquittal in the years following, until it was finally discarded as not being a mental disorder [27]. In the soon to follow landmark case of Daniel M'Naghten (1843), who shot at the Prime Minister but killed his secretary, a test was stated in which an offender was not culpable 'if he was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong'. The moral aspect is more or less dissolved in the cognitive capacity of knowing that something is against the law, instead of morally wrong. This phrasing still forms the basis for many insanity doctrines in criminal law throughout the (Western) world. In addition to tests of cognition, often tests of volition or the ability to control one's actions may be added, like the 'irresistible

impulse test'. Eigen [27] proves that also this test has far more ancient roots in English case law.

In current European provisions, it is common to find both a test of cognition and volition or control. The Belgian provision only seems to include control. Nevertheless Salize and Dressing [7] consider the definition of medicolegal concepts amongst members of the European Union 'ill-defined and lacking in standardization', but that may be explained also by the fact that they include dangerousness or risk for recidivism in their assessment.

3.4.3 The Scale of Responsibility: Gradual Versus Dichotomous

A greater diversity than in the definition and test of insanity can be observed in relation to the scale of legal insanity or responsibility. Most European jurisdictions consider it to be a gradual concept, while some (like Austria, Belgium, Bulgaria, France) assess it as a dichotomous concept.

It is logical that when a general causal criterion is used, like in the Netherlands, there is room for (gradations of) diminished responsibility. The Dutch legislator however chose, in order to ensure consensus between classical and modern theorists, not to mention diminished responsibility in the criminal code, but in practice it plays an important role [22]. It is remarkable that jurisdictions that have tests of cognition and/or volition in place differ in their view whether that is an all-or-none test or that diminished cognition and volition at the time of the crime are also possible.

Of course the issue of diminished responsibility is of importance to sentencing. Where non-responsibility leads to the exclusion of punishment, diminished responsibility generally leads to a lesser punishment due to the principle of punishment to the extent of guilt. In some jurisdictions, like Spain, diminished responsibility is necessary to be eligible for (certain) safety measures. In the Netherlands diminished responsibility functions de facto as a criterion for the TBS order, which explains the high percentage of personality disordered TBS patients in the system. In other jurisdictions, like Austria and Denmark, disordered offenders not qualifying for complete legal insanity may still be eligible for criminal or civil commitment into a (forensic) psychiatric hospital.

In jurisdictions within the United Kingdom, diminished responsibility is not related to the insanity defence at all—it is not a matter of degree but of a different nature. It serves as a mitigating factor in sentencing, mainly in the special case of murder to avoid a mandatory life sentence. This is substantively engineered by changing the mens rea element of murder into manslaughter [31]. This was derived from the humanitarian approach, originally in Scottish case law, to pardon mentally disordered offenders in capital cases [9]. The citation from Plato in §3.2.1 suggests a diminished responsibility of a similar principle, as the consequences for the perpetrator are less severe in case of a killing by a madman, as he does not seem to be considered completely blameless. Even though it has been suggested that dichotomous concepts are 'peculiarly foreign' to psychiatry, it is understood that the

dichotomy is also being preserved by the judiciary to avoid more influence of psychiatrists on legal decision-making [32]. The gradual or dimensional approach to responsibility may indeed have more 'face validity' but automatically adopts problems in the reliability of assessment. Indeed the Dutch experience has shown that even something like 'percentage responsibility' can be developed in practice in which there are far too many gradations than can scientifically be distinguished [33, 34]. At present the debate focuses on five versus three gradations [22]. Maybe they can look to Portugal for a compromise, as they have four.

3.5 Discussion

As universal as the diagnostics of medical concepts are, as culture-specific are the diagnostics of medicolegal concepts. Even though the moral tradition of not holding mentally disordered offenders criminally responsible seems to have similar roots across Europe, the legal context and the national perspective on its contents create a wide variety of doctrines and consequent assessment practices. This may hinder the exchange of knowledge and best practices amongst European forensic behavioural scientists and the equal treatment of mentally disordered offenders throughout Europe. However, as placement of patients is usually done on treatment needs and the level of dangerousness and not on the basis of (the degree) of responsibility, the doctrine may serve more as a distinguishing criterion in theory only, suggesting that there may be more commonalities at the level of routine practice [7]. Nevertheless, the precariousness of the doctrine and its connection to central aspects of criminal law seem to justify that a national support base is needed.

For most jurisdictions it can surely be argued that, as mentioned in an Editorial by the Harvard Law Review [35], 'a basic ambivalence in society towards mentally disordered offenders' exists. The tradition is being criticized for leaving possibly severe crimes unpunished and a demand for restoration unanswered, possibly even leading to people taking the law into their own hands. When, as described, Plato suggests exile as a sanction for murder while insane, he seems to take such considerations into account. Other critiques—mentioned and disputed by Morse for example [36]—include the diagnostic challenge (if not impossibility) of reconstructing the offenders state of mind during the offence, the distraction from meeting the needs of psychiatric patients in prison and the suggested relation to the heavily debated concept of free will. Abolishing the doctrine, relabelling it or limiting its use, are possible reactions to these critiques. For example, a few states in the United States have abolished the insanity defence, while other states have used a milder solution through rewording the verdict 'not guilty by reason of insanity' into 'guilty but mentally ill', to preserve the expressive function of attributing guilt [3]. But from the other end of the ambivalence, the abolishment in Sweden is intuitively felt to be too much of a break from the moral tradition to be satisfactory, and changes to the system are in progress [37].

What goes for Europe in general seems to be applicable to criminal responsibility in Europe as well: we are united by a distant moral tradition and divided by justified cultural subtleties.

Take-Home Messages

- The moral tradition of not holding mentally disordered criminally responsible for certain offences seems to have similar roots across Europe in Hebrew and Roman law and Greek philosophy, while the church influenced its further development.
- Responsibility doctrines in European jurisdictions differ according to their context within criminal law and procedure and their possible relation to sentencing law and placement of mentally disordered offenders in a (forensic) mental hospital.
- Responsibility doctrines in European jurisdictions differ on culture-specific issues as the definition of legal insanity, the tests of insanity (the required incapacities) and the view on the scale of responsibility.
- These differences may hinder the exchange of knowledge and best practices concerning forensic assessment amongst European forensic behavioural experts, but placement of patients is usually done on treatment needs and the level of dangerousness and not on the basis of (the degree) of responsibility.

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New Developments in Legal Systems and Their Impact on Forensic Psychiatry

4

Hans-Jörg Albrecht

4.1 Introduction

Forensic psychiatry has well established relations to the legal system, in particular the criminal justice system. The relationship has grown stronger over time and has diversified. It is asserted also that mental health systems in Europe look back on marked progress in the last half century. The relationship between forensic psychiatry and criminal justice has been influenced by theory and research criticizing negative side effects of long-term detention in forensic hospitals and the strong stigma placed on the mentally ill with associating insanity and crime. This in turn had encouraged the development of policies of decarceration, deinstitutionalization, and community-based supervision and treatment [1]. Reform debates on the insanity defense and related law amendments, for example, in Ireland, Scotland, and England/Wales, in fact are still based upon this line of reasoning when attempting to modernize legal language, to bring legal language closer to forensic psychiatry, and, beyond that, to reduce stigmatizing effects which might be associated with the label of "insanity" [2, 3, p. 50].

The interface between forensic psychiatry and the law was formed by the fundamental assumption that criminal punishment may only legitimately be imposed if the criminal act was carried by culpability which in turn requires free will (and free choice between behavioral options). The assumption of free will is based on cognitive capacity to discern right from wrong and the capacity to control one's acts. Mental conditions impairing either cognitive or control capacity affect free will and diminish or exclude culpability but have to be proven through expert (psychiatric) witnesses. Furthermore, the focus on mental illness within the framework of criminal law is also explained by the strong belief that some mental illnesses cause crime

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(in particular violent crime) and that psychiatry may deliver treatment which cures mental illnesses and reduces the risk of relapse in crime. The evolution of modern forensic psychiatry has been linked to several developments among which better understanding of the relationship between mental illness and criminality, the elaboration of legal tests of insanity, new methods of noncustodial treatment of mental disorders, and the changes in attitudes and perceptions of mental illness among the public are described as key achievements [4, p. 87]. However, new developments in forensic psychiatry are rather driven by a different set of issues and controversies. Among these issues conflicts between a welfare-based approach of crime control, punitive responses to crime, and concerns for security stand out [5, pp. 114–116] as does the significant shift away from a medical approach to mentally disordered offenders toward a rights-based approach. Of course, the question of how mental conditions are associated with crime, in particular violent crime, still is pursued in research [6, 7], and the role of forensic psychiatry in making decisions on culpability of offenders continues to trigger debates in forensic and legal arenas as do questions of which mental problems should be considered to impact on culpability, on criminal responsibility, and ultimately on sentencing [8, 9]. But, it is in particular a growing concern for human rights-adjusted mental health legislation in general and the legal status and (basic) rights of mentally impaired individuals which results in an increasingly dense web of legal rules and doctrines directing forensic psychiatric practices and provides for new challenges.

From the 1990s on, a comparative and European look at forensic psychiatry, forensic hospitals, and mental law attracted increasingly interest [10, 11]. To begin with, growing relevance of comparative forensic psychiatry is explained by a common trend in sciences to advance knowledge and innovation and improve practices through looking across borders [12]. Migration and an increasingly culturally and ethnologically heterogeneous nature of European societies then have contributed to raising interest in comparative studies in forensic psychiatry. But, while significant interest in comparative analysis of procedural and substantive criminal law can be noted in Europe, legal disciplines seem to be less interested in comparative forensic psychiatry law, and only few comparative studies address forensic experts in criminal proceedings, substantive criminal law, and related jurisprudence addressing criminal responsibility and mental illness or legal consequences of being judged not responsible of having committed a criminal offense. Almost all of the comparative studies dealing with legal aspects of forensic psychiatry since the 1990s are initiated and carried out by psychiatric/psychological disciplines [10, 13, 14]. The emphasis in these comparative studies is placed on internationally consented definitions and diagnosis of mental illnesses, the impact of forensic expertise on judicial decision-making and on the consequences of findings of insanity on the disposition of criminal offenders.

The interest in comparative legal studies on insanity, crime, and criminal law today is also pushed by widening legal angles through which legitimacy of judicial cooperation is analyzed. While international cooperation in legal matters in the last decades has been mainly driven by concerns for effective containment of terrorism and serious (organized) and cross-border crime, judicial decisions on extradition

today have also to consider how mentally ill offenders will be treated in jurisdictions requesting extradition. In the judgment Aswat v. the United Kingdom (application no. 17299/12) 14 April 2013, the European Court of Human Rights (ECtHR) has held that a schizophrenic detained in the UK should not be extradited to the USA as there would be a violation of Art. 3 European Convention of Human Rights (ECHR, prohibition of inhuman treatment). The Strasbourg Court observed that "… his extradition to a country where he had no ties and where he would face an uncertain future in an as yet undetermined institution, and possibly be subjected to the highly restrictive regime in ADX Florence (a super maximum security prison), would violate Article 3 of the Convention."

More specifically, the creation of a "common space of freedom, security, and justice" in the European Union (initiated through the Tampere program (2009) and regulated in Title V of the Treaty on the Functioning of the European Union), furthermore European policies of harmonization and mutual recognition of decisions in penal matters, and the establishment of European networks of criminal justice-related professions have underlined the importance of systematic collection of comparative legal information and internationalizing forensic psychiatry in the field of education and training as well as in its practices [15]. The interest of legislators in Europe in knowing about comparative mental health legislation and practices before amending the law [16] then has contributed to raising awareness about large variation in legal frameworks dealing with mentally ill offenders and the role of forensic psychiatry in the configuration of pathways to forensic care and treatment [13].

4.2 A Shift of Paradigm: Rights-Based Approaches

Most important in changing the legal frameworks within which forensic psychiatry operates in Europe (and increasingly on a global level) has been a common and today uncontested human rights perspective serving as a fundamental benchmark [17, p. 257]. In Europe, the human rights perspective has been strengthened through the Council of Europe and the European Union and what has been called a paradigm shift in favor of rights-based approaches to individuals with mental problems ([18, 19, p. 11] even notes a patients' rights revolution). The ECHR and jurisprudence of the ECtHR are of relevance when deciding on detention and treatment of mentally ill offenders. As early as 1979, the ECtHR has started to develop jurisprudence on fundamental questions of dealing with persons (and criminal offenders) of "unsound mind." The decision on "Winterwerp v. The Netherlands" is still one of the most cited in the field of law and forensic psychiatry and marks the beginning of the jurisprudence of the ECtHR on restrictions of liberty justified with an "unsound mind" (Art. 5 §1e ECHR). The "Winterwerp v. The Netherlands" judgment held that Art. 5 §1e ECHR does not provide for a comprehensive and binding definition of an "unsound mind." The ECHR leaves room for the legislator when defining unsound mind, mental illness, or insanity as its meaning is considered to be continually evolving (and changing). European legislators therefore are not obliged to provide for an exact definition of what establishes an "unsound mind." Laws on mental

conditions and criminal responsibility shall be able to accommodate advances in scientific knowledge and corresponding changes in the definition of "insanity." However, no arbitrariness is allowed in laws authorizing detention of individuals suffering from mental problems. A statutory basis has to be in place which requests medical expertise as a basis for judicial decisions and which allows for certainty and predictability. From the perspective of Art. 3 ECHR (prohibition of torture and inhuman, degrading punishment/treatment), the ECtHR held also that withholding adequate treatment (which must not be carried by intent on the side of the authorities) will trigger a verdict of inhuman or degrading treatment (ECtHR, M.S. v. The United Kingdom (Application no. 24527/08), 3 August 2012).

On a global level it has been the advent of the United Nations "Disability Convention" (ratified today by most European countries) which has brought fundamental changes and challenges for both criminal law and forensic psychiatry [20]. The Disability Convention has been hailed as a major step forward in the protection of human rights of mentally ill criminal offenders [19], but it entails difficult legal questions, yet to be resolved [20, 21].

Fundamental rights bear also on civil and criminal committal proceedings and the enforcement of judicial decisions placing mentally ill offenders in psychiatric hospitals. Particular relevance here have the question of "legal capacity" and the problem under which condition interference with legal capacity (and Art. 8 ECHR protecting privacy) may be justified [22, p. 11]. In general, although somewhat delayed, patients detained in psychiatric hospitals today in Europe are entitled in principle to the same rights which are available to sentenced (and fully criminally responsible) prisoners.

The role and tasks of forensic psychiatry have been shaped then by legal and political developments which give security, public protection, and protection of individual victims top priority [23]. Security is sought through identifying dangerous individuals and adjusting criminal law-based responses to the interest of protecting the public and individual victims (see, e.g., Bill C-14 amending the Mental Regime (Part XX.1) of the Canadian Criminal Code, [23]). Release from secure placements of criminal offenders is made dependent on assessments of future dangers. Predictions of dangerousness are requested today before deciding on detention and release from detention. A focus on security and comprehensive security policies encourage the use of long-term and/or indeterminate deprivation of liberty. Particular concern in this context can be noted for violent crime and sexual crime (in particular pedophiles).

Indeterminate detention in psychiatric hospitals is based on the assumption that a criminal offender suffering from mental problems should be detained as long as the danger of future crimes linked to these mental problems persists [24]. Conventional legal thinking assumes that the interest of protecting the public from serious crime outweighs the interest of the offender in freedom and may serve—independent from the possibility of treatment and cure—as a justification of detaining an offender in a psychiatric hospital [24, 25]. With placing the focus on public protection, however, placement in a secure psychiatric hospital adopts a character of preventive or incapacitating detention. Public protection evidently encourages also

the designation of certain categories of mentally disordered offenders as a particularly "high risk" [23, p. 49]. The latter approach departs from individualizing risk assessment and is therefore also at risk of infringing on the right to be judged on the basis of the facts of an individual case. Furthermore, the security concerns do not only create conflicts with rights-based approaches but turn against policies favoring community-based treatment and reduction of stigma.

Forensic psychiatry thus moved to the field of assessment of dangerousness and general security policies which are rather remote from the core area of psychiatric practices and expertise. This has contributed in forensic psychiatry to a rising tension between punishment and security on the one hand and treatment and reintegration on the other hand [26]. Forensic psychiatry is placed in a social and political environment which tends to widen professional accountability. Accountability of forensic psychiatry today goes beyond compliance with good medical practice applied to patients with mental disorders and includes observance of fundamental rights of patients as well as effective containment of dangers for public security [27, p. 454]. Forensic psychiatry therefore today operates under an increasingly dense web of legally defined conditions which affect in particular also questions of treatment once guided only by medical expertise, standards of good medical practice, and the best interests of the patient.

The shift toward a rights-based approach to mentally ill persons [18] started on the international level decades ago with the "Declaration on the Rights of Mentally Retarded Persons" proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971. The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) deal in detail with the rights of persons admitted to mental health care and emphasize standards of involuntary placement and treatment. The International Covenant on Civil and Political Rights provides for a comprehensive set of individual rights which in principle apply also for the mentally ill. The United Nations "Anti-Torture Convention" prohibits inhuman, degrading treatment and punishment as well as torture and establishes besides basic legal standards a system of supervision and monitoring which is focused on places of detention (including psychiatric hospitals). A comprehensive Convention on the Rights of Persons with Disabilities and its Optional Protocol, 13 December 2006 addresses issues of mentally ill persons, in particular questions of legal capacity and detention of the mentally ill.

In Europe, soft and hard law affecting forensic psychiatry and forensic patients principally has been issued through the Council of Europe. Recommendation No R (83)2 on legal protection of persons suffering from mental disorder placed as involuntary patients (1983) was supplemented by Recommendation 1235 (1994) on psychiatry and human rights. Recommendation No (99)4 as of 23 February 1999 establishes basic principles concerning the legal protection of incapable adults. A "White Paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment [28], preceded Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorders. Recommendation CM/Rec (2009) 3 addresses monitoring the protection of human

rights and dignity of persons with mental disorder. Particular legal relevance for European forensic psychiatry has then the European Convention on Human Rights and the European Convention against Torture. Within the framework of the ECHR, particular relevance for forensic psychiatry comes with the prohibition of torture and inhuman or degrading treatment and punishment (Art. 3), the right to liberty (Art. 5), the right to a fair trial (Art. 6), and the right to private life (Art. 8).

The focus on (human) rights of mentally ill individuals has also brought changes in the institutional framework which is established to monitor compliance with international and European laws and standards in legislation and forensic psychiatric hospitals. Particular emphasis is placed on all kinds of detention facilities because deprivation of liberty is assessed to expose detainees to an elevated risk of maltreatment and abuse.

Important elements in the rights-based approach to forensic patients and detention conditions concern monitoring by independent commissions and effective access to legal review systems [22, p. 10]. Monitoring of (forensic) psychiatric facilities and mental health-related law comes through several avenues. International conventions and the supranational framework of human rights protection:

> Oblige states to report on how conventions are implemented. State reports are then reviewed by a committee which advises as to where and how implementation should be improved.
>
> Provide for individual complaint procedures through which individuals are entitled to bring allegations of violation of fundamental rights before an independent court or an independent committee.
>
> Establish independent commissions mandated with visiting places of detention. Visits result in reports addressing problems of implementation and forwarded to governments.
>
> Require establishment of independent national structures authorized to visit places of detention.
>
> Allow ad hoc investigations carried out by rapporteurs or commissioners appointed by the United Nations or other supranational bodies.

United Nations conventions relevant for forensic psychiatry (International Covenant on Civil and Political Rights, UN Convention against Torture, UN Disability Convention) contain a procedure through which State parties on a regular basis or on request report on how the respective convention is implemented. State reports are due at certain intervals or at the request of those committees established to examine reports and monitor implementation of State Parties obligations. In the case of the International Covenant on Civil and Political Rights, the Human Rights Committee has the mandate to review state reports and make suggestions and recommendations to the State parties. The UN Convention against Torture provides for a Committee against Torture, and the United Nations Disability Convention establishes the Committee on the Rights of Persons with Disabilities.

The ECHR does not establish a State reporting system. But instead, the ECtHR has jurisdiction over cases brought through an individual complaint procedure and alleging violations of fundamental rights enshrined in the ECHR after domestic judicial appeals are exhausted. The judgments of the ECtHR have to be implemented by national governments. The Court, furthermore, can order that damage is paid by the government to those applicants whose rights have been found violated.

Then, the ECtHR has developed a procedure which places those European states at particular scrutiny from which a multitude of similar cases originate indicating a systemic problem. The so-called pilot-judgment procedure was invoked in the judgment ECtHR W. D. v. Belgium (application no. 73548/13, 6 September 2016). It was held that Belgian practice of detaining offenders with mental disorders in prison psychiatric wings where they do not receive adequate care and treatment exhibits a systemic problem. The problem results in a constantly increasing number of cases where Belgium routinely is found in violation of Art. 3 ECHR (prohibiting inhuman treatment through withholding adequate care for mentally disordered offenders) and in violation of Art. 5 §1 ECHR (infringement on the right to liberty as detention does only comply with Art. 5 §1 ECHR if the link between the purpose of detention and the actual conditions of detention is broken). Belgium was given a period of 2 years to solve the systemic problem, and proceedings in all similar cases (approximately 40) were adjourned.

An individual complaint procedure is also provided through the Optional Protocol to the International Covenant on Civil and Political Rights, by the UN Convention against Torture and the Disability Convention. These committees may receive complaints brought by individuals alleging violations of rights guaranteed by the conventions. Individual complaints are examined by the committees. The findings and assessments of the committee result in communication and consultation with the state which was found in breach of individual basic rights. This procedure, however, other than proceedings before the ECtHR, does not result in a judgment binding the state that has violated individual rights. Furthermore, the committees may examine particular situations through launching inquiries.

The European Committee for the Prevention of Torture (CPT) was established to monitor effective implementation of the European Convention against Torture (which prohibits torture as well as inhuman and degrading punishment or treatment). Monitoring is carried out in the form of regular visits of all those places in member states where persons are detained. This includes besides prisons also forensic hospitals. Reports on findings of such visits are forwarded to the government which should respond to the findings and proposals as to how to adjust conditions of detention and related practices to the standards of the Anti-Torture Convention. A similar monitoring system has been adopted through the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. A Subcommittee on Prevention of Torture has the task to visit places where persons may be deprived of their liberty in State parties in order to prevent conditions of detention which may result in risks of cruel, inhuman, or degrading punishment or treatment. Recommendations of the Subcommittee on Prevention will be discussed in a dialogue with state authorities on possible implementation measures.

The United Nations Convention against Torture and the Disability Convention oblige State parties in Optional Protocols to introduce national (and independent) bodies which have the right to visit places of detention (and psychiatric facilities) in order to examine whether conditions comply with the standards. The United Nations Convention against Torture seeks to establish a system of regular visits undertaken

by an independent body which will monitor also conditions of detention (and resulting risks of maltreatment and torture) in forensic psychiatric hospitals. The Disability Convention requires State parties to put in place a structure mandated with implementing and monitoring the convention (Art. 33). Art. 16 §3 of the Disability Convention obliges State parties to introduce effective monitoring of all facilities and programs designed to serve persons with disabilities by independent authorities. Effective monitoring must extend also to forensic hospitals. In Europe, the CPT monitors the implementation of the obligation to have independent monitoring mechanisms in place (see, e.g., CPT 2013, §127 for forensic psychiatric hospitals in Portugal).

Finally, the United Nations and the Council of Europe through Human Rights Commissioners provide for a general possibility to monitor places of detention and to launch investigations into particular areas in order to monitor implementation of human rights. In Europe, the European Commissioner of Human Rights has made mental health law, psychiatric treatment, and forensic hospitals a particular issue in reports as of 2008 and 2012 [22, 29, 30].

The particular focus of human rights instruments on places of detention and a legally endorsed and generalized suspicion that individuals deprived of liberty are at a particular risk of infringements of basic rights have moved also forensic psychiatry into the spotlight of monitoring and supervision. And, nongovernmental organizations, among them also organizations critical of forensic psychiatry, increasingly influence not only the making of international human rights instruments but also jurisprudence resulting from individual complaint procedures and monitoring of forensic hospitals.

4.3 A Changing Sociopolitical Climate and Changing Practices

Looking at practices of forensic psychiatry, internationally still significant variation can be observed. Comparative data, specifically describing forensic psychiatry are not available on the international nor on the European level, but general data on mental health systems show that Europe counts some 7.4 psychiatrists per 100,000 of the population while in Africa the rate amounts to 0.07 psychiatrists per 100,000 [31, p. 53]. This enormous gap points to a quite different relevance of forensic psychiatry in criminal justice systems of various world regions (most probably also to differences in the relevance of mental disorders for criminal justice practices) and raises furthermore the question of how modern communication technology can contribute to alleviate the problem of access to forensic psychiatric and psychological services [32]. However, significant differences in the rates of psychiatrists per 100,000 of the population can be also observed in Europe (and OECD countries, see [33, p. 25].

Comparative data on civil and criminal commitments to forensic hospitals in Europe do not exist. This is considered a general problem which creates obstacles for assessing “quality and effectiveness of the various legal frameworks and

forensic care provisions" throughout the European Union member states [34, p. 446]. In some European countries, a significant increase in the number of inmates held in forensic hospitals was observed during the last decades (see, e.g., [35] for Germany; [36] for Austria). The increase is explained by a rise of admissions to forensic hospitals and by an increase in the average duration of detention in psychiatric hospitals ([35, p. 35]; see also [37]). Swedish research has shown that duration of confinement in forensic psychiatric hospitals is particularly marked for violent offenders [38, p. 641]. In Germany, (non-violent) sexual offenders experience the longest periods of detention in a psychiatric hospital [35, p. 38]. The increase in the number of admissions and the increase in the average length of confinement may be assumed to reflect security concerns and lower (legal) thresholds of committing criminal offenders to psychiatric hospitals and increasing reluctance to release offenders from forensic detention [25]; it might be also a result of strict and effective containment of long prison sentences (and life imprisonment) in countries where individual guilt has been given priority over deterrence and incapacitation in sentencing. This in turn might have made resort to detention in psychiatric hospitals more attractive [39].

While the question of what determines sentencing practices and whether sentencing is biased and discriminating against immigrants and ethnic minorities has received significant attention since the 1980s, research on biased admissions to forensic psychiatric hospitals is scarce. Evidence from the UK points to marked differences in admissions for different ethnicities [40]. In Denmark, an ethnic minority background has been found associated with higher rates of involuntary admissions to psychiatric hospitals and involuntary treatment. In particular for men, an ethnic minority background correlates with involuntary admission to psychiatric care [41, p. 9]. Furthermore, it is assumed that a significant share of prisoners detained in regular prisons suffers from psychiatric problems and does not receive adequate treatment [42–45]. Mental health problems among criminal offenders include personality disorders and alcohol and illicit drugs problems. The magnitude of mental health problems in prisons is associated with high suicide rates [46]. The pilot-judgment procedure initiated through the judgment ECtHR W. D. v. Belgium (application no. 73548/13, 6 September 2016) against Belgium underlines the significance of this problem.

The sociopolitical climate within which forensic psychiatry operates has changed significantly in the last decades as have changed penal systems and policies guiding the development of criminal law and punishment. While there is still concern for marginalization and stigmatization of criminal offenders diagnosed with mental disorders (see, e.g., the proposal of the Law Reform Commission (for England/Wales) 2013, 46 to replace insanity by a lack of ability to conform to the law due to a "recognised medical condition") and new treatment optimism has been found to emerge slowly after decades of treatment and rehabilitation pessimism [47], the victim of crime and potential victims of crime have moved irrevocably into the penal policy arena and with them new legislation which seeks to empower victims of crime and to protect effectively victims of crime also in criminal proceedings against mentally disordered offenders [48]. However, the issue of victims' rights in (criminal or

mental health) proceedings against offenders with mental disorders has not yet been explored in detail (for a North American perspective, see [48, 49]).

Criminal justice systems once focused on the criminal offender (and rehabilitation) now seek to accommodate the needs and interests of victims and in particular to serve interests of potential victims. New concern for crime victims seems to fuel on the one hand calls for tougher sentences and the appetite for criminal punishment and on the other hand interest in more security through incapacitating dangerous criminal offenders. Both, the appetite for punishment and the interest in incapacitation seek solutions in long periods of secure confinement. Placement in psychiatric hospitals as a consequence of complete absence of or diminished criminal responsibility of criminal offenders certainly may be considered to have incapacitating effects. Penal commitments to forensic psychiatry regularly still come in the form of indefinite deprivation of liberty which will be terminated only if dangerousness has been reduced effectively and reduction is confirmed by psychiatric expertise (see, e.g., [24]). However, in Norway the Breivik case has shown that incapacitation through indefinite commitment to a psychiatric hospital (which is based on a finding of lack of criminal responsibility) will not necessarily meet public expectations and find public approval [50]. Public attitudes on mental illness and legal dispositions of the mentally ill offender evidently are still influenced by the belief that acquittal based on insanity will result in lenient treatment and possibly quick release of insane offenders [48] and that a too wide conception of insanity will negatively impact on criminal law-based crime prevention and deterrence [9]. The case of John Hinckley in the USA underlines the significant influence high-profile cases involving forensic psychiatry may have on legal frameworks as do cases preceding recent reform of the insanity defense statute in Canada [23]. But, despite calls for complete abolition of the insanity defense (or a finding of lack of culpability due to mental disorder, see [24, p. 77]), abolition policy evidently did not find wide support (see, e.g., the New Zealand [51, p. 30]). Sweden so far remains the only country where in principle all mentally ill offenders are held criminally responsible and treatment needs are accommodated in the sentencing decision as well as in the enforcement process ([52]; see also [53] for ongoing debates on reforming the “insanity defense” in Sweden).

No uniform development can be noted for criminal justice policies with respect to mentally disordered offenders in Europe. While rights-based approaches seek to strengthen the position of the mentally ill in criminal proceedings, concerns for victims and public security tend to move criminal law and punishment toward emphasizing accountability and just desert.

4.4 Criminal Responsibility and Mental Disorders: Challenges

The United Nations Disability Convention, however, when recognizing legal capacity (Art. 12 §2) also of persons suffering from mental problems has been interpreted as requesting abolition of “a defense based on the negation of criminal

responsibility because of the existence of a mental or intellectual disability" [54, p. 47]. Instead, it is argued, "disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant" [54, p. 47]. In fact, the ongoing debates on the consequences Art. 14 of the Disability Convention will have on how insanity (or mental problems) will be dealt with in criminal justice systems reveal that the convention had deserved a more in-depth discussion of its possible legal consequences for mentally disordered criminal offenders and the rules governing the disposition of mentally disordered offenders. It demonstrates also growing influence of nongovernmental organizations critical of both detention in general and forensic psychiatry. If the Disability Convention urges for a radical departure from conventional approaches and requests a complete prohibition of deprivation of liberty based on the existence of any disability, including mental disorders or intellectual deficits, then a fundamental question of alternative practices and suited criminal law-based legal regulations of mental disorder turns up [21]. Contrasting Art. 14 1 (b) of the Disability Convention stating plainly that "the existence of a disability shall in no case justify a deprivation of liberty" with Art. 5 §1e ECHR allowing for deprivation of liberty of persons of "unsound mind" results then in an open dissent. The ECHR and the United Nations Disability Convention are headed evidently in different directions. The Disability Convention would be also a significant move away from the basic standards established through the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991). These include in Principle 16 fundamental standards to be complied with when authorizing involuntary admission to a mental health facility and with that acknowledge that detention based on the finding of mental disorders may be legitimate.

While unanimous conviction prevails that the ECHR recognizes differential treatment of persons of "unsound mind" to be legitimate, a strict interpretation of the Disability Convention as outlined above seeks to minimize and ultimately outlaw what is assessed to be discriminatory practices [55, p. 25]. A conflict emerges also when looking at Art. 12 of the Disability Convention and the concept of legal capacity. The ECtHR continues to recognize a mental disorder as justifying limitation of legal capacity, but the Commissioner for Human Rights has found that "the European human rights system has not yet fully incorporated the paradigm shift envisioned in the CRPD towards granting persons with disabilities a primary right to support in their decision-making" [30, p. 16].

The interpretation of Art. 14 adopted by the Committee on the Rights of Persons with Disabilities ([56], No. 7) refers to discussions of the scope of Art. 14 during the drafting which resulted in rejecting a limitation of prohibition of detention based on a finding of disability alone. Also detention based on a combination of insanity and dangerousness is considered to be discriminatory and in violation of Art. 14. Although jurisprudence of the European Court of Human Rights applies strict standards as to the conditions under which a person of "unsound mind" may be detained, Art. 5 e clearly states that an "unsound mind" is a legitimate ground for deprivation of liberty. And, judgments of the ECtHR, while recognizing the existence of the Disability Convention, reiterate that detention of a mentally disordered person "may

be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons" (ECtHR, Case of Stanev v. Bulgaria**,** Application no. 36760/06), Judgment, 17 January 2012, no. 146). Even where no treatment is envisaged (or possible), the ECtHR considers detention in compliance with Art. 5 ECHR if "the seriousness of the person's condition in the interests of ensuring his or her own protection or that of others" (ECtHR, Case of Stanev v. Bulgaria**,** Application no. 36760/06), Judgment, 17 January 2012, no. 157).

The ECHR is a child of the 1950s and an era when an "unsound mind" did not raise concerns when it came to justifying deprivation of liberty (nor did it raise concerns as "vagrancy" is also still a ground listed in Art. 5 §1 and justifying detention). Mental disorders were assessed to raise the risk of violent crime or self-harm [57, 58]. And, an additional judicial finding of dangerousness in terms of risks of future crime based on psychiatric expertise and a precise statutory framework allowing for fair proceedings was considered to present sufficient protection of human rights.

But, lack of or diminished culpability due to an unsound mind not only justifies deprivation of liberty in a psychiatric hospital and possibly involuntary treatment. Lack of culpability carries also protection of criminal offenders of unsound mind from harsh punishment (and protection of criminal children either completely exempt from criminal responsibility or considered to have diminished culpability), an issue also raised under international law addressing the question of eligibility for the death penalty. International law requests that persons of unsound mind should not be sentenced to death nor be executed (see the United Nations Safeguards guaranteeing the rights of those facing the death penalty, 25 May 1984). And, evidently, most European State parties did not see problems arising from Art. 14 for national criminal codes regulating the connection between insanity, criminal procedure, and punishment when signing and ratifying the Disability Convention. So far, only the reservations of The Netherlands and Norway—introduced when ratifying the Disability Convention—declare that these State parties understand the convention to allow "for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards." For England/Wales Peay [55, p. 25] stated that the Government has been in "something of a state of denial" (about non-compliance with the Disability Convention). Norway confirmed its position in the State Report 2015 ([59], No. 112) underlining that Art. 14 must be read as prohibiting deprivation of liberty based solely on a judgment of unsound mind and that corroboration of this interpretation is found in the legislation and practice of State parties to the Disability Convention. This interpretation is supported by the Human Rights Committee's General comment no. 35 on Article 9 (liberty and security of person) of the International Covenant on Civil and Political Rights [60, p. 19].

The Committee on the Rights of Persons with Disabilities, however, continues to urge State parties to bring standards and tests regarding "unfitness to stand trial" or "unfitness to plea" as well as legal rules determining deprivation of liberty of

persons with unsound mind in line with Art. 12 and Art. 14 of the Disability Convention (see, e.g., [56, 61]; see also [29]). Support in favor of such reforms is voiced by nongovernmental organizations neither affiliated with law nor with forensic psychiatry and taking sides with those considered victims of (forensic) psychiatry. NGOs have gained significant influence in the drafting of international standards (and conventions) and in the interpretation of human rights law.

The position of the Committee on the Rights of Persons with Disabilities obviously is based upon two premises.

> A finding of lack of culpability (or denying criminal responsibility) based on an "unsound mind" carries risks of stigma and exclusion which must be contained effectively.
>
> Nondiscrimination requests criminal offenders diagnosed with an "unsound mind" must be treated as are treated those offenders found fully responsible and only be deprived of liberty when adjudicated guilty of a criminal offence.

Partisans of the position that the Disability Convention should be interpreted as allowing for different procedures, treatment, and dispositions of persons (and offenders) of unsound mind invoke the culpability principle which insists on full cognitive capacity and capacity to control one's acts as necessary conditions of criminal culpability and criminal punishment and as conditions to participate actively in fair trial proceedings. A criminal trial concerns a charge of criminal wrongs and responsibility for such wrongs. Legitimacy of criminal proceedings therefore depends on defendants able to understand these charges and to respond adequately [62, p. 446]. A criminal trial involving persons who do not comprehend their situation and therefore are not in a position to defend themselves effectively and, moreover, punishment inflicted on an offender whose cognitive or control capacity during the criminal act was seriously impaired would result in verdicts of "unusual" or "inhumane" treatment and punishment, an infringement on human dignity, and violations of the fair trial principle [20]. Interpretation of Art. 12 §2 and 14 thus is decisive for the legal framework which regulates in criminal procedural law how offenders of "unsound mind" are processed and in substantive criminal law which legal consequences may result from a disability attributed to mental illnesses.

Most criminal justice systems today provide for alternative procedures if a criminal suspect (or criminal defendant) is found to be insane and lacking culpability [10]. Alternative procedures may be applied if the defendant is assessed to be unfit to stand trial (or to plead) before trial procedures started. In this case either diversion to mental health proceedings or alternative criminal proceedings (if a criminal code provides for a second track of measures of rehabilitation and security) are initiated. The difference is important though as the ECtHR will assess justification of deprivation of liberty in proceedings where a criminal court motivates a committal to a psychiatric hospital by a criminal offense committed in a state of unsound mind (and continuing dangerousness) on the basis of Art. 5 §1a (lawful detention of a person after conviction by a competent court, see ECtHR Case of Klinkenbuss v. Germany, Judgment 25 February 2016). If an offender is diverted to the mental health system, then Art. 5 §1e, detention of persons with an unsound mind, will be

applicable. Here, proceedings may result in commitment to psychiatric hospitals if dangerousness is established. In case a criminal trial has started, either proceedings are terminated (and alternative procedures begin) or the defendant is acquitted and referred to the mental health system or (in systems with a second track of measures of rehabilitation and security) committed to a psychiatric hospital by the criminal court. A finding of not guilty because of an "unsound mind" and dangerousness followed by a committal to a psychiatric hospital will then open a range of questions related to involuntary placement in forensic psychiatry. Here, involuntary treatment raises issues with respect to Art. 12 and 14 of the Disability Convention.

In general, current reforms of unfitness to stand trial and to plead seem to acknowledge that diversion from the regular criminal process should be a "last resort" to be applied only if the capacity to participate effectively in trial proceedings is lacking and impairment of that capacity cannot be compensated [63, p. 3].

With respect to German criminal law, Pollähne [21] has suggested to bring insanity rules in line with the prohibition of discrimination through wording used in the provision which regulates the consequences of a "mistake of law." The result would be a general exclusion of culpability for all offenders who when committing a criminal offense lacked comprehension of the wrongfulness of the act. While such an approach in fact reflects a general and not discriminating ground for establishing lack of culpability, it does not account for those conditions which do not impair cognition but affect the capacity to control the act. Moreover, significant differences between various grounds now hidden under the umbrella of "lack of comprehension" still would call for different responses. The reason to excuse an act committed under the condition of a "mistake of law" normally is found in the complexity of legal regulations (in particular those applicable in the economy, commerce, or taxation), sometimes also in significant cultural differences in assessing the wrongfulness of certain acts [64]. However, this type of excuse will not result in a need of further measures as such a defense may work only once. Lack of comprehension as a consequence of a mistake of law regularly is eliminated through the criminal trial itself. While some psychological or psychiatric conditions may have also only temporary effects on comprehension and criminal culpability, others will continue to impair cognitive and control capacity. Along more or less the same line of arguments and from the viewpoint of common law, compliance with the Disability Convention (or interpretation of Art. 12, 14 by the Committee) is sought through "subjectifying" criminal defenses and replacing insanity defenses by general defenses which justify or excuse if the offender believed in circumstances that, if true, would have amounted to justification or excuse of the offense [20]. Also here, impairment of control capacity would not be included, and also here, the problem will be just moved below the surface of "subjectifying." Of course, the most important question following the statement that an offender believed in circumstances which would justify an act of homicide will be why the offender believed so. And, it will certainly make a difference whether the offender believed that a gun was pointed toward him or her or whether the offender believed that another person is part of a large-scale conspiracy ultimately aimed at destroying the world.

Thus, the debate on how the Disability Convention should be interpreted reflects at the same time a basic conflict about how broad the insanity defense or exculpation based on insanity should be and a conflict about legitimate grounds for broadening or restricting insanity defenses. Calls for restrictions (or complete abolition) of insanity defenses are not justified with a possibly damaging loss of deterrence but with protecting human rights (and human dignity) of disabled persons. Withholding criminal responsibility (and blame) because of insanity is equated with denying that a person can be addressed as a "reasonable" person, as a fellow participant (or fellow citizen), and an equal in legal practices [62, p. 449, 65]. And, behind that reasoning two suspicions hide. A first suspicion is well entrenched and asserts that a special defense of insanity furthers stigma and exclusion and, moreover, "perpetuates the extremely damaging myth that people with mental disability are especially dangerous or especially lacking in self-control" [20] and ultimately exposes individuals with mental disabilities to discriminatory and inhumane practices (in particular in the form of involuntary medical treatment) and the risk of long-term and disproportionate confinement in psychiatric hospitals. A second suspicion concerns that the emergence of new clinical pictures might be triggered not by a legitimate attempt to exempt the inculpable from criminal punishment but by the interest to incapacitate offenders considered to be particularly dangerous through opening a pathway into closed psychiatric institutions.

It cannot be expected that law and practice of State parties to the Disability Convention will in the foreseeable future change toward complete abolition of insanity defenses, diversion of those assessed unfit to stand trial and plead to alternative proceedings, and involuntary commitment to forensic hospitals [66]. In fact, if commitment to psychiatric hospitals (either justified with a criminal offense committed while mentally disordered and dangerousness caused by that mental disorder) would not be acceptable because of discriminating against the disabled, then of course, the perceived need of public protection (or protection of individuals from self-harm) would not desist to call for consideration. But, what could be alternative legal grounds which would be on the one hand "de-linked from disability" and on the other hand "neutrally defined so as to apply to all persons on an equal basis" [66, p. 175]? A neutral definition will certainly be wider than current criminal justice and mental health systems provide for in Europe and therefore carry the risk of widening powers of detention. The ECHR today allows detention only when imposed by a criminal court in response to a criminal offense (Art. 5 §1a) or when falling under other enumerated grounds listed in Art. 5 ECHR (among them an "unsound mind") and thus restricts the state's power of detention. The only option of a neutrally defined ground which would not discriminate against disabled persons will be "dangerousness." It can be assumed that introduction of dangerousness would find massive political support in face of ongoing debates on how to respond effectively to terrorism, violent crime in general, and sexual offenses and how to prevent such crimes of persons not assessed to be of unsound mind nor close to preparing or committing such offenses (acts which would carry a sentence of imprisonment). The German Federal Constitutional Court when dealing with the question of (retroactive) preventive detention in Germany which was judged to be in violation of the

ECHR by the ECtHR has found that a mental disorder which does not exclude or diminish criminal responsibility and therefore falls well below the threshold of insanity defenses established by criminal law may invoke nevertheless the ground of "unsound mind" to justify detention in a treatment facility (Federal Constitutional Court, 2 BvR 1516/11, 15 September 2011). The ECtHR has held that the finding of a mental disorder (sexual deviance), the necessity of treatment, and a high risk of serious crime comply with detention based on Art. 5 §1e (unsound mind). The ECtHR said also that detention justified properly with requirements coming with detaining a person of unsound mind will not amount to "punishment", but remain treatment (ECtHR Bergmann v. Germany, Judgment, 7 January 2016). Sexual predator laws in the USA exhibit a parallel line of reasoning [67]. Neither the line between criminal responsibility and exclusion of criminal responsibility nor the line between a psychologically completely healthy person and one mentally disordered and dangerous but criminally responsible can be drawn through applying psychiatric methods. These lines will ultimately be drawn by law and politics [53, p. 48]. But there is still the question of how far forensic psychiatry should be removed from determining these lines.

De-linking mental disorders, culpability, and dangerousness completely would reduce the potential of discrimination to the disadvantage of mentally disordered offenders at the expense of risks of widening the powers to detain dangerous persons in general significantly. It would also entail a shift in the role of forensic psychiatry which moves away from providing expertise on the links between mental disorder, culpability, and dangerousness toward expertise on links between mental disorders, the necessity (and possibility) of treatment, and dangerousness. The emphasis of psychiatric expertise, however, would be then on prediction of dangerousness.

But, the Disability Convention has brought new momentum to a process of reassessing some crucial issues associated with linking an unsound mind and criminal law. Reassessment refers to the recognition that persons with disabilities should not be seen merely as recipients of charity or medical attention but as holders of rights who have "inherent human dignity worthy of protection equal to that of other human beings" [18] and are capable to make valid decisions. Placing emphasis on proportionality and addressing the problems allegedly associated with findings of unfitness to stand trial and involuntary commitment to psychiatric hospitals result in scrutinizing particularly diagnosis of medical conditions establishing insanity, link between various mental disorders and (violent) crime, and predictions of dangerousness.

4.5 Adjudication, Detention in Forensic Psychiatric Hospitals, Dangerousness, and Proportionality

From the viewpoint of mental disorders, adjudication of criminal offenders carries several risks. An offender might be found guilty, although a mental disorder has impaired cognitive or control capacity and is subject to a more severe penalty than

would have been imposed if a mental disorder would have been correctly diagnosed. Punishment then may also result in serving time in prison facilities where adequate treatment cannot be provided. Adjudication may result in a finding of not guilty due to insanity and in indeterminate confinement in a psychiatric hospital because the offender is assessed to exhibit a high risk of re-offending. Here, also the problem of correct diagnosis arises as arise the problems of assessing dangerousness. Seen from the outcome of criminal proceedings, both classifications as culpable and insane may work to the advantage and the disadvantage of criminal defendants.

The indeterminate nature of a criminal commitment to a psychiatric hospital has drawn criticism in particular from the viewpoint of proportionality. In fact, a sentence of detention in a psychiatric hospital may result in a period of confinement far longer than a prison sentence imposed on a culpable defendant for a similar crime (see, e.g., ECtHR Case of Klinkenbuss v. Germany, Judgment 25 February 2016, where the complainant had spent 28 years in forensic psychiatric hospitals for criminal offenses committed as a juvenile which could have resulted if found completely culpable in a maximum prison sentence of 10 years). And, even less serious crimes therefore carry a risk of lengthy detention for offenders for whom lack of criminal responsibility or diminished criminal responsibility has been found. In some European criminal code books, proportionality has been recognized as limiting imposition and duration of confinement in a psychiatric hospital (also the Supreme Court of Canada has adopted the "least onerous and least restrictive test to the type of detention imposed as well as on conditions of continued detention, [23]). In the German criminal code, §62 stresses that detention in a psychiatric hospital may not be ordered if—in face of seriousness of adjudicated criminal offenses and those predicted—detention would be disproportionate. Italian criminal law introduces proportionality criteria from another angle and provides in Art. 222 of the penal code that the minimum duration of detention in a psychiatric hospital is 10 years for crimes for which the law provides a life sentence and 5 years for crimes that provides sentences of less than life. In Switzerland, the maximum period of detention in a psychiatric hospital has been set at 5 years (§59 Swiss Criminal Code). Detention can be renewed for another 5 years in case of persisting dangerousness. The Dutch criminal code restricts an order of treatment in a psychiatric hospital for offenders not held responsible to 1 year (sec. 37). An "entrustment order" (terbeschikkingstelling, sec. 37a) may be imposed if the offender suffers from a mental disease or defect must not have necessarily impaired culpability. Duration of entrustment orders is graded on the basis of crime seriousness and dangerousness and may amount to indeterminate confinement in case of serious violent crime.

In Germany, indeterminate committal to a psychiatric hospital received widespread public and professional attention in the wake of the "Mollath case" [25, 68]. Mollath—accused of assaulting his wife and acts of vandalism—was assessed insane and acquitted. The criminal court, however, imposed a measure of rehabilitation and security in the form of indeterminate detention in a psychiatric hospital where he remained for 7 years for criminal offenses which would have attracted a suspended prison sentence at most if he would have been found guilty. Debates on proportionality and effective safeguards against abuse of forensic psychiatry

ensued and resulted in an amendment of the criminal code in 2016. While the Association of German Defense Councils had suggested to place an absolute limit of 8 years on commitment to forensic psychiatric care and to restrict forensic psychiatric detention to serious crimes of violence [69], the amendment which ultimately went into force in 2016 now provides in §67d (6) German Criminal Code that confinement to a psychiatric hospital may not exceed 6 years unless it is established that the mental condition carries a high risk of relapse in serious crimes of violence. Implementation of proportionality is moreover sought by intensifying judicial review of persisting dangerousness on the basis of (external and independent) psychiatric expertise.

In general, a trend toward restricting indefinite detention in a forensic psychiatric hospital to a risk of serious crimes of violence (and acts endangering health and life of others) seems to gain support. Nevertheless, strict and effective implementation of the proportionality principle will be possible only by imposing mandatory limits on the total period of detention [70, p. 232, 71, p. 6].

Another avenue toward proper consideration of proportionality is opened through the development of alternatives to secure placement (or closed psychiatric institutions) in the form of community-based forensic psychiatry and implementation of the "last resort" principle and ultimately also through adopting multi-agency approaches which seek to provide coordinated and intensive support in after-release settings and in the community [72]. Resorting to community-based forensic psychiatry as a less intrusive way of dealing with mentally disordered offenders is backed up by evidence that community-based systems are not more costly than closed psychiatric care and, if well managed, tend to provide better-quality services [22, p. 9]. In Italy, legislation went into force in 2014 which (after deinstitutionalization policies implemented in the 1970s) is considered a second revolution in forensic psychiatry [34]. The aim of the new legislation is to dismantle and ultimately abolish large forensic psychiatric facilities and to transfer responsibility for forensic psychiatric care (and for insane and dangerous criminal offenders) to the national mental health system. Current forensic psychiatric hospitals shall be replaced by small-scale residential facilities (not more than 20 inmates) or community-based psychiatric care. The implementation of the new law shall result in a process of discharging patients of forensic psychiatric hospitals to small residential facilities and into community care and restrict new admissions to "exceptional cases" [34, p. 445]. Although the process of closing conventional forensic psychiatric hospitals was in some aspects delayed, it was concluded "that the transfer of forensic hospital patients to community psychiatric services has been a positive experience overall" [73, p. 37].

The question of whether decisions on criminal culpability were wrong and have resulted in consequences to the disadvantage of criminal defendants is not only triggered by the risk of indeterminate confinement as a consequence of wrongfully assuming a defendant was mentally ill but also by a wrong finding of criminal culpability because of the risk of harsher criminal punishment than deserved. A finding of guilt does not automatically result in indeterminate confinement to a psychiatric hospital but (if dangerousness is not established) in mitigation of punishment or

complete acquittal. A wrongful conviction may also result from false confessions resulting from interrogation practices which expose suspects with mental problems and intellectual deficits to particular risks. Moreover, an offender suffering from mental disorders has to be admitted to adequate care and treatment. According to the ECtHR's jurisprudence, withholding appropriate care and treatment may raise issues of inhuman and degrading punishment/treatment (Art. 3 ECHR). Art. 2 ECHR and the right of life may be invoked in case mental problems result in suicide (see ECtHR, Renolde v. France (application no. 5608/05), 16 October 2008). Health screening of offenders when admitted to pretrial detention or prison as a first safety measure therefore must be introduced in prison laws.

Prediction of dangerousness has become a prominent topic affiliated with security [74, 75]. An assessment of dangerousness is necessary and requested by criminal law before imposing preventative detention or committing an offender to a psychiatric hospital. Also decisions on dangerousness may be wrong. However, a finding of dangerousness implies that two types of mistakes can occur. Dangerousness may be wrongly assumed, and an offender is admitted to a forensic psychiatric hospital although this offender would not relapse into crime. On the other hand, an offender may be judged to be not dangerous, will not be detained, and after release commits a serious crime. The first type of mistake (or error), of course, will not be easily detected. The second type of errors results regularly in significant public attention, in pressure on the legislator, and possibly also in criminal charges and/or civil law suits against those deemed to be responsible of wrongly assessing dangerousness [27, 76, p. 455]. Of course, errors coming with statements on probabilities may not be equated with mistakes, and all methods of prediction will result in errors. But, expectations of the public and the judicial system tend to request minimization (or complete exclusion) of errors and move forensic psychiatry toward an "unfairly defensive" role through neglecting, first, the probabilistic nature of assessments of dangerousness and, second, the closeness of dangerousness associated with mental disorder and dangerousness associated with "free will" [73]. Some higher courts in Europe, in fact, have held that prediction of dangerousness may not be based on actuarial instruments alone but must be based on clinical assessments of individual conditions. The German Federal Court of Justice has found that an assessment of dangerousness following the application of Static 99 was insufficient (German Federal Court of Justice), decision as of 30. 3. 2010, 3 StR 69/10). The Swiss Federal Court has set aside judgments of trial courts which assessed dangerousness on the actuarial instrument FOTRES alone (Swiss Federal Court 6B_772/2007, as of 9. 4. 2008; 6B_424/2015 as of 4. 12. 2015).

Some European countries have established Criminal Case Review Commissions which are mandated to examine convictions of persons when doubts arise as to the wrongfulness of a finding of guilt (see [77, p. 215] for England, Scotland, and Norway). In other countries, reopening of criminal proceedings (to the advantage of a convicted criminal offender) applies on grounds of new evidence which may result in an acquittal (or mitigation of punishment). A study on reopening criminal proceedings in Switzerland has found that new evidence on mental problems of convicted offenders played a significant role for granting a retrial in serious criminal

cases. New psychiatric expertise was decisive in three out of four convictions for homicide [78, p. 1161]. However, a major problem seems also to be wrong confessions from mentally disordered suspects [79, p. 148].

4.6 Involuntary Treatment and Coercion in Forensic Psychiatry

Wide acceptance of the rights-based approach to the treatment of defendants with mental problems has also resulted in refueling well-entrenched debates on involuntary treatment in psychiatric settings. Reasoning based on Art. 12 §2 of the Disability Convention asserts that also in the context of involuntary treatment jurisprudence and standards established by the ECtHR (and state legislation and practices) is "incompatible with … Art. 12 §2 and should no longer be regarded as valid" [80, p. 415]. Involuntary treatment has been scrutinized in jurisprudence of constitutional courts and the ECtHR. But, the ECtHR in principle holds that involuntary treatment may be legitimately applied if it was persuasively shown to be necessary (Gennadiy Naumenko v. Ukraine (application no. 42023/98, 10. 2. 2004) and if a statutory basis allows for predictability of forced treatment and fair proceedings (ECtHR, X v. Finland (Application no. 34806/04), 19 November 2012).

The German Federal Constitutional Court in a landmark decision as of 23 March 2011 (2 BvR 882/09) has declared involuntary treatment to infringe on the right of physical integrity as well as the right to self-determination. According to the reasoning of the Court, impaired capacity of discernment might even intensify and deepen an infringement if a mentally impaired person experiences involuntary treatment as particularly threatening. The focus is placed on the impact involuntary psychiatric treatment has on the body of a patient in the form of physical side effects of medicaments but also on the impact certain medicaments have on mental processes in the brain. In particular the latter is considered to have the capacity to affect the core of personality (privacy). However, the Federal Constitutional Court argued that in principle and under very narrowly defined conditions involuntary treatment may be justified. The Court asserts also that the Disability Convention does not prohibit involuntary treatment. On the contrary, Art. 12 §4 of the Disability Convention is interpreted as implicitly recognizing legitimacy of involuntary treatment because it requests implementation of proportionality and strict rules which protect against conflicts of interest and abuse. According to the 2011 judgment, substantive and procedural law must be in place which recognizes the relevance of the (natural) will and is guided solely by an interest of the detained person him-/herself to restore the foundations of self-determination (and the capacity to work toward release to the community). Involuntary medication of a detainee cannot be justified by a danger for others (detention prevents such danger effectively). A basic condition of involuntary treatment concerns convincing evidence that lack of capacity of comprehending the necessity of specific treatment is caused by the mental problem which shall be treated. From this starting point, the Court outlined requirements for legislation authorizing involuntary treatment in (forensic) psychiatric hospitals. First, a

law on involuntary treatment has to follow a standard test of proportionality. Treatment must be suited to restore the capacity of self-determination and present the least intrusive measure. Proportionality in this sense requests a serious attempt to achieve consent based on full information (on treatment, aims, and possible effects) and on trust (see in this respect United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991, principle 11 §9 requesting full information also in cases where legal capacity is impaired). Then, proportionality must be established through weighing the predictable benefit of treatment against the burden placed on the involuntarily treated person which should result in a clear preponderance of benefits. Second, implementation of the proportionality principle demands also for procedural safeguards. In order to allow for effective judicial review, detailed information that a measure of involuntary treatment is to be applied has to be provided sufficiently early. Another element in the procedural aspects of proportionality concerns full records of the process of initiating and carrying out involuntary treatment (see also ECtHR, Dvořáček v. Czech Republic (application no. 12927/13), 6. 11. 2014, where it was held that a specific form setting out consent and informing of the benefits and side effects of treatment would have reinforced legal certainty for all concerned, but the failure to use such a form was insufficient for a breach of Art. 3 ECHR).

Finally, the particular risks coming with coercion under conditions of detention call for an independent examination prior to carrying out involuntary treatment. The German Federal Constitutional Court in this respect invoked principle 11 §6b and §13 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 which emphasize the need for an independent (external) review of decisions related to involuntary treatment. Independent reviews could be done by a custodian, by an ombudsman, or by a judicial authority. In fact, the conditions outlined include also a model of "supported decision-making" as required by Article 12 of the UN Disability Convention. The ECtHR has expressed the view that it shares the opinion of the German Federal Constitutional Court elaborated in the 2011 decision. Involuntary hospitalization may be used only as a last resort and in absence of a less invasive alternative, if it carries true health benefits without imposing a disproportionate burden on the person concerned (ECtHR, Pleso v. Hunagry (Application no. 41242/08), 2 October 2012, no. 66).

Conclusions

Current challenges for forensic psychiatry follow from legal developments which emphasize rights-based approaches to those assessed to suffer from mental disorders. In particular the Disability Convention has provoked a new debate on whether and to what extent mental disorders and intellectual deficits may justify an assessment of lack of or diminished culpability and involuntary admission to psychiatric hospitals and treatment. Strong concern for fundamental rights of detainees in forensic hospitals has resulted in increasingly strong monitoring by independent organizations. Forensic hospitals thus are exposed—as are prisons or police holding cells—to the suspicion that places of detention are particularly

prone to risks of maltreatment and abuse. Paramount interest in security and protection of the public and crime victims has moved forensic psychiatry toward assessment of dangerousness and assessment of (causal) links between mental disorders and dangerousness but also toward assessments of alternative methods (community treatment) as elements in tests of proportionality. Forensic psychiatry increasingly has to deal with questions which fall outside the core area of professional expertise and to answer for practices (and results) which are primarily the outcome of legal and policy decision-making.

Take-Home Messages

- Forensic psychiatrists and psychologists should be aware of new developments in legal systems across Europe, since it affects their daily practice.
- Current legal developments emphasize rights-based approaches to those assessed to suffer from psychiatric disorders.
- Forensic psychiatric hospitals are exposed to the suspicion that they are particularly prone to risk of maltreatment and abuse.
- Forensic psychiatry and psychology increasingly have to deal with questions which fall outside the core area of professional expertise.

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The European Impact on National Forensic Psychiatry

5

Anton van Kalmthout and Paul Mevis

5.1 Introduction: Relevant European Mechanisms

The central duty of the Council of Europe is to safeguard the fundamental rights of members of the public. Unsurprisingly, the Council gives particular attention to the legal position of mentally disordered persons, and specifically their position under criminal law. The care provided to mentally disordered prisoners during the execution of sanctions can easily fall short of the required standards. Traditionally, therefore, the influence of 'Europe' and the involvement of forensic psychiatry are geared predominantly toward how criminal sanctions and their execution are given shape, including the intake of mentally disordered prisoners and their transfer to proper facilities for care and treatment. Nevertheless, the legitimacy of imposing and executing criminal sanctions presupposes a legitimate and fair trial. If every 'normal' suspect in criminal law is already 'vulnerable' in respect of the all-powerful authorities and their daunting criminal law system, this holds all the more true for mentally disordered suspects. As such, Europe is increasingly shifting to include protecting mentally disordered suspects during trial. This carries over to the weight that this matter carries within forensic psychiatry. The following sketches out the principal existing laws, instruments and documents and how they affect forensic psychiatry for adults.[1]

The first instrument that the Council of Europe possesses for safeguarding fundamental rights is the European Convention for the Protection of Human Rights

[1] The separate rules for children are not addressed here.

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and Fundamental Freedoms ('ECHR'),[2] which defines various rights. Complaints about suspected violations of any of those rights may be brought before the European Court on Human Rights (ECrtHR). Member States are required to comply with that court's decisions and, if necessary, amend their national laws accordingly. More important, the ECHR's system is based on the idea that the Member States must properly implement the rights enshrined in the ECHR in their national laws. In addition to this passive approach adopted by the Council of Europe, another instrument that is relevant to prisoners is the anti-torture mechanism. To reinforce the safeguard against torture and inhuman or degrading treatment (Article 3 ECHR), a mechanism has been created in which the European Committee for the Prevention of Torture (CPT) visits locations where people are deprived of their liberty by instructions of the authorities, to work together with the Member States to prevent and protect against torture and other inhuman or degrading treatment or punishment.[3] Both these mechanisms play a part in safeguarding mentally disordered members of the public at law and as such have implications for forensic psychiatry.

Like the Council of Europe, the European Union has in recent years increasingly influenced the legal position of members of the public with a mental disorder who find themselves in trouble with the criminal justice system. The European Union's involvement in criminal law is aimed primarily at effective cooperation between Member States in criminal cases. That cooperation is based on the principle that Member States must trust each other's legal systems. However, the close cooperation based on this principle is effectively jeopardised if elementary safeguards for members of the public are not realised at the European level. For example, the European Court of Justice has put a halt to mutual cooperation in transferring suspects and convicted criminals to Member States where the quality of the prison system had been established by the ECrtHR, based in part on the CPT's findings, to be in violation of Article 3 ECHR. The instruments on which the EU can call to realise the elementary rights of individuals for purposes of actual and effective mutual cooperation in criminal cases do not overlap entirely with those of the Council of Europe: the EU can use directives to force Member States to amend their national laws. In this context, the vulnerability of suspects that needs protection has already triggered a 'Directive on procedural safeguards for children who are suspects or accused persons in criminal proceedings'. However, mentally disordered suspects can rely only on the European Commission's Recommendation of 27 November 2013 on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings,[4] and it is unlikely that a directive will follow. In part this stems from the differences in legal and social traditions of dealing with

[2] For the UN framework, see the International Covenant on Civil and Political Rights.

[3] A mechanism exists at the UN level that is somewhat similar, under the Optional Protocol to the UN Convention against Torture.

[4] Commission Recommendation of 27 November 2013 on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings 2013/C 378/02. Verbeke et al. [6] advocate increasing the scope of the measures.

mentally disordered members of the public, while another issue is that it is much more difficult to define 'mentally disordered' than it is to attach a particular age to the socially recognisable criterion of 'child' or 'minor'.[5] As a consequence, the simple fact that mentally disordered individuals require additional attention is one of the most important responsibilities of forensic psychiatry.

5.2 Mentally Disordered Suspects: Acknowledgement of Their Vulnerability

Once the ECrtHR's assumption of the vulnerability eo ipso of each 'normal' suspect or accused in the criminal process is accepted, it is a small step to require additional attention for the heightened vulnerability of other suspects, accused and convicted persons, as exemplified not only by children but also by mentally disordered suspects. Their heightened vulnerability sometimes needs to be accommodated. This need for accommodation is underlined by the fact that the ECHR, the ECrtHR and the EU all assume that despite a mental disorder it is possible to conduct legitimate criminal investigations against mentally disordered suspects, who may also be subjected to a fair trial despite their disorder. Similarly, the mere execution of a criminal sanction such as a prison sentence is not automatically deemed to be in violation of—for instance and in particular—Article 3 ECHR for the sole reason that the individual so sentenced has a mental disorder. That assumption is essentially correct: not every mentally disordered suspect or convicted person has a heightened vulnerability that precludes the legitimacy of the criminal procedure or that must be accommodated by extraordinary safeguards. In fact, this assumption demands *adequate* accommodation commensurate to the degree of vulnerability. That accommodation should not be merely enabled, or even prescribed, in national law; what accommodation is required in a concrete situation, and for what reason, is often impossible for the court, public prosecutor or other criminal justice official to establish for themselves. Instead, they will often need to call on forensic psychiatry and rely on the opinion of an expert in that field. Conversely, this means that forensic psychiatrists will need to familiarise themselves with legal proceedings, their purpose and their scope.

It is important to note here that the criminal procedure in each case consists of a number of phases: specifically (in the order in which they occur) preliminary inquiry, prosecution and trial and (if the suspect is convicted) execution of the criminal sanction imposed. These separate phases are also linked at the level of fair trial, given that granting a suspect rights and safeguards in one phase may have bearing on the fairness of the criminal procedure in a subsequent phase. For example, the ECrtHR assumes that one of the reasons underlying a suspect's right to legal assistance while being questioned by the police is to avoid miscarriages of justice, which may occur if the court reaches the wrong decision based on the evidence. With some disorders in particular, the suspect might be extremely susceptible to suggestion or

[5] In the EU directive: the age of 18.

fantasy that could cause him to confess to offences never committed.[6] It is not without good reason that when considering whether the suspect was given a fair trial within the meaning of Article 6 ECHR, the ECrtHR always considers the procedure as a whole, i.e. every related and successive part of the criminal procedure in a particular criminal case.

It is important here that the need for accommodation and therefore the mental disorder be identified quickly. The possibility that a suspect has a mental disorder and that the judicial authorities need to allow for the possible vulnerability and need for accommodation should be acknowledged in the criminal system from the moment of the individual's first dealings with the criminal system—at the latest when he is arrested on suspicion of having committed the offence. This requires early screening procedures and mechanisms, to identify any relevant disorders or illnesses as soon as possible. The result should be an effective link to conclusions about the possible and viable use of procedural and participation rights by the accused, if necessary indicating relevant accommodating measures. For a long time, early screening was not mandatory by international standards. However, this might change with the relevant provisions of paragraph 4 of the EU Recommendation, which reads:

> Vulnerable persons should be promptly identified and recognized as such. Member States should ensure that all competent authorities may have recourse to a medical examination by an independent expert to identify vulnerable persons, and to determine the degree of their vulnerability and their specific needs. This expert may give a reasoned opinion on the appropriateness of the measure taken or envisaged against the vulnerable person.

As evidenced by the phrasing of this clause, when establishing and acknowledging that the suspect has a disorder, the authorities need to be able to call on independent experts. It does not stipulate that the vulnerability can only be established based on the forensic psychiatrist's opinion; however, such a requirement could be included in the country's national laws. Yet in this regard the role of forensic psychiatrists in informing the criminal justice authorities, and specifically the criminal court or trial judge, is also affected by the fact that Recital 7 contains a warning that a legal remedy must be available to suspects to protect against any establishment of vulnerability if it would prejudice the exercise of their fundamental rights. This risk of prematurely depriving the individual of his rights and responsibilities comes into play in situations where, for example, the individual's right to personally participate in his trial and actively contribute to his defence might be restricted. It is precisely for this reason that the decision on the vulnerability and its implications (both procedural and otherwise) must be made by the court rather than a behavioural specialist such as a forensic psychiatrist. Nevertheless, he needs to be aware

[6] Cf. the infamous Swedish serial killer Sture Bergwall, aka Thomas Quick, who was convicted for eight murders to which he had confessed but that he had not committed. He was released in 2013 after having spent 22 years in a forensic clinic. For an English-language overview of the case of Sture Bergwall/Thomas Quick, see https://search.proquest.com/docview/1115056204?accountid=13598.

of his position and the scope of his advice in this respect. The law (and in particular criminal law) must provide sufficient reliable procedures for querying such advice and opinions, for example, by allowing the defence to consult another forensic psychiatrist. The possibilities in the various countries may be determined by the degree to which the procedural position tends toward the adversarial or the inquisitorial.[7]

In this respect, forensic psychiatry may and should not only be expected to advise on concrete criminal cases: the field also has a role to play in training criminal justice officials. This includes developing mechanisms for transforming a vulnerability that has been recognised in the suspect into effective and modified treatment of that suspect. This does not appear to happen automatically, even if that vulnerability has been recognised [1]. It can also be expected of forensic psychiatrists to be able to distinguish feigned mental vulnerabilities [2]. The first steps toward developing and implementing a reliable measuring instrument have already been taken at the European level.

5.3 Fitness to Stand Trial

Although not every disorder should automatically mean that the disordered suspect must be accommodated in the criminal proceedings, and such accommodations make it possible to conduct a fair trial of disordered suspects, nevertheless situations exist where the extent of the suspect's disorder renders criminal prosecution inappropriate. One reason might be that the disordered suspect is entirely incapable of understanding the prosecution. Prosecution then becomes meaningless if its purpose is to make the individual understand that his actions broke the law and as such were 'wrong'. Alternatively, prosecution might be inappropriate if it is evident that the suspect cannot be held culpable by reason of his disorder, and he can therefore invoke the insanity defence [3]. Forensic psychiatry is perfectly suited to play a part in informing the judicial authorities that such a defence is valid. Yet the need to provide for such modalities for avoiding prosecution does not stem from the ECHR, though. This changes, though, if the disordered suspect is no longer capable, even with accommodating measures, of participating in the prosecution brought against him properly and with a sufficient degree of active involvement. This ability is referred to as 'fitness to stand trial' [4]. How this influences the right to a fair trial as enshrined in Article 6 ECHR differs according to how adversarial or inquisitorial the criminal procedure is structured under the relevant Member State's national law. Yet to date the ECrtHR has not ruled that Article 6 requires any charges to be dropped, trials to be suspended or cases to be dismissed. It might be argued that the articulated influence of a disordered accused's vulnerability demands a change in approach, at the level of the ECrtHR and—as a result—under the Member States' respective laws [5, 6]. This is where forensic psychiatry comes into play. Deciding whether the suspect is fit to stand trial helps to prevent the administration of

[7] See also Chap. 1 of this volume.

criminal law where prosecution does not serve any true purpose or interest of criminal law enforcement; instead, it merely prevents the individual from receiving proper care outside the scope of criminal justice.

5.4 Fair Trial; Trial Rights

The fact that being prosecuted by the authorities already places any person in a vulnerable position is reflected in the rights that the phrasing of Article 6 ECHR grants the suspect in order to conduct a proper defence. These are the right to a fair hearing, the right to be present during trial and to conduct a defence, the right to legal assistance, the right to be informed properly and to a letter of rights, the right to examine all witnesses and, in more general terms, the right to challenge the evidence against him or her, etc. In the wording of the ECrtHR:

> The Court accepts the Government's argument that Article 6 § 1 does not require that a child on trial for a criminal offence should understand or be capable of understanding every point of law or evidential detail. Given the sophistication of modern legal systems, many adults of normal intelligence are unable fully to comprehend all the intricacies and all the exchanges which take place in the courtroom: this is why the Convention, in Article 6 § 3 (c), emphasises the importance of the right to legal representation. However, "effective participation" in this context presupposes that the accused has a broad understanding of the nature of the trial process and of what is at stake for him or her, including the significance of any penalty which may be imposed. It means that he or she, if necessary with the assistance of, for example, an interpreter, lawyer, social worker or friend, should be able to understand the general thrust of what is said in court. The defendant should be able to follow what is said by the prosecution witnesses and, if represented, to explain to his own lawyers his version of events, point out any statements with which he disagrees and make them aware of any facts which should be put forward in his defence. (see, e.g. Stanford, cited above, § 30)[8]

Again, the degree to which the suspect is actually expected to actively exercise control depends somewhat on whether the relevant criminal proceedings in that particular country are based predominantly on the adversarial model or on the inquisitorial model. In many countries, criminal procedure has recently been experiencing a shift, placing greater demand on the suspect's responsibility and ability to properly organise a defence and establish a course of action. A requirement that applies in all instances is that the suspect, not just his legal counsel, must at least be able to comprehend the defence and, while perhaps not fully controlling the choices made, have at least some understanding of those choices. While the demands imposed by the ECHR are not exceedingly high,[9] that minimum standard must be satisfied. The suspect's personal involvement cannot be replaced entirely by the counsel acting for him. If the suspect has a disorder that heightens his vulnerability, the provisions of Article 6 ECHR incontrovertibly

[8] ECrtHR 15 June 2004, no. 60958/00 (*S.C. v. the United Kingdom*), par. 29.

[9] ECrtHR 31 October 2013, 17,416/03 (*Tarasov v. Ukraine*), par. 98.

mean that effective accommodating measures must be taken for that suspect in allowance for his heightened vulnerability. The criminal justice authorities have a positive obligation under the ECHR to ensure that even disordered suspects can enforce their right to effective participation in the criminal proceedings. Absence of this accommodation renders a fair trial against the disordered suspect impossible. The European Union's Recommendation matches this approach adopted by the ECrtHR, in that it contains some requirements that give further shape to the conditions for effective participation by suspects whose disordered mental capacity heightens their vulnerability. For example, 'Persons with disabilities should receive upon request information concerning their procedural rights in a format accessible to them' (par. 8) and 'Any questioning of vulnerable persons during the pre-trial investigation phase should be audio-visually recorded' (par. 13). Similar to the presumption of innocence, the recommendation introduces a 'presumption of vulnerability': 'Member States should foresee a presumption of vulnerability in particular for persons with serious psychological (…) impairments, or mental illness or cognitive disorders, hindering them to understand and effectively participate in proceedings' (par. 7). The recommendation also identifies another important theme that applies specifically in respect of vulnerable suspects and in particular suspects whose vulnerability is heightened by their disordered mental capacity. Paragraphs 5 and 6 read:

> Vulnerable persons should not be subject to any discrimination under national law in the exercise of the procedural rights referred to in this Recommendation. (…) The procedural rights granted to vulnerable persons should be respected throughout the criminal proceedings taking into account the nature and degree of their vulnerability.

This non-discrimination principle concerns the risk for which the disordered suspect is protected against himself to such a degree that he is denied any possibility of effective participation in person. The task of protecting the suspect's interests during the criminal proceedings is then put in the hands of others, in particular his legal counsel. This presents another possible violation of the right to a fair trial. In part for this reason, the ECrtHR assumes that a suspect's legal counsel in criminal prosecution should never fully assume the suspect's position, to ensure a fair trial despite the suspect's disorder.[10] Here, the desire to continue the prosecution despite everything, particularly for serious offences, in fact poses a threat to suspects of heightened vulnerability.

It is evident that forensic psychiatrists also have an important role to play here, in shaping and safeguarding the right to a fair trial. Their services can—and in some cases should—be engaged to inform the criminal court about a particular suspect fitness to stand trial, what the extent of his vulnerability is in the right to participate in the criminal proceedings and what additional accommodating measures are needed to guarantee effective participation of a suspect whose vulnerability is heightened by a disorder.

[10] Cf. Article 5 of the 2006 UN Convention on the Right of Persons with Disabilities.

5.5 Execution of Sanctions

In terms of execution of criminal sanctions in respect of disordered suspects and convicted persons, the legitimacy of the detention is based in part on Article 5 ECHR. If the criminal sanction is aimed (at least in part) at preventing further offences (particularly serious offences), a relevant factor is that the detention must satisfy the requirements of Article 5(1)(a), (e) and (c) ECHR. A factor to consider here is that prolonged detention after having been convicted in court diminishes the link to that conviction, and further detention can no longer be based on Article 5(1)(a). Further lawful detention is then only possible if the procedures, conditions and structure of the execution satisfy the ECrtHR's requirements for the legitimacy of detention on one of the other grounds set out in Article 5(1) ECHR.[11] The risk of new serious offences must be '*sufficiently concrete and specific*'.[12] In particular, the execution must be geared toward locations that offer an environment for care and treatment.[13] Many penal institutions where disordered offenders who pose a risk to society are held in detention after their conviction do not satisfy this fundamental condition. Holding the individual in a penal institution that does not offer sufficient care may constitute a violation of fundamental and human rights. Psychiatric reports may be both necessary and helpful to prevent these violations. Of particular importance here is Article 35 of Recommendation No. Rec(2004)10 concerning the protection of human rights and dignity of persons with mental disorder, which applies '*the principle of equivalence of care with that outside penal institutions*'. Patients may not be exposed to any discrimination in penal institutions: their care may not be withheld or reduced simply because they are in prison. This vulnerability is where independent supervision of mental disorders in penal institutions comes into play.[14]

The detention must also be lawful: it must be in accordance with national laws and with the ECHR. In the latter respect, the ECrtHR in particular requires that the competent authority must have established the existence of a disorder, based on the opinion of a behavioural specialist who possesses sufficient medical expertise relevant to the condition or disorder.[15]

This establishes the importance of forensic psychiatry. The input of this expertise in relevant proceedings before the criminal court is not only a factor in determining

[11] For example, cf. ECrtHR 17 December 2009, no. 19359/04 (*M. v. Germany*), and ECrtHR 13 January 2011, no. 6587/04 (*Haidn v. Germany*).

[12] ECrtHR 17 December 2009, no. 19359/04 (*M. v. Germany*), par. 102.

[13] ECrtHR 30 July 1998, no. 25357/94 (*Aerts v. Belgium*), par 48.

[14] Cf. Recommendation Rec(2004)10 concerning the protection of human rights and dignity of persons with mental disorder, Article 35(4): 'An independent system should monitor the treatment and care of persons with mental disorder in penal institutions'.

[15] ECrtHR 5 October 2000, no. 31365/96 (*Varbanov v. Bulgaria*). The source of these general requirements is still ECrtHR 24 October 1979, no. 6301/73 (*Winterwerp v. The Netherlands*), par. 39. More recently, see ECrtHR 2 October 2012, no. 41242/08 (*Plesó v. Hungary*). See also the mentioned Recommendation Rec(2004)10 concerning the protection of human rights and dignity of persons with mental disorder.

the required standard of lawfulness and legitimacy of the detention required by Article 5 ECHR in cases involving a mental disorder; it may also apply to its continuation and for placement in an appropriate environment (either for treatment or otherwise). In certain circumstances, the disordered individual in question will require the behavioural specialist's input to safeguard his rights under the ECHR. The behavioural specialist informing the court deciding on the detention must provide an understanding of the disorder and an estimation of the associated risk of repeat offences, in order to help prevent situations where the disordered individual is prematurely put in long-term detention without any prospect of appropriate treatment and the possibility of release. Precisely because decisions to detain an individual or to extend their detention may also be made if the patient/prisoner refuses to cooperate in a behavioural report,[16] it can be difficult for the behavioural specialist to properly carry out that duty to inform the authorities. In many countries, reports from behavioural specialists will also be considered in the review required by the ECrtHR for lifelong imprisonment.[17]

As the European Union's approach shifts focuses on effective cooperation in criminal matters, it is clear that this cooperation is under pressure where the standard of care and humanity in the execution of sanctions falls short of the minimum required by Article 3 ECHR—and perhaps more encouragingly where the quality of detention does not meet the positive criteria laid down in Article 10 of the UN's International Covenant on Civil and Political Rights. The European Union is not developing any instruments to increase the quality of detention as such, or at least not beyond the scope of the 2009 Procedural Roadmap for strengthening the procedural rights of suspected and accused persons in criminal procedure, to ensure cooperation in criminal matters. In this respect, it relies on the Council of Europe's mechanism. The case law handed down by the ECrtHR in connection with Article 3 ECHR by extension considers the CPT's opinions and factual findings on the detention situation in the various Member States of the Council of Europe.

The basis assumption is the same as for Article 6, where the mere fact that the suspect has a mental disorder that renders him vulnerable does not mean that he cannot be given a fair trial. What matters is recognising the vulnerability of the vulnerable suspect and where necessary accommodating that vulnerability. The same holds true for Article 3 ECHR. The mere fact that a disordered person is sent to prison after having been convicted and given a criminal sanction, for example, a prison sentence, does not constitute a violation of Article 3 ECHR. However, according to case law of the ECrtHR, that clause does in fact require that the prison system must at the minimum offer facilities for giving the disordered prisoner proper care and treatment.[18] This does not automatically mean that someone who

[16] ECrtHR 3 March 2015, no. 73560/12 (*Constantia v. The Netherlands*).

[17] ECrtHR 9 July 2013, nos. 66069/09, 130/10 and 3896/10 (*Vinter v. the United Kingdom*); ECrtHR 26 April 2016, no. 10511/10 (*Murray v. the Netherlands*); and more recently ECrtHR 17 January 2017, no. 57592/08 (*Hutchinson v. the United Kingdom*).

[18] ECrtHR 26 October 2000, no. 30210/96, (*Kudla v. Poland*) par. 94. In April 2016, the ECrtHR published a factsheet entitled 'Detention and mental health', summarising the ECrtHR's case law.

has been convicted should otherwise be granted his freedom or be transferred to a mental hospital.[19] The limits to Article 3 ECHR emerge principally if the detention (particularly if it is long) results in a more onerous penalty, and specifically deterioration of the individual's mental health. This again underlines the particular vulnerability of disordered prisoners and specifically their vulnerability in terms of the ability to assess and complain about the nature and manner of the care and treatment that they receive (or do not receive) in prison.[20] Essentially, three elements together in particular determine the existence of a violation of Article 3 ECHR:

> The Court observes that there are three particular elements to be considered in relation to the compatibility of an applicant's health with his stay in detention: (a) the medical condition of the prisoner, (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of an applicant. (see *Mouisel*, ibid., §§40-42; *Melnik v. Ukraine*, no. 72286/01, §94, 28 March 2006; and *Rivière v. France*, no. 33834/03, §63, 11 July 2006)[21]

Care for mentally disordered prisoners explicitly includes preventive care to avert suicide, which is often a greater risk in detention than outside. The World Health Organisation especially advocates properly educating and training prison staff [7]. While the ECrtHR does not rule out the option of involuntary treatment, particularly of patients lacking capacity, even in detention it is subject to a strict requirement of 'medical necessity'.[22] Involuntary treatment must be compliant with the rules of the Convention on Human Rights and Biomedicine (the Oviedo Convention of 1997).[23] Article 35(3) of Recommendation Rec(2004)10 concerning the protection of human rights and dignity of persons with mental disorder adds, 'Involuntary treatment for mental disorder should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder'.

The ECrtHR's criteria should be seen as an effort to apply to mentally disordered prisoners the more general standards that the ECrtHR applies in cases of sickness. The court summarised its principle once again in September 2016:

> The Court further reiterates that Article 3 of the Convention imposes on the State a positive obligation to ensure that a person is detained under conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject the individual to distress or hardship exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, the person's health and well-being are adequately secured by, among other things, the provision of the requisite medical assistance and treatment (see *Kudła v. Poland* [GC], no. 30210/96, § 94, ECHR 2000-XI; *McGlinchey and Others v. the United Kingdom*, no. 50390/99, § 46,

[19] ECrtHR 18 December 2007, no. 41153/06 (*Dybeku v. Albania*), par. 41.

[20] ECrtHR 18 December 2007, no. 41153/06 (*Dybeku v. Albania*), par. 41.

[21] ECrtHR 20 January 2009, no. 28300/06 (*Slawomir Musial v. Poland*), par. 88; see also ECrtHR 18 December 2007, no. 41153/06, (*Dybeku v. Albania*), par. 42.

[22] ECrtHR 24 September 1992, no. 10533/83 (*Herczegfalvy v. Austria*), par. 82.

[23] Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.

> ECHR 2003-V; and *Farbtuhs v. Latvia*, no. 4672/02, § 51, 2 December 2004). In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. Medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole. Nevertheless, this does not mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities. (see, *inter alia, Blokhin*, cited above, § 137)[24]

What is remarkable and striking is the assumption that care in detention should essentially be equal to the care in free society. No reason exists not to apply that principle to prisoners with a mental illness as well, as enshrined in Article 35 of Recommendation Rec (2004)10 concerning the protection of human rights and dignity of persons with mental disorder, quoted above.

The European Court on Human Rights reviews this against Article 3 ECHR, by considering whether that article has been violated. In general, accepted is that a violation requires a minimum level of severity. Given the nature of the subject matter and the care for mentally disordered prisoners in the prison system, as one of the most vulnerable groups in terms of human rights, the Council of Europe provides 'soft law' developing further rules for mentally disordered prisoners. For example, Rule 12.1 and Rule 12.2. of the revised European Prison Rules state:

> Persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose.
>
> If such persons are nevertheless exceptionally held in prison there shall be special regulations that take account of their status and needs.

These rules assume—in principle—that the prisoner will be transferred to proper facilities if his mental disorder so necessitates.[25] Further examples of how the rules for mentally disordered prisoners have been given shape can be found in the rules of the CPT, as mentioned above.

5.6 CPT Standards

Complementary to the judicial retroactive mechanism of the ECtHR, the 1987 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT) set up a nonjudicial preventive mechanism to strengthen the protection of people deprived of their liberty against violation of Article 3 of the ECHR. A special committee (the CPT) has been set up to monitor the treatment of people deprived of their liberty. The main task of this committee is to visit places in the Council of Europe Member States where people are deprived of their liberty, such as police stations, prisons and psychiatric hospitals. Visits are

[24] ECrtHR 1 September 2016, no. 62303/13 (*Wenner v. Germany*), par. 55.

[25] See also Recommendation No. R(98) 7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison (April 1998).

carried out by delegations, usually existing of several CPT members, accompanied by staff members of the secretariat and, if necessary, by additional experts and interpreters. As a rule, a medical doctor and a psychiatrist are part of each delegation. CPT delegations have unlimited access to all places of detention, the right to move inside such places without restriction and the right to interview persons deprived of their liberty in private and the right to communicate freely with anyone who can provide information. It has also unrestricted access to any information—including medical files and records—it considers necessary to carry out its preventive work. After each visit, the CPT sends a detailed report to the State concerned. This report includes the CPT's findings and its recommendations, comments and requests for information and responses to the issues raised in its report. These reports and responses form part of the ongoing dialogue with the states concerned.

Based on the visit reports that are drawn up after the visit, the CPT has developed general standards for some of the substantive issues, which it pursues when carrying out visits. These standards, together with the visit reports and the annual general reports, provide States clear guidelines on how persons deprived of their liberty should be treated. Even though the CPT standards and reports are not binding on States, the CPT has developed its own standards and safeguards for prisons and other places of detention in a more detailed manner than any other European instrument to be able to monitor conditions in prisons and other places of detention more objectively [8, 9].[26] Over the years, the CPT has become a 'fact finder' for the ECtHR. The jurisprudence of the ECtHR shows that the CPT standards, as developed over the last 28 years are more and more applied in individual cases before the ECtHR. This is especially the case when the ECtHR is confronted with aspects of detention regarding which the ECtHR has not previously ruled [10].[27]

Health-care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate, because:

> An inadequate level of health care can lead rapidly to situations falling within the scope of the term inhuman or degrading treatment.[28]

For that reason, the CPT has formulated a set of general criteria and standards that should be guiding for all health-care services, irrespective of the place of detention or the mental state of the prisoner or patient. These standards concern amongst others access to a doctor, equivalence of care, patient's consent and confidentiality,

[26] R. Morgan, 'The European Committee for the Prevention of Torture and Inhuman or Degrading Punishment or Treatment', in: D. Van Zyl Smit & F. Dünkel (eds.), *Imprisonment Today and Tomorrow. International Perspectives on Prisoners' Rights and Prison Conditions*, The Hague: Kluwer Law International 2001, p. 717; J. Murdoch, *The Treatment of Prisoners. European Standards,* Strasbourg: Council of Europe Publishing 2006, p. 45.

[27] On the relationship between the ECtHR and the CPT and their contribution to an effective and efficient protection of prisoners against torture and inhuman or degrading treatment or punishment, see Hagens [12].

[28] 3rd General Report (1992) (par.30).

preventive health care, living conditions, professional independence and professional competence, medical screening on admission, transmissible diseases (HIV/AIDS) treatment and prevention, suicide/self-harm prevention, hunger strikes, treatment of sex offenders and detention of prisoners with physical disabilities [11]. The general character of these standards implies that they also apply to mentally disordered prisoners. However, accommodating these persons in a prison setting means in daily practice that their psychiatric illness remains untreated which according to the CPT:

> leads to ad hoc measures which may easily constitute inhuman and degrading treatment.[29]

It is therefore that, in line with Article 35 of Recommendation Rec (2004)10 concerning the protection of human rights and dignity of persons with mental order, the CPT has repeatedly pointed out that persons suffering from severe mental illness, requiring psychiatric assessment and/or treatment, should not be accommodated in ordinary prisons, but 'whatever their legal status, should be assessed and treated in a medical facility'.[30] However, when they still are accommodated in a prison setting, the consequence should be that they should be treated according to the specific standards that in addition to these general standards have been formulated for the treatment of involuntary patients in a forensic psychiatric institution. In this respect, the standards make a clear distinction between the involuntary placement and involuntary treatment procedure. The admission of a person to a psychiatric establishment on an involuntary basis should not preclude seeking informed consent to treatment. Involuntary placement and involuntary treatment require procedures that are surrounded by safeguards to avoid inhuman or degrading treatment. For the involuntary placement and its prolongation, the standards prescribe that the procedure to order such a placement should offer guarantees of independence and impartiality as well as of objective medical expertise. Except emergency cases, the formal decision to place a person in a psychiatric hospital should always be based on the opinion of at least one doctor with psychiatric qualifications, and preferably two, and the actual placement decision should be taken by a different body from the one that recommended it.[31] The patient should have the effective right to be heard in person by the court during placement or appeal procedures, should be entitled to legal assistance, should receive a copy of any court decision and should be informed in writing about the reasons for the decision and the avenues/deadlines for lodging an appeal.[32] The same rights apply to the judicial review procedures that according to the CPT should take place at reasonable intervals.[33] Important safeguard is also that the court when reviewing the placement is informed by a psychiatric expert's

[29] Visit to Turkey (2004) (par.83).

[30] Visit to 'The Former Yugoslav Republic of Macedonia' (2010) (par.93).

[31] Visit to Belgium (2001) (par.144).

[32] Visit to Lithuania (2004) (par.133) and visit to 'The Former Yugoslav Republic of Macedonia' (2006) (par.148).

[33] Visit to Switzerland (2011) (par 117) and 8th General Report (1997) (par.56).

opinion which is independent of the psychiatric institution where the patient is held.[34]

Involuntary placement should not be construed as authorising treatment without his consent. According to the CPT, all medical treatment should be based on the free and informed consent of the patient. Consequently, every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. This means that:

> Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole.[35]

Given the potential for abuse and ill-treatment, especially the use of means of restraint in a psychiatric setting is of particular concern for the CPT. In many of the establishment visits, the CPT is confronted with an excessive and disproportionate recourse to means of restraint and with types of restraint that could well be considered as degrading, such as handcuffs, metal chains and cage beds. In order to prevent the overuse and abuse of means of restraint, the CPT in its 16th General Report of 2006 has formulated a detailed set of standards that should be guided when psychiatric patients are exposed to instruments of physical restraint (such as straps, straitjackets or enclosed beds), chemical restraint (medicating a patient against his/her will for behaviour-controlling reasons) and seclusion (involuntary placement of a patient alone in a locked room).

According to these standards, a general rule should be that a patient should only be restrained as a measure of last resort in exceptional situations in order to prevent imminent injury or to reduce acute agitation and/or violence which may not last longer than the emergency situation requires. For that reason, the restraint of patients should be subject of a clearly defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be nonphysical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.[36] If in emergency situations resort to restraint is unavoidable:

> It is imperative that every single case of resort to means of restraint be authorised by a doctor or, at least, brought without delay to a doctor's attention in order to seek approval for the measure.[37]

This indicates that the CPT has strong reservations to the practice in many establishments visited to use blanket consents because:

> In the CPT's experience, means of restraint tend to be applied more frequently when prior blanket consent is given by the doctor, instead of decisions being taken on a case by case (situation by situation) basis.[38]

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[34] Visit to Moldova (2015) (par. 171).

[35] 3rd General Report (1992) (par.47).

[36] 16th General report (2006) (par. 39, 43–44).

[37] Visit to Portugal (2008) (par. 127).

[38] 16th General Report (2006) (par. 44).

Also other standards highlight the responsibility of the medical staff in protecting the psychiatric patient against inhuman or degrading use of means of restraint. This may be the case if:

> The application of restraints is resorted to as a means of convenience for the staff or as a sanction for perceived misbehaviour or as a means to bring about a change of behaviour.[39]

It will be apparent that even in the phase of executing criminal sanctions, the fundamental rights described here assume proper consultation of forensic psychiatrists and psychologists. Mental disorders must be recognised promptly. It is vital that sufficient care and treatment be provided. If they are not, not only will the legitimacy of the detention be queried, the quality of how the detention is given shape might in fact constitute a violation of Article 3 ECHR. Forensic psychiatry needs to realise that its experts must, can and wish to help prevent any violations of the fundamental rights of mentally disordered prisoners. It is important that psychiatrists working at penal institutions also have the job of organising care and treatment for their patients. The medical services offered to persons deprived of their liberty, irrespective of their legal status or the place where they are accommodated, should always be based on the principle that medical practitioners act as their personal doctors. Especially in respect to persons with serious mental disorders in prisons or forensic psychiatric institutions, who are strongly dependent of the medical specialists, a positive doctor-patient relationship is essential in safeguarding the health and well-being of these patients. Doctors, psychiatrists and other medical professionals have a prominent role to play as well in protecting the patient against ill-treatment. They should always be aware that their decisions or interventions can result in situations falling within the scope of the term ‘inhuman or degrading treatment’. It is therefore also a matter of principle and medical ethics as is stated repeatedly by the CPT that medical personnel should never participate in any part of the decision-making process resulting in any type of disciplinary sanction. Unlike the question of the individual’s ‘fitness to stand trial’, even prison psychiatrists are not required ‘to certify that a prisoner is fit to undergo punishment’.[40]

Conclusion

The European impact on national forensic psychiatry underlines the need for proper treatment and procedural safeguards from a human rights perspective. Its aim is not to avoid law enforcement, but to make it legitimate. This double position calls upon forensic psychiatrists to be aware of their position and influence in the legal process. Essential for their work is not only to diagnose and treat (properly) but also to realize proper attention for the specific vulnerability of mentally disturbed citizens toward judicial authorities and to help them in organising effective accommodating measures for that citizen, in allowance for his or her heightened vulnerability. In this respect, the European impact is an ongoing challenge for national forensic psychiatry and the daily work of forensic psychiatrists.

[39] 16th General report (2006) (par. 43).

[40] CPT Standards (73).

Take-Home Messages

- The first take-home message from this debate is that in fact *every* person as suspect in criminal law is in some way vulnerable, because of the overwhelming power of the authorities and their system. This applies even more for mentally disordered suspects. Despite a mental disorder, a person can be subjected to criminal investigation and can be put to (a fair) trial and/or can be put in prison. But the acknowledgement of vulnerability and additional accommodation of safeguards to compensate the vulnerability require the expertise of the forensic psychiatric. The accommodation of the safeguards depends on the degree of vulnerability, in which decision will be based on the opinion of forensic psychiatrics.
- The second message to take home is that the European impact on national forensic psychiatry can no longer be denied. The CPT standards of safeguards, which should be in order in every Member State, and the influence of the ECrtHR jurisprudence are examples of that influence. The cooperation between the European Union countries in criminal matters based on the principle of mutual trust faces the risk of being discontinued in case of too big differences. National measures concerning forensic psychiatry cannot be sufficient without taking into account the European standards.
- The third take-home message is the importance of the forensic psychiatrist in the legal process of criminal law enforcement. Due to their position, they can have a big influence on the outcome of the process, but more important on the position of the vulnerable suspects. They have not only a role to play during trial concerning procedural rights but also a role during the execution of sanctions.
- The fourth take-home message derived from the CPT standards concerns the safeguard that a decision to treat a person for a psychiatric disorder without his/her free and informed consent should be separate from the decision on involuntary placement in a psychiatric institution. These are two distinct issues, and patients should be requested to express their position on both issues separately. A placement order should never be constructed as authorising involuntary medical treatment.
- The last message relates to the use of disciplinary measures vis-à-vis psychiatric patients. Such measures aim at sanctioning patients' behaviour, which is often likely to be related to a psychiatric disorder and should be approached from a therapeutic rather than a punitive standpoint.

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Part II

Service Provision and Frameworks

Mapping Offender-Patient Pathways

6

Bradley Hillier, Christopher Lambourne, and Pamela Taylor

6.1 Offender Pathways: Beyond Fixed Placements

The movement of offenders with mental disorder between the criminal justice and healthcare systems is a complex and, at times, idiosyncratic process. It varies between countries in thresholds, legal mechanisms and processes, powers of psychiatrists and courts and also settings available at different stages of the criminal process. A key part of the work of forensic psychiatrists is provision of expert advice for the courts and others throughout services and pathways, but, in Europe, it is always also about delivering appropriate mental health services by some mechanism at almost any stage of the criminal justice system, although details vary [1]. The first opportunity usually occurs on arrest, when the police may ask for medical advice. It may even be at this point that, if the alleged offence is not very serious, but the suspect appears very disturbed, she/he may be diverted from the criminal justice system into the healthcare system and any criminal procedures discontinued. In all European countries, some expert input to the criminal court will be expected if mental disorder is suspected in the accused, although not all countries require psychiatric evidence at pre-trial or trial phases of the hearing; in Sweden, for example, the courts proceed straight to a trial of the facts, and all psychiatric evidence is taken in respect of

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disposal after conviction. In most countries, most psychiatric input is, in fact, likely to be at the sentencing phase of the court hearing, in particular on whether a medical disposal would be optimal. While many countries have specialised health services, some, such as Spain, provide specialist secure clinical services only within prisons. Where there are health service options, then transfer between penal and hospital settings may also occur, as necessary, after a custodial sentence has been imposed. In all countries, however, the medical role in placement decisions is advisory. Decisions are always taken by the courts or other official bodies.

Within the European Union, each legal system has evolved within the historical context of that country's culture and governmental and political system, as has the provision of health services. In some countries, and certainly in the UK, individual cases have had significant impact both on legal developments and on healthcare provision. In the UK, as a common law country, such cases may not only predispose to a change in statute but also create a precedent in individual cases and, thus, case law. A detailed discussion of legal systems and their provisions for offenders with mental disorder is given elsewhere in this book [2].

The EU provides for the free movement of citizens between its member countries. Whether it be patients or recognised specialists moving between EU countries, it is important for forensic mental health practitioners to have some general understanding of the likely pathways through the criminal justice and healthcare systems in each other's countries. There are opportunities for mutual training of people recognised as, or becoming, experts in their own countries (see [3, 4]).

In this chapter, as offenders with mental disorder are rarely, if at all, simply "placed", but rather moved between systems and up and down security and treatment levels according to need, our aim is to introduce the reader to the concept of "mapping offender pathways". These provide a visually helpful way to understand the movement, sometimes diversion, of offenders at different legal stages of a criminal process between physical settings and, in most cases, back to the community, as applied in different countries. The examples of offender pathways given in this chapter arise from a series of semi-structured interviews (see Appendix 1) with senior (medical) forensic psychiatric trainees and recognised specialist practitioners in the country mapped who have also attended the Ghent Group annual seminars (see [3]). In order to minimise the complexity of the mapping tasks and comparisons, we have focussed on pathways in respect of one key event for an individual and with reference to forensic psychiatrists specifically—a homicide offence. Potential pathways available to the legal process when mental disorder is present were identified and mapped using recognised mapping techniques, further described below. We sent the resultant maps to the participating specialists for checking and further comment. This builds on previously published preliminary work [5]. It is important to note that, given significant variability between different systems and the range of offences triggering assessments in everyday practice, these maps can only be indicative of common and likely outcomes. It is also the case that few systems are static, so it is likely that new developments will change the picture from time to time; however we hope that this way of thinking about service organisation and service user progress will open more dialogue between experts from across the EU so that we can learn ever more from each other.

6.2 What Is "Mapping"?

Mapping or, more accurately, "process mapping" [6] is an evidence-based management tool that may be used in a variety of commercial and public sector settings, including health service development. Within the UK it is a recognised and established quality improvement tool employed to support insights into demand for services and their costs and quality. It can also be used to frame education in best practice by embedding clinical standards, identifying clinical service redesign priorities and proactively managing clinical risk in developmental models. It is for these reasons that the NHS Institute for Innovation and Improvement [6] recommends process mapping as the corner stone of quality improvement. Further, mapping can be used in the process of organisational change, to facilitate transition from a current situation, or "as is" map to the desired or improved system—the "to be" map, showing where key developmental steps can be taken with minimal disruption to still needed elements of service.

There are standard ways recommended for obtaining information for creating relevant maps. This usually involves the organisation of a workshop with members of different disciplines who are able to provide insights from a variety of viewpoints. The layout of these maps is consistent and simple. Horizontal rows have been used to represent visually an organisation's role in each step of the pathway. This technique, often referred to as providing "swim lanes", can be used in many ways to represent people, roles, care settings or chronology. Points of crossing the swim lanes help to highlight the number of interagency handovers that should or do occur. Events along the process are presented within standardised shapes to indicate when an event is simply one step in the pathway (rectangles), a decision point (diamonds) or an end in itself (oval), including the ultimate destination.

6.3 Mapping Specific Pathways

Attendees at the 2014 Ghent Group residential seminar were provided in advance with a scripted case, drawn from a real homicide case but with any identifying details removed. Some questions were then posed about the various stages of the legal process. The following day each participant was interviewed separately about responses to such an offender in his or her country. The broad areas covered were the legal process, when and how mental health clinicians (in particular psychiatrists) become involved in that and the availability of opportunities for movement between the criminal justice and mental health systems for the (alleged) offender. Countries studied by this method were Austria, England and Wales (E&W), Finland and the Netherlands.

6.3.1 Austria

Austrian mental health and criminal justice legislation was last reformed in 1973. It places mentally disordered offenders fully under the jurisdiction of the criminal

courts and code and provides for a criminal justice-led forensic psychiatric system [7]. When an alleged homicide offender is suspected of having a mental disorder, the legal process is designed to identify and manage any mental health problems at an early stage in the legal process. Such an individual would usually be remanded to a specialist "hospital prison" (a specific stand-alone setting which is an equivalent to a hospital but in fact part of the prison service from an administrative and financial perspective) where assessment and treatment can occur in conjunction with the court process (see Fig. 6.1). Expert evidence is given at trial by a psychiatrist who is explicitly independent of any care and treatment ever offered to the alleged offender. The expert generally, but not always, has completed a recognised course on assessing offenders with mental disorder and giving evidence in court. The system is inquisitorial, and, generally, only one expert is called. The expert is expected to provide evidence on the state of mind of the individual at the time of the alleged offence, and the court must determine whether there is enough evidence for a verdict of not guilty by reason of insanity, or partial criminal culpability. Austria makes a distinction at the point of sentencing as to the form of penal institution most appropriate for an individual, as determined by the decision on culpability/responsibility and illness-related "dangerousness". If an individual is found to have committed the homicide but not be responsible on grounds of mental disorder *and* continue to present with illness-related dangerousness, he or she would generally be sent to a specialist psychiatric "hospital prison" (*Justizanstalt Göllersdorf*, "Göllersdorf prison").

If the individual is found guilty and responsible for the homicide, but to have "mental abnormality of higher degree" present at the time of the offence, then he or she may be sent indefinitely to an ordinary prison for the sentence but *must have* psychiatric treatment in either a specialised prison (*Justizanstalt Wien-Mittersteig*) specifically for these cases or in places in specialist wings of the three largest prisons, depending on availability of places. In either case, the criminal justice system will determine release, albeit with advice from clinical experts. Special healthcare disposals within prison are only considered when the prison sentence would be greater than 1 year under normal circumstances.

In the event of a successful not guilty by reason of insanity defence, if the offending individual is deemed to pose no continuing risk to others, then she/he may be released unconditionally.

6.3.2 Finland

The assessment and treatment of offenders with mental illness in Finland is mainly regulated by two laws: the Finnish Mental Health Act 1990/1116 and the Criminal Law 1889 [8]. The Finnish criminal law recognises three categories of criminal responsibility: "full responsibility", "diminished responsibility" and "no criminal responsibility" [9] (Fig. 6.2).

Within the Finnish legal system, mentally disordered (alleged) offenders may be detained in a hospital from the point of arrest when there are clinical or

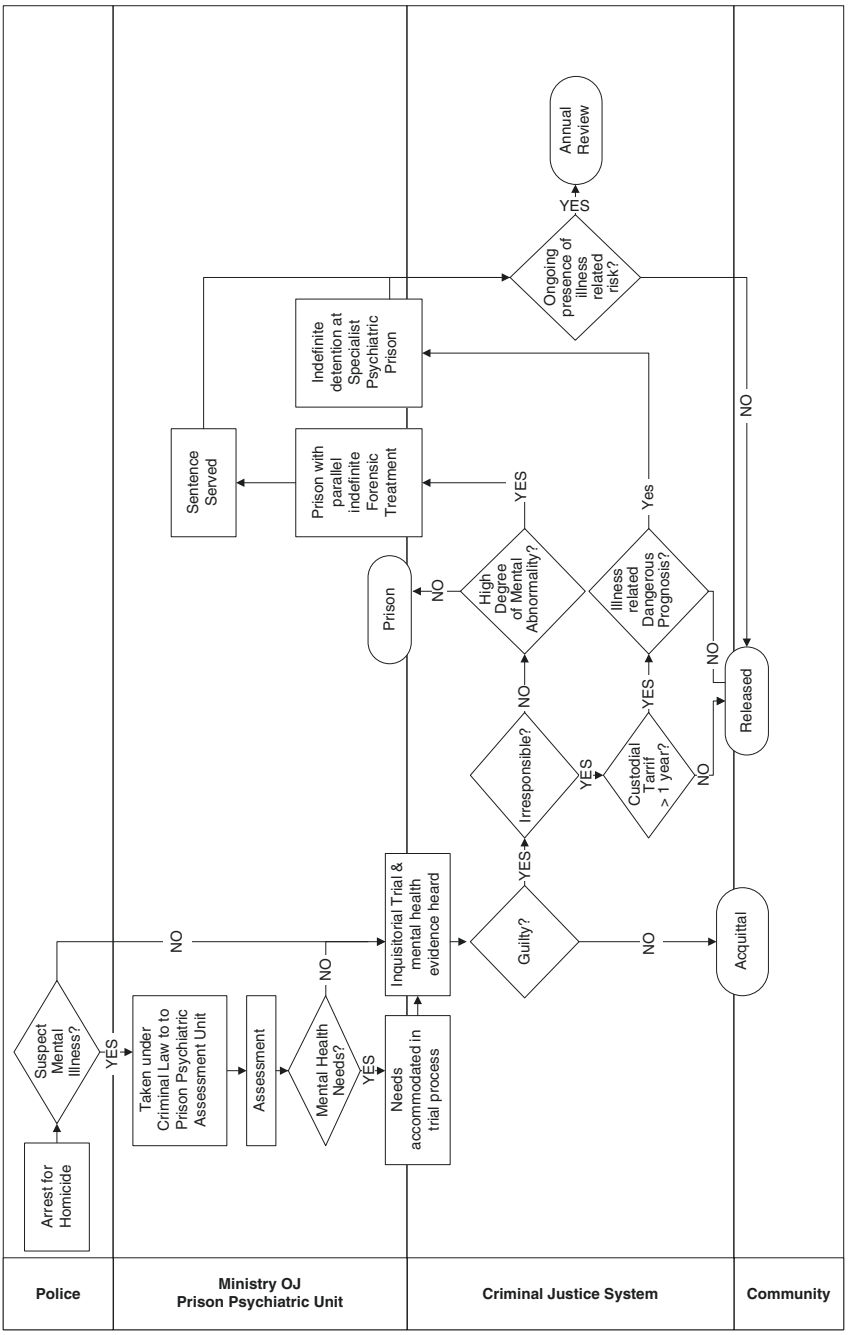

Fig. 6.1 Austrian forensic care pathways

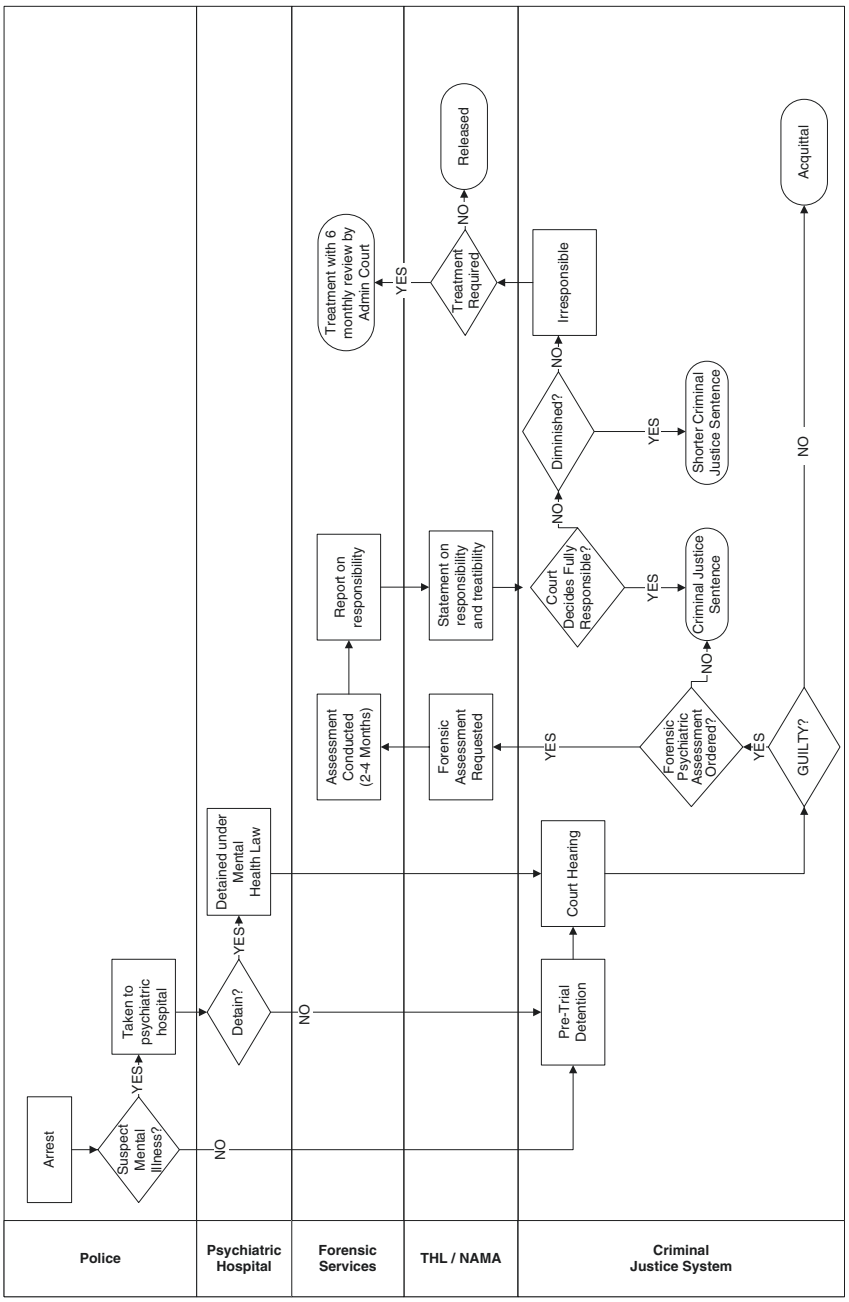

Fig. 6.2 The Finnish forensic care pathways (December 2015)

security-related reasons for doing so. This may be a general psychiatric hospital if safe, or a specialist, secure forensic psychiatric hospital. The legal system is inquisitorial, so issues relating to the ability of the alleged offender to submit a plea and/or conduct a defence are not a primary issue, although the investigating judge and prosecutor must take them into account in the criminal justice process.

The judge has the discretion to order a psychiatric assessment either during the pre-trial investigation period, or after prosecution. If the offence is sufficiently serious, as in homicide, but defined as attracting a sentence of greater than 1 year, the examination may be ordered against the examinee's will. This is requested from the *Terveyden ja hyvinvoinnin laitos* (THL—National Institute for Health and Welfare), which is a governmental health organisation within which operates a forensic mental health section. THL will arrange an admission to an appropriate psychiatric setting, which in the case of homicide is likely to be one of the state psychiatric hospitals, such as Niuvanniemi State Hospital. It could, however, include other university forensic psychiatric clinics or hospitals or the prison psychiatric hospital Vankimielisairaala. The assessment takes 2 months and includes extensive information from various sources, such as standardised psychological tests, physical examinations, laboratory tests, behavioural observation and repeated interviews by a forensic psychiatrist and the multidisciplinary team. The final forensic psychiatric report includes a psychiatric diagnosis according to both ICD-10 [10] and DSM-5 [11] criteria, an opinion on the level of criminal responsibility and an assessment as to whether the offender fulfils criteria for involuntary psychiatric care. THL prepares an independent statement for the court. In most cases recommendations are found to be in agreement with the forensic psychiatric report [9].

In Finland, for a finding of diminished responsibility or lack of responsibility, it is necessary that the actions which constituted the offence were due to "insanity, deep mental retardation or a serious disorder of mental health or cognition, rendering the sufferer unable to understand the nature of the act or its illegality, or so that their ability to control their actions was crucially limited". Only in cases where responsibility is considered to be completely lacking may the individual be sent to a specialist forensic hospital setting for treatment if this is regarded as necessary. If it is agreed that these criteria are met, treatment may be ordered by THL against the individual's will if she/he is mentally ill, his/her mental illness is at risk of worsening or she/he may endanger the health or safety of him/herself or others *and* no other psychiatric services would suffice; these are, in fact, exactly the same criteria as for all involuntary psychiatric treatment [8]. If THL does order treatment, this must be, according the Mental Health Act, delivered in a unit that "has the facilities and special expertise required for the treatment of the patient", and there is no further role for the sentencing court. The *determination* of need for treatment in these circumstances being by the health service body rather than the criminal court is unusual in European countries [12].

There are two state hospitals in Finland dedicated primarily to the care of offenders with mental illness (although they also admit other patients who cannot be treated anywhere else): Vanha Vaasa Hospital, Vaasa, and Niuvanniemi Hospital, Kuopio. The former has around 150 beds, the latter around 300; there is also a third 116-bedded

unit at Kellokoski hospital, which operates within the Helsinki University Hospital [9]. The length of stay for patients within these services is, on average, 4–9 years. The detention is reviewed by the administrative courts on a 6-monthly basis [13]. After discharge, patients are required to be in supervision for 6 months, during which they are regularly seen by a psychiatrist; this period may be extended, as deemed necessary. Concerns about treatment compliance or rising risk may result in recall to hospital. Absolute discharge is decided by THL. Once the "forensic status" of the patient disappears, she/he is once again treated as everybody else in Finland and possibly liable to civil detention if becoming seriously mentally ill [13].

6.3.3 Netherlands

In the Netherlands, the role of forensic psychiatric services is defined within the Criminal Code of the Netherlands [14]. The Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) plays a crucial advisory role throughout the medico-legal interaction over alleged offenders with mental disorder (Fig. 6.3).

In our homicide case, courts in the Netherlands may raise the issue of mental disorder before trial, requesting a specialist forensic psychiatric assessment, or *Pro Justitia* observation. This may occur in a variety of settings; with a serious alleged offence, it is likely to be in the high-security Pieter Baan Centre in Utrecht. This national centre, run jointly by the NIFP and Ministry of Security and Justice, is only for pre-trial assessments of up to 7 weeks, advising the judiciary on any need for examination of the suspect in relation to legal accountability, the chance of reoffending and optimal treatment and security. In the event of a finding of guilt, an expert witness from the Pieter Baan Centre may be called to attend court and give evidence. The Netherlands' courts operate a "sliding scale" model to judge criminal responsibility: total absence of responsibility, severely diminished responsibility, diminished responsibility, slightly diminished responsibility and complete responsibility. A special provision which the court may consider is *Terbeschikkingstelling* (TBS; "Treatment on behalf of the State"); degree of responsibility accepted informs availability of a TBS disposal.

The goals of TBS are explicitly to protect society, to treat the offender where she/he cannot pose a danger to the public while in treatment and to facilitate reintegration within society. The latter is achieved, as in most countries, through a "testing out" process of increasing levels of liberties and leaves [15]. Imposition of a TBS order requires that the following criteria are met: the offender was suffering from a mental disorder at the time of the offence; this mental disorder significantly or wholly diminished responsibility for the actions; the offence would otherwise have resulted in a prison sentence of at least 4 years; and the individual must pose a continuing risk to society. In practice, it is also the case that it is considered that non-TBS Penitentiary Psychiatric Centres (PPCs), provided within prisons for those servicing custodial sentences, are not considered appropriate. Only the lack of definition of "mental disorder" for these purposes leaves imposition of the order open to interpretation. An alternative may be for the court to impose a combined sentence

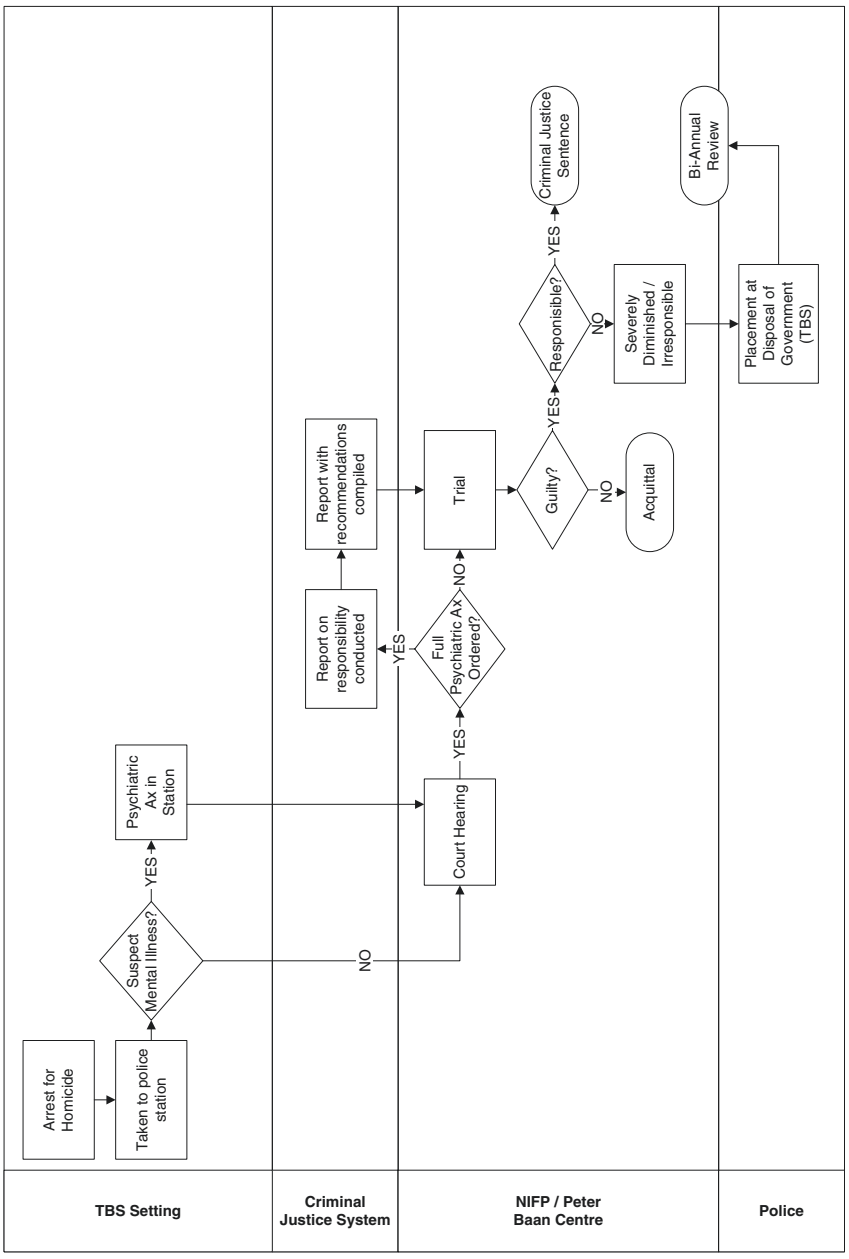

Fig. 6.3 The Netherlands forensic care pathways

for those who are not judged to be completely lacking responsibility, consisting of a prison sentence followed by a TBS measure. The prison sentence is served first to reflect the need to be held accountable for the crime. In practice this is usually a minimum term of 2 years, and then transfer to the TBS setting occurs. In all cases, whether arising directly after the court hearing or following the imprisonment component, the TBS measure is imposed for 2 years initially and must then be reviewed every 2 years by the court. A TBS measure may be extended by the court every 2 years, after considering advice from the clinical team, if it is deemed necessary in order to protect society and proportional, given the nature of the index offence(s). When repeatedly renewed, an independent expert opinion is required every 6 years to give an assessment of the TBS patient's progress and prognosis [14]. It is noteworthy that any concept of "treatability" is not of relevance to the court, but simply the combination of dangerousness and psychiatric or psychological disorder [16].

The "mandatory treatment" component of the TBS is delivered across several Ministry of Security and Justice settings, some of which have a pathway of graded security levels within them and not. They include Forensic Psychiatric Centres (FPCs) at the more secure end of the spectrum, through Forensic Psychiatric Clinics (FPKs) and General Psychiatric settings with a Forensic Department (FPA) at the physically lowest security end. Within the TBS system, there are some particular principles which guide the therapeutic approach. "Tolerated procedures" for maintaining security are clearly defined, such as searches by staff and restraint as proportionate to the risks posed by individuals within the setting [17]. "Meaningful activities" and work are provided, although it is not mandatory for detainees to participate in these. With respect to enforced medication, the guiding principle is against it for people with mental illness who have the capacity to give consent. For very severely disturbed patients without capacity to give consent and for whom the psychiatrist in charge considers there is no other treatment, the treating psychiatrist may apply to a multidisciplinary panel within the organisation to consider enforcing medication in specified dosage; if permission is granted, this is reviewed by the same panel every 2 weeks. A 2011 visit by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) found that approximately 10% of TBS patients had been subject to enforced medication in this way, usually with depot antipsychotic medication [18].

In 1999 the TBS system began to develop the concept of "long-stay" wards for detainees who were not progressing to discharge (see Chap. 10, [19]). Discharge, unless mandated instead of order renewal in court, occurs under the review of the criminal justice system. Risk reduction and rehabilitation must be demonstrated, generally through evidence of engagement with therapy (including compliance with medication, psychological and occupation therapies) and progress through security levels. The Ministry of Justice appoints two independent experts (a psychiatrist and a psychologist) to give evidence, but the final decision is with the court [14]. An option of placement in "approved premises" is available, providing it can be demonstrated that the individual is showing reasonable recovery from his or her mental disorder and is complying with his or her treatment programme [16]. This is particularly useful as the individual at this stage of progress may live and/or work partly in

the unit and partly in the approved community premises. A specialist community mental health team will then make frequent assessment and support visits to the detainee when in the extra-mural setting, with the option of returning the individual fully to the secure TBS unit if there are signs of recurring symptoms of mental disorder and/or increasing risk to society.

The Dutch TBS system is currently undergoing reform in terms of policy direction, in part to reduce the number of beds. Although it is unclear how this will be achieved, the Custodial Institutions Agency has been charged with closing three FPCs, thereby reducing capacity for TBS patients from 1, 867 in 2013 to 1339 in 2018 ([20]; see also [14]).

6.3.4 England and Wales

The legal system of England and Wales (as well as Northern Ireland and Scotland which have related but distinct laws) arises from a common law tradition, relying both on statute and case precedent. It allows for a good deal of flexibility in managing alleged offenders with suspected mental disorder. At every stage of the process, questions are asked about relevant aspects of mental state, so, for example, there is as much concern about whether a person is fit to be interviewed by the police and under what circumstances as about the safety of the individual in custody. The legal framework allows for transfer into the healthcare system at any stage of the process; after a criminal justice disposal, the individual may be transferred into the health service if she/he needs assessment or treatment for a mental disorder and, if appropriate, transferred back into the criminal justice on substantial improvement or recovery. Compulsory treatment is not possible in prisons except in a bona fide emergency (Figs. 6.4 and 6.5).

In court, an expert psychiatric input may be called at any stage of the hearing—pre-trial on fitness to plead, during the trial with evidence pertinent to decisions on level of responsibility for the offence, if any, and afterwards, on sentencing or other disposal. Expertise in these circumstances is defined by knowledge or experience, according to case law; the expert must be ready to set out his or her qualifications and experience; and statutory law defines the number of experts from whom and how the court must hear evidence within the Mental Health Act [21]. These are in the s37 and s37/41 original legislation in the MHA (for more information, see http://www.legislation.gov.uk/ukpga/1983/20/section/37 and http://www.legislation.gov.uk/ukpga/1983/20/section/41).

As a serious charge, murder or manslaughter will always be referred to a higher or Crown Court; if unfitness is found by the presiding judge, then a jury be empanelled to hear the trial, which will be of the facts alone. Such cases are rare. It is also rare for mens rea to be tested in court, but homicide is the exception, because in the UK there is a mandatory consequence of life imprisonment if found guilty of murder. This is the only offence for which a defence of *diminished responsibility* may be advanced, an insanity defence, which may be applied to any crime except those of strict liability, such as motoring offences. If successful, the insanity defence

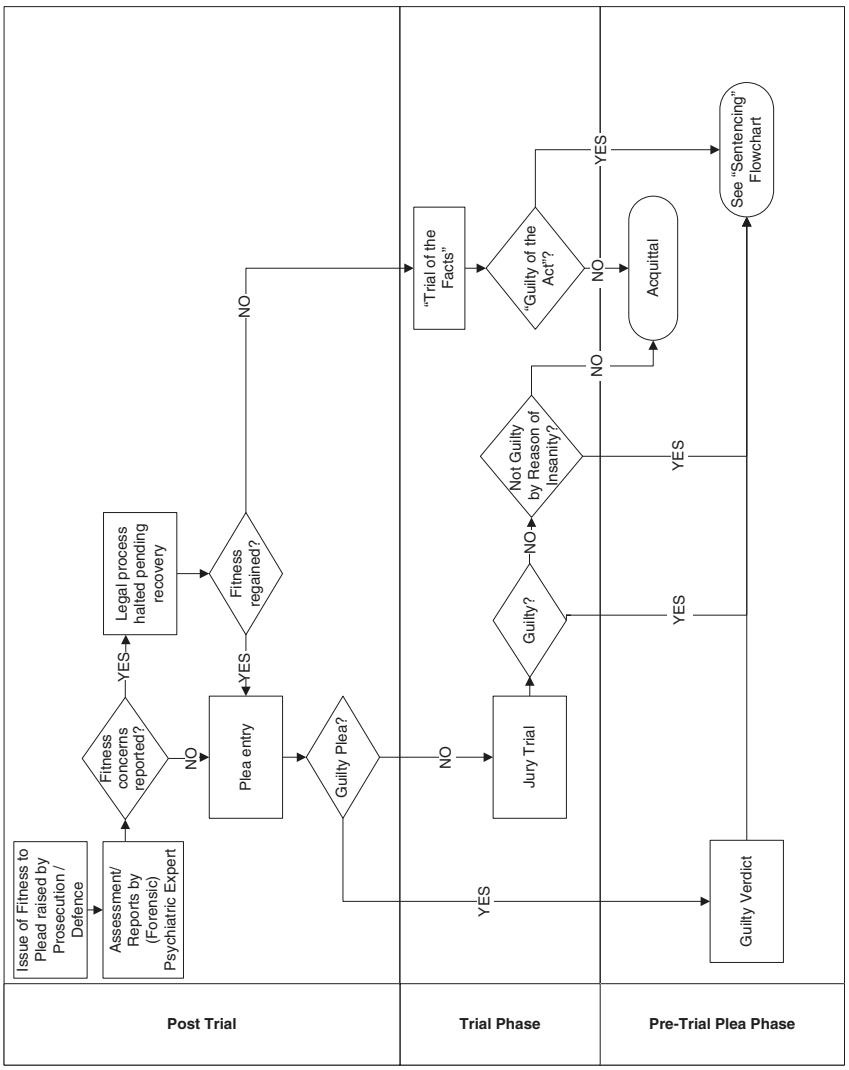

Fig. 6.4 Mental health factors during legal proceedings in England and Wales—pre-sentence

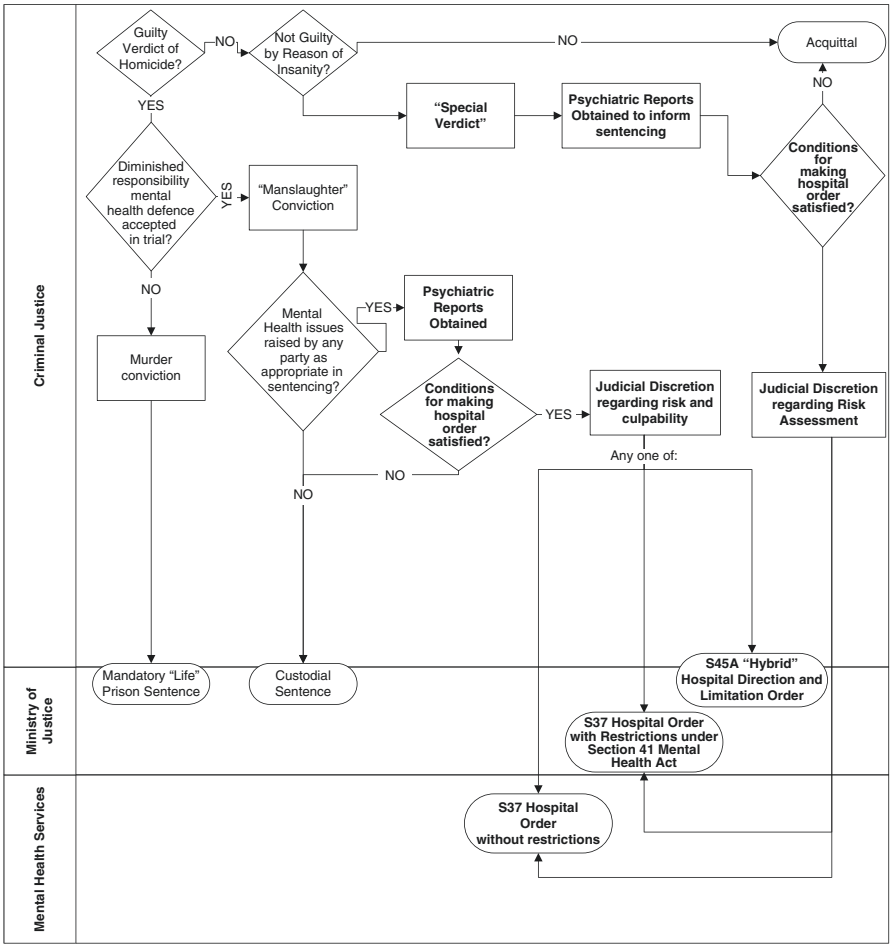

Fig. 6.5 Forensic mental health sentencing disposals within England and Wales

allows a verdict of *not guilty by reason of insanity*, but both statute and case law have led to a pragmatic approach such that if the individual is regarded as a risk to others or, indeed, to self as a result of the mental disorder, then he or she may be ordered to a hospital within the health service system, privately or publicly provided but always funded by the National Health Service (NHS). A successful defence of diminished responsibility leaves the accused with a conviction, but the lesser conviction of manslaughter rather than murder. This allows the judge complete discretion in sentencing. If the mental disorder is still prominent and still contributes to risk, then sentence may be set aside in favour of a hospital disposal, usually with restrictions on discharge so that the clinicians may not discharge the patient without the approval of the Ministry of Justice or a specially convened First-tier Tribunal (FTT) specialising in mental health (chaired by a judge). Otherwise the judgement

of diminished responsibility may be taken as mitigation and a less severe sentence imposed. The judge may still give a life sentence but, for example, impose a short tariff (the period of time which the offender *must* stay in prison), but may give a fixed term or even a community penalty.

Once sentence has been passed or a hospital order made, the law requires periodic review for all except the shortest sentences. In the prison system, the independent parole board is responsible for holding hearings. The first would be held just before the tariff is reached. If release is not ordered, then further hearings will occur at intervals until this happens. There is a requirement for the parole board to consider annually the need for a hearing. In practice the actual hearings tend to occur every 1–2 years. Where mental disorder had been recognised in the original court hearing—or subsequently—an expert psychiatric report would be expected. In hospital, the case for continued detention or not is heard by the First-tier Tribunal. If not released, patients may apply annually and *must* have a hearing at least once every 3 years whether they request it or not [21]. The powers of both the parole board and the tribunal are restricted to release/not release, but each may make recommendations for other changes, such as testing out in lower security conditions. People under life sentence remain liable to recall to prison for the rest of their lives in the event of breech of parole conditions or reoffending; people under restricted hospital orders, but not unrestricted hospital orders, remain liable to recall to hospital on the same sort of grounds, unless at some point they are granted an absolute discharge from the order by the tribunal. In prison or the hospital, it would be expected/advised that the detainee would engage a lawyer to support them through these processes, generally at public expense.

In the case of a serious offence like a homicide, processes of another kind will also follow when patients start to leave from the hospital and after discharge. They are likely to be subject to Multi-Agency Public Protection Arrangements (MAPPA; [22]). For most, this simply means referral to the local inter-agency MAPP Panel, but where cases give rise to particular concerns, the panel may convene meetings and/or require special community arrangements. MAPP Panels are almost exclusively police-led, which concerns clinicians, but once a case is designated as a MAPPA case, then proportionate information sharing occurs between relevant mental health providers, and the local MAPP Panel is a requirement.

Provision of specialised Community Forensic Teams (CFT) or Forensic Outreach Services (FOS) has developed as the philosophies of general adult and forensic psychiatric services have diverged. The former now tend to work towards episodes of care and crisis intervention, whereas for offender patients, maintenance of health is vital. Against hope, therefore, forensic and general adult psychiatric services tend to work in parallel to each other, although there is no model which absolutely prevails in England and Wales, and wide regional variability. Funding sources and duration remain unclear, in part as a result of various reorganisations of funding streams for healthcare (at least in England). The most recent development in England, the *Mental Health Five Year Forward View* [23], indicates an appetite for further development of community mental health services for mentally disordered offenders, taking account of local needs.

6.4 Common Themes and Differences Identified from Mapping Offender-Patient Pathways

6.4.1 Timing of Allowance for Mental Health Issues During the Criminal Justice Process

It may seem like an obvious statement but, first, it is worth noting that for the four countries considered, the maps confirm that it is possible for the courts to take mental health into account, if not at all stages of the criminal justice process, then at least during sentencing and following imprisonment. As homicide is a serious offence, no country allows for complete diversion out of the criminal justice system before charges are brought, and any transfer to healthcare within this period would be to in-patient care under specific legal provisions pending charges because the individual requires urgent treatment.

The first real medico-legal question which could arise is that of fitness to plead and/or stand trial, and here the mapping shows differences between countries. Crucially, England and Wales *requires a plea to be entered to proceed owing to the adversarial nature of the legal process. If there are concerns that the defendant's mental state at the time of court hearings is impaired and it is raised by any party*, psychiatrists are called upon to provide evidence to the court regarding this. Austria does not regard this as critical in the same way reflecting differences within the inquisitorial/civil law tradition and the role of the defendant. There are intermediate positions in Finland and the Netherlands whereby there is legal discretion in the Netherlands to take the ability to stand trial into account, as well as in Finland where the investigating judge or prosecutor must take this into account. Psychiatric evidence is not necessarily required but can be taken into account to guide the investigation. The principles that guide this are enshrined within the "right to a fair trial" under Article 6 of the European Convention on Human Rights (ECHR) [24].

Notwithstanding these differences, common ground is that in all countries, most of the psychiatric effort goes into evidence to support decisions on sentencing/placement from court.

6.4.2 Availability of Specialist Secure Hospitals

Some differences arise as to the nature of the services available. The Netherlands has hybrid health and justice services, some services being provided in the TBS system in stand-alone units funded and managed by the Health and Justice Departments of government, and some within prison psychiatric centres. Similarly, there are no secure forensic hospital units provided by the health service alone in Austria. Here, however, all specialist healthcare provision for offender patients is in the prison system. In both the Netherlands and Austria, clinicians are employed by the agency running the unit. In Finland and England and Wales, clinicians may provide clinical services in prisons but are always employees of the health service.

Where hospital treatment is required, this takes place in hospitals which are run by the healthcare system and subject to healthcare system audits.

The broader picture across the EU of provision of forensic services is similarly variable in provision and standards, although we do not have the scope to detail this further here. Forensic mental healthcare is regarded as a low-volume high-cost subspecialty that may not be prioritised in countries with lower resources for healthcare or imprisonment.

6.4.3 Enforced Treatment?

As Austria's forensic mental healthcare is entirely within criminal justice-run institutions, enforced treatment may be given in a prison setting, albeit an adapted or specialist prison units. In the other countries reviewed here, treatment cannot be enforced in a custodial setting, although in the Netherlands' TBS units, this can be varied under the very specific circumstances described above. Indeed, in England and Wales and in Finland, *need* for treatment is the catalyst for switching from a criminal justice to a healthcare pathway. Nevertheless, it can be seen from the maps that several jurisdictions now provide for combining treatment and punishment—with consecutive mental health and imprisonment aspects. Even the UK has succumbed to this with the "hybrid order" available within mental health legislation. To the best of our knowledge, no one has evidenced the nature and quality of outcomes after a hybrid order. Our hypothesis is that they would increase the likelihood of serious reoffending. Either the therapeutic attachments of a satisfactorily treated individual are severed and she/he is allowed to drift and probably deteriorate under punishment, confused about the meaning of any of it, or a difficult-to-treat individual is summarily returned to prison in a further episode of rejection.

In many cases, the divisions between treatment and punishment are far less delineated. Many people who have a mental disorder and have killed another person, do not have a disorder of a nature or degree that would have resulted in a hospital admission had they been in the community. While this does not mean that they do not require treatment, many can be treated, effectively, as outpatients within a prison; in England and Wales, they would be seen by health service personnel coming into prisons. More serious mental disorder may, however, become apparent during imprisonment, and the person may then need transfer to a hospital. The countries we mapped differ in whether that is within the healthcare system, the prison system or a hybrid system.

6.4.4 Nature of Aftercare and Other Community Provisions

Although our primary task was not to review care and treatment beyond the institution, the mapping discussion did identify some similarities and differences in aftercare and follow-up. Austria is only now in the process of developing community

forensic mental health services, which may be accessed from the prison in the form of a "conditional release", but that there is no mandatory requirement for the individual to engage with these once their detention has come to an end. Transitionary arrangements in the Netherlands, which may for a while hold the individual simultaneously in institutional and community services, are described above. The Finnish system does have a comparable follow-up period, reviewed in 6-monthly blocks, but which may extend indefinitely, although many/most individual would expect eventually to be discharged by the THL and be regarded as "without any forensic status", and fully reintegrated into society. One of the more distinctive aspects of the situation in England and Wales is the MAPPA model described above (see also [25]). The principle of movement along a continuum from high dependency to healthy independence, occasionally disrupted by relapse or other events but actively facilitated by "paving the way" and "testing out", is well accepted [26].

6.4.5 The Role of the Forensic Psychiatrist

The forensic psychiatrist's various roles differ somewhat between EU countries. For an offence as serious as homicide in its various forms, it would generally be the case that the court would require someone in court who has whatever level of forensic psychiatric training is typical for the country, although only in Finland is it required that such psychiatrists are members of the specialist board. In some, but not all countries, the main concern is to separate the expert and treating roles [27]. In most countries—which operate an inquisitorial system of justice—the expert report is invariably commissioned by the court, and so invariably available to the court. In the UK, with its adversarial system, the court may indeed commission one or more expert reports, but so also may the prosecution and the defence; the expert report for the defence need not necessarily be produced in court providing the defence does not rely on any information or opinion uniquely provided in it. We have already noted some differences in stage of the criminal hearing at which expert evidence is taken.

Forensic psychiatrists may then also have considerable roles in the pathways out of services, in the legal process of release of constraints as well as in more conventional rehabilitative processes. In all the countries reviewed, psychiatric evidence is usually required to inform the decision-making process of whichever organisation or justice framework is responsible for ordering release from detention, but a common theme that it is always the reviewing body taking the decision.

6.5 Conclusion and Future Directions

This chapter confirms that the pathways for offenders with mental disorder take account of mental health needs and the relevance of mental disorder to fair process, judgements, disposal and aftercare—in all the countries studied. There are, however, some quite substantial differences of detail. A great strength of the mapping

process we have described is that it has helped dialogue about our services' mutual understanding of how they work. Other countries too may now find they could be useful to help inform patients, relatives and victims about what they may expect of the months and years which follow first involvement with the criminal justice system.

Take-Home Messages

- Process mapping provides a quick visual reference tool for understanding offender-patient pathways through the legal and clinical systems.
- It may have applications for information leaflets for patients and their relatives and for fellow professionals.
- In all jurisdictions, a person alleged to have committed a homicide who has suspected mental disorder can expect that arrangements will be made to meet mental health needs at any stage of the criminal justice pathway.
- In all jurisdictions, a person may expect that expert psychiatric reports will affect how she/he is dealt with, whether convicted of that offence or, in some countries, found not guilty by reason of insanity.
- The pathway mapping shows the extent to which we are similar or may differ in where services are provided; research comparison of outcomes given these inherent differences would be useful.

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6.6 Appendix: Briefing Note: Preparatory Questions for Care Pathway Interviews

6.6.1 Introduction

This briefing note will prepare you for the care pathway interviews we will be conducting at the conference. We have listed key questions below which are broken down into stages. This should support a detailed discussion during interview and encourage some reflection in advance. Our intention is to clearly and visually describe the care pathway for mentally disordered offenders in a range of countries. This builds on work already completed for both Denmark and the UK (Danish Pathway attached for reference). You will be involved in the review and approval of the relevant pathway(s) once completed.

We would like to thank you for your time and contribution to this work.

6.6.2 The Case Study

We would like to use the following scenario to explore the questions below.
The police are called by a neighbour to a residential property where there has been a serious disturbance. The police attend the scene and find a man who has stabbed his wife multiple times. The wife is dead and the man is in a highly agitated state.

6.6.3 Care Pathway Interview Questions

6.6.3.1 Arrest

Stage	Question	Things to think about
Arrest	What happens at the scene of the crime if? i. the police do not suspect any mental health issues? ii. the police do suspect mental health issues?	Consider who is contacted at this point by who. Where the suspect is taken to (e.g. police station/ hospital/other)
Arrest	What assessment will be done by who at this stage?	Consider capacity, fitness to be interviewed, etc.
Arrest	Assuming there is a mental health concern following assessment, what would happen next?	Where is the person held? Who is responsible for him? What legal framework is detention under at this time and who decides this? Is this the Court, Police, Judge, Psychiatrist/Doctor, Minister?

6.6.3.2 First Court Hearing

Stage	Question	Things to think about
First court hearing	At the first court appearance, which court in your legal system would this be?	Are there specialist mental health courts available? Who would bring this action? i.e. police, state, private, other?
First court hearing	Does the accused have to make a plea at this stage?	What are the available pleas?
First court hearing	Would a psychiatrist be present?	How are psychiatrists appointed? What will they be asked to advise the court on? What are the limits of their authority at this stage?
First court hearing	Who raises concerns on mental health in the court setting?	Is this a lawyer, judge, magistrate?
First court hearing	Assuming it is deemed that the person had an active psychotic illness, what would happen next?	Where is the person held? Who is responsible for him? What legal framework is detention under at this time and who decides this? This may be Court, Police, Judge, Psychiatrist/Doctor, Minister, etc. What is needed to make this order and who carries it out? Are there logistical/practical considerations here, e.g. bed availability?

6.7.3.1 Care/Detention Provided in Interim Period

Stage	Question	Things to think about
Care/detention	What (mental) healthcare services are available to the accused during detention?	What level of psychiatric input is available during this period and in what setting? How long might this period be? Is there any interaction with the court in this period?

6.7.3.2 Trial

Stage	Question	Things to think about
Trial	Are there circumstances where the defendant would not reach the trial stage?	What is the threshold for this? At what stage could this occur and who would authorise this via which legal framework?
Trial	What kind of trial would take place in what type of court?	Who would represent the suspect, what type of court would this take place in? What input would psychiatric services have in this process? Are there special psychiatric defences and are they absolute?
Trial	Assuming there is no dispute on the facts, and the offence is psychotically driven, what would happen to the defendant?	(Where is the person held? Who is responsible for him? What legal framework is detention under at this time and who decides this? This may be Court, Police, Judge, Psychiatrist/Doctor, Minister, etc. What is needed to make this order and who carries it out? Are there logistical/practical considerations here, e.g. bed availability, etc.? Does the judge have the ability to override psychiatric opinion?

6.7.3.3 Post-trial Assessment

Stage	Question	Things to think about
Post-trial assessment	What type(s) of assessment(s) would be done following conviction to review the mental state of the defendant?	Is this to inform sentencing or simply a legal requirement to assess periodically? Who will be the recipient of the assessments? Is the defendant able to challenge these assessments?

6.7.3.4 Transfer or Discharge

Stage	Question	Things to think about
Transfer or discharge	What are the circumstances in which the defendant can be transferred or discharged from one setting to another (e.g. prison to hospital)?	Can they be discharged to the community from hospital, or transferred to prison? Who would make this decision? How often might this be reviewed? Can defendants be transferred from prison into the hospital/psychiatric system following a mental health concern?

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Organization and Funding of Forensic Psychiatric Facilities Across Europe

7

Ellen van Lier and Vicenç Tort-Herrando

7.1 Introduction

The scope of this chapter in not an in-deep revision regarding all forensic psychiatric services provided by all the European countries. The information about the service provision in several countries is scarce and not up-to-date. A further problem is that the definition of what we mean by forensic services depends on national laws and health systems. For example, sometimes prison psychiatry is included and other times not. The main focus will be to broadly describe the main services provided across European countries and to describe the funding of these services and the consequences of different funding types. Finally we will also look into ethical issues and professional views, in scope varying from psychiatric ethics to social ethics.

7.2 Description of the Forensic Health-Care Systems by Public Health and by Justice

European countries use specialist forensic facilities, general mental health-care services and the prison system to place and treat mentally ill or disordered persons who have committed minor or serious offences. The degree of involvement of each of these sectors and their individual patterns of usage differ widely throughout

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Europe [1]. In addition, within each of these sectors, different states provide a variety of service types which differ considerably with regard to organization as well as to quantity or intensity of care [1].

The placement and treatment of mentally disordered offenders are a controversial issue within the criminal justice systems of Western societies. The handling of mentally ill offenders by a criminal justice system is an indicator of the ability of a society to balance public safety interests with the achievements of modern psychiatry and of its ability to incorporate basic human rights principles into penal and mental health practice.

The organization and delivery of psychiatric forensic services are influenced by a balance between the public safety and the individual rights and treatment needs. Thus the provision of services is determined by national laws and health-care systems in the different European countries. This situation makes it difficult to give a unique view of Europe's forensic psychiatry service provision, although all the European countries have a national legal framework to deal with mentally ill offenders (pretrial or sentenced) including inmates that have become mentally ill in prison settings.

Forensic psychiatry, at first glance, seems to differ from one country to another due to different historical developments, different legal systems and different mental health systems [2]. In spite of that, forensic psychiatry has several goals shared across countries, principally:

- Assurance of treatment for severely mentally ill people who become delinquent
- Giving evidence to courts in cases when the offender's mental responsibility is in question
- Working effectively at the interface of the law and psychiatry, and, in so doing, working well with other clinical and nonclinical professionals in the field
- Preventing relapse of offenders with mental disorder

As a specialized sector of mental health care, forensic psychiatry has inevitably been affected to some degree by the changes in this field over the last decades [3–5]. However, varying degrees of involvement in the reform process have resulted in the emergence of varied models of forensic care across Europe. Some countries have integrated their forensic services quite tightly into the general mental health-care system, whereas other countries have developed separate arrangements for the care of mentally ill offenders, which are set apart from general psychiatry.

7.2.1 Facilities and Services for Mentally Ill or Disordered Offenders

Overviews or typologies of forensic psychiatric services must take account of differences in legal concepts between states, as well as of the different stages in the legal process through which a person passes, when suspected of, or found to have

committed, a crime whilst mentally disordered. All these factors determine the type of detention ordered and the type of service concerned. The type of detention is influenced principally by:

- The stage in the legal process (pre- or posttrial)
- The legal status of the person concerned—whether a suspect, defendant, convicted person, detained person or a patient
- The criminal responsibility of a mentally ill or disordered offender

7.2.2 Specialist Forensic Facilities

Specialist forensic facilities are the most common type of service in which criminally non-responsible mentally ill offenders are placed and treated. As an overall category, this includes specialist forensic hospitals, specialist forensic wards in psychiatric hospitals or even—as a rare option—specialist forensic departments or wards within general hospitals. Although such placements are used most frequently posttrial, they may also be used for mentally ill or disordered persons who have yet to come to trial.

Some of the less populous countries (e.g. Luxembourg and Ireland) tend to have one central forensic hospital that serves the whole country and which might be supplemented by minor forensic care capacities in general psychiatric hospitals, whereas more populous countries (e.g. Germany, England and Wales) have a diversity of forensic provision [6].

Mentally ill offenders who have committed serious offences and who are being held as criminally non-responsible constitute the core clientele of forensic facilities, although there are some exceptions to this rule, most often for reasons of bed availability or security.

A substantial proportion of European countries (e.g. Finland, France, Ireland, England and Wales, Sweden) admit aggressive, violent or "high-risk" non-offending mentally ill individuals to forensic facilities. This is done most often under civil detention orders, but this is not necessarily so in all cases. Amongst these countries Finland is not requiring an offending history as a major criterion for admission to forensic care [6].

7.2.3 General Psychiatric Facilities

During the pretrial phase, it is common in many European countries for offenders suspected of being mentally disordered to be admitted to general psychiatry hospitals on a short-term basis (e.g. for assessment purposes). Posttrial, admissions to the non-forensic wards of general psychiatric hospitals are rare in most states, especially as far as criminally non-responsible patients are concerned. Some countries explicitly exclude these patients from posttrial placement in general mental healthcare facilities with the most severe offences.

In countries that do not apply the concept of criminal responsibility, like England and Wales, Ireland and Sweden, priority is given to the need for treatment as a placement criterion [6, 7]. In these countries, security considerations or the availability of treatment places may influence a decision for placement in general psychiatry.

Due to lack of data, it is difficult to draw any firm conclusions about the overall quality of forensic care in general psychiatry wards. Posttrial placement of forensic patients on general psychiatric wards might be evidence of positive features—the existence of a wide range of psychiatric provision or of an integrated treatment approach (where sufficient services are available, both in general mental health care and in the forensic sector). But it could also mask a shortage of places in the specialized forensic care system and a shift of burden to general psychiatry, which may often be poorly equipped to offer appropriate treatment or security.

7.2.4 Outpatient Forensic Care

Although outpatient care is an integral part of general mental health care nowadays, specialist outpatient care for forensic psychiatric patients is underdeveloped. Follow-up may be usual in many European countries or indeed mandatory in the case of probation orders, conditional discharge or as a general aftercare measure, but specialist services are usually lacking. Some countries as Austria, Belgium, Germany and the Netherlands currently provide forensic outpatient services as a specific posttrial measure. The Netherlands are the most well-provisioned state in this regard, equipping each forensic hospital (TBS facility) with an outpatient unit to provide forensic outpatient and aftercare, in addition to such highly specialized services as forensic home treatment or forensic sheltered accommodation. But transferring patients from inpatient care to outpatient care can prove difficult due to judicial restrictions, public opinion and limited capacity. Also the transition of patients from forensic care to general psychiatric care is very difficult sometimes. In some countries (e.g. Italy and Spain) community psychiatric forensic services do not exist. In those cases the forensic outpatient care can be provided, when criminally non-responsible mentally ill offenders are presenting no public threat, by regular community mental health services.

7.2.5 Forensic Services for Offenders with Specific Mental Disorders

Where countries offer forensic services for offenders with specific mental disorders, these services in most cases are related to substance abuse. Austria, Belgium, Germany and the Netherlands currently offer such substance abuse services for offenders. In Belgium problem behaviour clinics for sex offenders exist. Specific diagnosis-related treatment programmes may also be available for forensic patients in other member states but most often only as part of wider treatment programmes

in general psychiatric hospital services, forensic units or prison services (e.g. Portugal, Greece or Spain). Treatment for sex offenders is also provided in some European countries, but these usually are of limited capacity and usually part of more general prison-based programmes Last but not least, there were some specific treatment programmes for patients with personality disorders like dangerous and severe personality disorders (e.g. in England and Wales) [6]. These services have shown no clear benefits (and very high cost), and they were closed down but still have services for offenders with personality disorders.

7.2.6 Prison Services

Prison services are the most crucial sector and the most difficult to describe when evaluating procedures for the placement of mentally ill offenders across Europe. All countries that apply the concept of criminal responsibility in their jurisdiction place mentally ill or disordered persons who are held fully responsible for their offences in prison services or penitentiaries. However, that does not necessarily mean that special prison wards or adequate psychiatric treatments for such people are indeed available.

Prior to trial, prison services are considered acceptable and are used by most of the countries for detaining offenders suspected of suffering from a mental illness or disorder, e.g. for assessment purposes or during transitional periods until the final placement is ordered. In Portugal, however, the court is never entitled to place in prison a person who is suspected of being mentally ill; instead the individual is placed in a specialist forensic facility, even if the mental state of the suspect has been not assessed by an expert.

Posttrial placement of criminally non-responsible mentally ill offenders in a prison is hardly a legal option across Europe. In several countries, however, limited capacities in forensic facilities may determine the (temporary) placement in prison of people fulfilling the legal criteria for specialist forensic treatment.

People who have committed serious crimes and who are suffering from psychiatric disorders not legally qualifying them for forensic care depending on the valid legal system are usually given prison sentences. Most often excluded are the non-psychotic mental illnesses, substance abuse disorders, personality disorders or the sex offenders. Individuals suffering from these disorders impose a heavy burden on prison systems. It is likely that there is a serious under-provision of psychiatric services for such conditions in some European states.

7.2.7 Forensic Facilities in the Private Sector

Forensic facilities in the private sector are applied in varying degrees in some of the European states. In the Netherlands, the majority of forensic institutions (five out of seven TBS hospitals) are in private ownership. Forensic Psychiatric Centre Veldzicht and Forensic Psychiatric Centre de Oostvaarderskliniek are the only ones run by the

Ministry of Justice. Historically, it was possible to be admitted in a psychiatric hospital for treatment against a patients will from 1886 in the Netherlands. In 1928, TBR was implemented which could be given for any committed offence, and the first asylum was opened. Judges applied TBR regularly, and soon the asylum had capacity problems, which led to the opening of more clinics and to the revision of this law in 1933, 1951 and in 1988, when TBS was formed to insure better treatment for patients, since many patients had a history of psychiatric treatments and treatment options where very limited until that time. There has always been a relation between general mental health facilities and forensic facilities, but during the course of time, forensic psychiatry has more and more become a speciality of psychiatry. Forensic psychiatric facilities are integrated in the pathway of psychiatric treatments.

In Spain, out of the four national psychiatric penitentiary hospitals, those in Catalonia and Basque country are run by private psychiatric providers, whereas in England and Wales, private forensic units are used by the NHS only where no beds are available in its own facilities. In England and Wales, on the other hand, the intention is to phase out private involvement in forensic care by building more forensic units within the National Health Service. Some federal states in Germany plan to privatize federal forensic facilities.

7.2.8 Forensic Bed Capacities

Wide variations in definition of forensic beds and considerable, yet unknown, numbers of undeclared beds for mentally ill offenders in general psychiatry or the prison system are serious methodological obstacles to calculating forensic bed rates or any such indicators. Consequently, recent studies to develop a set of European mental health indicators do not include any estimates of forensic care capacity [8]. The information available, from some countries in Europe, were:

- The total number of declared forensic beds (for pre- and/or posttrial placement)
- The number of declared forensic beds per 100,000 population (forensic bed rate)

Additional problems of definition have to be considered. Beds on psychiatric or general prison wards were not included in the estimates, although some countries occasionally use prison placements for detaining criminally non-responsible offenders. Unspecified forensic beds in general psychiatric hospitals could be identified for some member states and were included in the total number of forensic beds, whereas for others the undeclared or unspecified capacities in general mental healthcare facilities could not be quantified and thus were left out.

The highest rates of forensic beds are in countries like the Netherlands, Germany or England, whilst the lowest are in Portugal, Spain or Italy. Most of the European countries have increased the number of forensic beds in the last years [9, 10].

Current data suggest a north-south divide within the Europe, with remarkable differences between similarly populous countries in Central and Southern Europe

(e.g. Austria or Belgium compared to Portugal, or Spain compared to England and Wales). Low forensic capacities in Italy, Portugal, Spain or Greece might reflect a different concept of mental health care in those countries, commonly characterized by low numbers of hospital beds in general psychiatry, home-based care and a considerable burden on the families of the mentally ill. However, it is doubtful whether general mental health-care conditions in these countries also affect forensic service provision, given the rather different security considerations and other requirements of forensic care.

For Central/Eastern European or Scandinavian countries, further analysis is needed to determine whether high forensic bed rates do indeed reflect a policy of separating forensic from general mental health care whilst providing adequate capacity (as could be hypothesized for Germany) or whether there may be other reasons.

For Eastern European countries, Mundt et al. [11], however, described a mixed picture with increases in forensic bed numbers between 1999 and 2009 in some countries (e.g. Hungary, Poland) and decreases in others (e.g. Czech Republic and Latvia).

The poor reliability of current indicators should always be kept in mind, and therefore caution should be exercised in drawing any conclusions or making comparisons of capacity between European countries.

7.2.9 Preventive Detention

In many countries, preventive detention following forensic treatment of or the completion of prison sentences by mentally ill or mentally non-disturbed offenders who are considered to be extremely dangerous or resistant to treatment is a topic of discussion. The measure is seen as a specific means of enhancing public safety and reducing the risk of reoffending. Most commonly, such measures are advocated by public opinion or mass media campaigns, especially in the aftermath of spectacular crimes committed by mentally ill or disordered persons. Many experts consider preventive detention to be a most delicate subject, likely to seriously tip the balance between public safety and the human rights of the persons concerned if it is not applied with special care and according to clearly defined legal criteria.

Although criteria or legal procedures may differ, preventive detention is currently implemented in some states. For example, in Denmark and in Germany (Sicherungsverwahrung), unlimited detention is possible in cases of dangerous non-psychotic mentally ill offenders. In Belgium a similar form of preventive detention exists for severe sex offenders. The measure is ordered at trial. Preventive detention after completion of a prison sentence or a treatment order is not provided in Denmark, however. In several states that do not recognize the concept of preventive detention, civil commitment laws may provide a legal means of continuing detention of dangerous patients who have served prison sentences in full or have been discharged from forensic facilities (e.g. in the Netherlands).

7.2.10 Lifelong Forensic Placement

Aside from any measures allowing preventive detention, lifelong detention of mentally ill offenders can be imposed in some of the states, in the event that the legal or medical criteria for forensic care are met and are confirmed regularly by reassessment. The frequency of lifelong forensic placements differs, although in general it does not occur very often. Modalities might vary also. For instance, in England and Wales, lifelong orders when imposed may allow compulsory supervision of patients in the community after discharge and allow recall to hospital when they relapse, whereas in other States, lifelong forensic care means an uninterrupted inpatient stay in a forensic facility.

In Spain, lifelong forensic care is scarce as the most forensic patients are transferred to general psychiatric hospitals for continuity of care, and their treatment is continued often on an involuntary basis after their stay in a forensic hospital. This situation exists in Spain because a preventive detention does not exist, and mentally ill offenders cannot be held in a penitentiary psychiatric hospital longer than the sentence applied. Furthermore, security and capacity problems in general psychiatry increase the risk of quick discharges or of absconding of these patients.

7.3 Supervision and Regulation of Forensic Facilities Across Europe and Its Consequences

Responsibility for funding, supervising and regulating forensic facilities differs across Europe. Regulation and supervision of facilities and of treatment are a means of quality control. Although levels and intensity of regulation and supervision may vary across the Europe, one indication as to whether the main emphasis in forensic care in a given country is upon the medical or the procedural aspects (e.g. security aspects) may lie in whether the responsibility for supervision or regulation lies with the judicial authorities (e.g. the Ministry of Justice) or with a health agency (e.g. the Ministry of Health). The need of some European regulations (regarding both health and security as protecting of human rights) could help to harmonize the forensic facilities across Europe.

7.4 Funding

Forensic placements are funded from varying departmental budgets within the states, with a substantial financial responsibility for treatment placed upon the national Ministries of Justice, whereas general mental health care is financed through health budgets or some joint payments from both departments (Health and Justice) or a different pay, as in Spain (except Catalonia), by the Home Office Ministry that take care of the penitentiary services.

The Ministry of Justice is the most common authority for reimbursing the cost of forensic assessments. Only in England and Wales and Finland is this the

responsibility of the Ministry of Health. This might indicate that the forensic assessment is widely conceived of as a legal procedure, whereas the subsequent detainment is seen as a responsibility of national health authorities.

The reimbursement of forensic care by Justice Departments may cause some problems, e.g. by setting financial incentives for exporting into forensic care mentally ill individuals who have committed only minor offences or who are merely aggressive. This paradoxical and stigmatizing effect, which is likely to undermine the integration of forensic and general psychiatric care, has been observed at least in Austria [12].

Even public funding for forensic psychiatry is not popular. In 1993, Reiss and Roth [13] compared research monies expended in the USA per potential life lost due to various causes; for cancer it was $794, for AIDS it was $697, for cardiovascular diseases $441, but for violence it was just $31. This funding differential probably was then and still is similar in other developed countries. Also, research money is more often granted to short-lived projects [2].

Another difference is means of finance. Currently some countries tend to follow a similar system funding as in the health system. A fixed budget tends to be less used and more a funding by objectives (with a diversity or variables like length of stay in psychiatric settings, type of disorders, type of interventions made and so on).

Some examples of the above described are:

Netherlands: After some serious incidents in the TBS system, political pressure in the Netherlands has risen to reform the system. This has led to an inquiry by a parliamentary commission on the organization of treatment of forensic patients. One of the conclusions was to reform the TBS system and other forensic mental health-care services and was the starting point for treatment in prison in the penitentiary psychiatric centres (PPC). Political pressure to reform psychiatric care in prison had as a main goal prevention of criminal behaviour after discharge, not the provision of care. With the goal of reducing recidivism in 2007, financial budget for the improvement of mental health was transferred from the Ministry of Health, Welfare and Sports to the Ministry of Justice. The prison service used these funds amongst others to finance forensic capacity in several community mental health-care facilities throughout the country and to enlarge the capacity of forensic care units within the prison system with the establishment of penitentiary psychiatric centres. The main goal of treatment in the PPC is treatment as usual, i.e. equality of care compared to treatment in general psychiatry. Also psychiatric treatment facilities were claimed and financed by the Ministry of Justice in general psychiatry.

England and Wales: A switch in funding also took place in the UK. From 2000 the NHS was largely responsible for prison mental health (Department of Health 1999 and 2001). Based on the Bradley report [14], the NHS was from April 2013 completely in charge. One of the main recommendations in the Bradley report was to tackle the over-representation of people with mental health problems in prisons in England. There were recommendations to divert offenders with mental health problems from custodial settings, to reduce the waiting time for people who need to be transferred from prison to hospital for urgent mental health treatment and for the

NHS to take on responsibility for providing health services in police stations [15]. The NHS is now responsible for the commissioning of all health services with the exception of emergency care, ambulance services and out-of-hours services, for people in prisons in England. These include secondary care services (hospital care) and public health including substance misuse services. To achieve this goal, there has been since 2013 a transition from bodies like the NOMS (National Offender Management Service), individual police forces and Youth Justice Board to the NHS. The NHS has committed itself to a seamless transfer in provision of services, using the same standard and quality of care that can be expected in the community [15]. So in this aspect, there is a parallel to the situation in the Netherlands.

Spain: The assessment of the mentally ill offenders is in the charge of the Institute of Legal Medicine and Forensic Sciences (professional body that helps the Magistrate to take decisions related with health problems as mentally ill offenders) and is funded by the Justice Department in all of Spain. The care and treatment of the mentally ill offenders in prison in Spain is paid by the Home Office Department (which is in charge of prisons). In Catalonia and the Basque Country, the Health Department is responsible for the health system in prison (including mentally ill offenders). Recently, this situation is changing, and in the next years the Spanish National Health Service will take care of the health care in all prisons. An increase of the budget has not been discussed, despite the aim to have a system equivalent to psychiatric services in the community. In Spain, Mental Health Services are not responsible for the treatment for drug misuse and for sexual and violent offenders. These programmes are in charge of the rehabilitation services of the prison system [16, 17].

7.5 Advantages and Disadvantages of Different Systems

The first thing that can come to mind is that treatment follows money, i.e. if there is no judicial title, there is no surplus finance for treatment. Health care is less funded in some countries compared to Justice-based finance. This could lead to problems in continuity of care and does in practice, at least in, for example, the Netherlands. The problem here is that treatment needs of a patient after discharge remain the same regardless of the funding type, but in the end, there can be less money available in general psychiatry. In some European countries, continuity of care is accomplished better, for example, in Germany, where aftercare is provided in the forensic setting as opposed to in general psychiatry. There may also be a double standard in providing mental health care to offenders, i.e. prevention of recidivism versus treatment of the disorder. Sometimes but not always, these goals overlap, and it is imaginable that the way the treatment is financed will have its consequences in this respect. In other words goals of treatment could be set by the financier. It is not always clear how inclusive treatment should be. For example, should providing housing, work and so on be part of the deal? Both funding types have pros and cons. For example, the Ministry of Justice will be inclined to buy services in a prison-like setting, but the culture in these settings can make it more difficult to treat forensic psychiatric

patients sometimes. Treatment in a forensic setting can be difficult in suspects denying their crime because of the focus on prevention of recidivism. Are they always capable of providing adequate care? Who wants to work in a prison? Not many psychiatrists are prepared to work in a prison setting, and not all psychiatrists are capable to work there [18]. Reality shows equivalence of care can be hard to realize where the Ministry of Justice is only responsible for financing the treatment, for example, in Belgium and Hungary. And it is estimated that a shift in resources of 5% of the budget for criminal justice to health could double the money available for primary care trusts [19]. Treatment in general psychiatry has the advantage of relying on a long tradition where treatment in a forensic setting means introducing a new way of perception for prison staff with all the inherent problems. On the other hand, general psychiatry will be inclined to deliver psychiatric treatment as usual and probably has less focus on forensic aspects, like, for example, risk assessment and management, which can lead to the overseeing or neglect of potential dangerous behaviour.

Overall, what seems to be most important is the fact that complex ways of financing lead to problems in cooperation and development of joint projects between forensic settings and general psychiatry and in the ever so important continuity of care.

7.6 Continuity of Care

In Austria and Germany, discharges of forensic patients are always conditional. This could be considered as an appropriate and flexible means to balance patient rights and interests (e.g. to the shortest possible restriction on liberty) with public safety.

However, the majority of the Member States seem to favour a medical perspective, emphasizing the treatment needs of the patient and safety issues as criteria in discharge decisions. One major disadvantage of this approach is its tendency to neglect proportion. It could, for instance, condemn a schizophrenic patient ordered in forensic care because of a minor assault to detention for as long as his illness prevails.

Time frames for discharges on licence/conditional discharges differ within the states. Although there are studies suggesting diminishing recidivism rates as a consequence of forensic treatment, the evidence on the risk of reoffending after removal of restriction orders should be increased.

So, whatever the system, continuity of care has to prevail as the main goal. This of course can be achieved in many different ways. Looking at the way different systems are organized, one could assume that, at least in theory, the NHS system gives more guarantees for continuity. In both the UK and the Netherlands, equivalence of care in prison is a main goal, but there are doubts about achieving this goal in the UK [20], so in practice there are doubts at least in the UK. In the Dutch system, there is a large gap between forensic and general psychiatry. This problem is accentuated by the fact that there is less money available for treatment 1 year after

discharge. It seems that countries were there exist parallel forensic community services and general psychiatry services in the community experience a large gap. In Spain, all the patients that are released and/or have finished their sentence have to be vinculated to social services in the community. For some people that have no family or social network or are in illegal status, it is difficult to organize a follow-up by mental health community services. Although all studies show the importance of forensic, community and rehab services having a close relationship to maintain and improve the care given to all patients in the community, in practice this seems hard to realize regardless of the system organization [21–23].

7.7 Ethical Issues and Public Opinion

Public opinion differs from one country to other but does play a considerable role in forensic psychiatry. In some countries the problem is stigmatization; in another the problem is related with some offences (serious offences, sexual offences), and in some countries, the conditions of living/care seem to be a major problem. There is little in-deep debate about mentally ill offenders. Nevertheless, public pressure is rising, for example, in the UK and the Netherlands. Mentally ill patients are associated by a substantial part of the public as prone to violence. In Spain the discussion arises when a violent or sexual crime happens but tends to decrease after the trial. Treatment is, sometimes, seen as a waste of money; absolute security is demanded from the justice authorities and from forensic psychiatry, and no degree of recidivism seems acceptable. In the public opinion treatment of offenders is hardly tolerated and then only if it guarantees absolute security, which is of course impossible. The matter can draw in the field of mental health care and is the subject of regular mass media coverage, with enormous public interest in high-profile cases. It is difficult to explain to the media that most of the mentally ill people are not violent and most of the times are more a victim than a perpetrator of crime. Psychiatric professional bodies, like psychiatric associations, need to take more proactive actions to prevent stigma and place treatment rather than security on the agenda for forensic mental health-care agencies.

7.8 Ethical Issues and Professional View

When looking at the organization of the forensic mental health-care system, there are some ethical issues and professional views that need to be taken into consideration. For example, the question rises which patients need to be treated in the forensic field. Are mentally ill offenders to be regarded as “the most vulnerable” who need to be pulled into treatment, or is there more to it [15]? Sometimes discrepancies exist between general and forensic psychiatrists in their approach to what some patients’ needs are. Debate may rise as to what level of offending qualifies a patient for forensic care instead of being treated in general mental health-care facilities, and the same can apply to the type of offence committed. Being treated in forensic

mental health care can cause considerable stigmatization. On the other hand, in some cases there are doubts whether the care of some violent or sexual offenders fall in the field of psychiatry. Another issue is what the main goal of treatment is, as there can be a discrepancy between public protection and treatment benefits of patients. Is security by treatment an attainable goal and is it ethically right to set this goal? And what is the optimal level of security needed in each case? Are people placed in the right level of security that is needed? If maximal security is demanded, who will pay and how do we proceed to maintain humanitarian principles? In many cases there seems to be a lack of balance between therapeutic interests and public protection. Does the way the forensic field is organized and funded affect decisions made in these matters?

Conclusions

Specialist forensic facilities are the most common type of service in which criminally non-responsible mentally ill offenders are placed and treated. This type of care is provided by a wide variety of services depending on legal and health-care systems, funding types and cultural history (about dealing with mentally ill offenders). Mentally ill offenders who have committed serious offences and who are being held as criminally non-responsible (so far as this concept is applicable in individual member states) constitute the core clientele of forensic facilities, although there are some exceptions to this rule, most often for reasons of bed availability or security. Some countries (Finland, France, Ireland, England and Wales, Sweden) admit aggressive, violent or "high-risk" non-offending mentally ill individuals to forensic facilities. This is done most often under civil detention orders, but this is not necessarily so in all cases.

This variety of approaches for detaining and caring for violent mentally ill patients has not been examined further by international research. Thus, it is unknown whether one approach is more effective than or superior to others. From a theoretical point of view, it could support crime prevention to place and treat aggressive or violent mentally ill patients in forensic facilities, even when their crime record is blank.

On the other hand, a considerable rise of forensic patients over time could also indicate insufficient treatment arrangements in general mental health care for violent mentally ill patients, who are adequately cared for only after having committed a crime and being placed under forensic regimes.

Variations in definition of forensic beds and considerable, yet unknown, numbers of undeclared beds for mentally ill offenders in general psychiatry or the prison system are serious methodological obstacles to calculating forensic bed rates or any such indicators. Despite all definition problems, calculation estimates suggest a north-south division within the European Union, with marked differences between similarly populous countries in Scandinavia, Central and Southern Europe. Whether low forensic capacities in South European member states reflect the overall mental health-care standards in those countries (low numbers of hospital beds in general psychiatry, home-based care and a considerable burden on the families) remains to be analysed [6].

Although outpatient care is today an integral part of general mental health care, specialist outpatient care for forensic patients is underdeveloped. Follow-up may be usual in many states or indeed mandatory in the case of probation orders, conditional discharge or as a general aftercare measure, but specialist services are usually lacking. In some countries, informal types of forensic outpatient care are implemented, when criminally non-responsible mentally ill offenders representing no public threat are cared for by community mental health services.

The wide difference in legal and health law in Europe is one of the reasons for a diversity of models. Ranges from high, medium and low security resources in the UK, to the TBS system in the Netherlands or others systems like in Spain present difficulties in summarizing and advocating one highly recommended system. The same applies to specific problems as sexual offences or severe personality disorders being treated by forensic services in some countries and by prison services in others countries and treatment of the most violent offenders in these facilities as the respective national health system tends to take care of the petty offences.

7.9 General Recommendations

Although it proves virtually impossible to describe a preferred system for the organization and funding of forensic mental health care in Europe, due to all the differences discussed above across Europe, there are some general recommendations to be made. First, whatever the funding system and service provision system, at least, the same quality and equivalence to the national standards of each country have to be ensured for all forensic mental health care. In all countries there should be a comprehensive forensic service provision including both hospital and community treatment as well as equivalent psychiatric care in prison settings, when applicable. All people in forensic settings (both in legal and illegal status) should have the same level of care. And also continuity of care after patients are discharged from the forensic services has to be guaranteed. In the next years, the gap between forensic and general psychiatry should be narrowed. And last but not least, the budget should include some funding for training, education and research in forensic settings [24].

Take-Home Messages

- Equivalence of care should be guaranteed.
- Continuity of care should be guaranteed.
- Availability of finances for training, education and research should be guaranteed.
- Some anti-stigmatization programmes should be implemented.

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Part III

Specific Skills

Challenging Language Barriers

8

Esperanza Gómez-Durán and Roland Jones

8.1 Introduction

There are more than 20 officially recognised languages, more than 60 indigenous regional and minority languages and many nonindigenous languages spoken in Europe [1]. The use of native language helps preserve cultural heritage and identity and promotes social cohesion among those who share the common tongue. However, the diversity that is much celebrated is inevitably problematic when there is a need for communication but no language in common. These problems are no more profound than between users and practitioners of medical and criminal justice systems, where matters of health, justice and liberty are concerned [2]. Understanding how to overcome such language barriers is becoming increasingly important for healthcare providers around the world, and an increase in research on language barriers has been recently reported [3].

In this chapter we discuss areas in which language may be a barrier to effective communication and to the exchange of knowledge for clinicians. We discuss potential difficulties in communication in clinical and forensic settings and how they may be overcome, including clinical interviewing and psychometric assessments. We also discuss the barriers to professional mobility and the difficulties associated with the effective dissemination of research and information where language is concerned.

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8.2 Overcoming Challenges in Communication with Patients

Communication between patient and clinician is fundamental in healthcare but particularly so in the field of mental health where verbal communication forms the main channel by which to access the mind of the patient, to elicit and to interpret precisely what has been said and how.

Even before a consultation has even been arranged, for a non-native speaker, language may be a significant barrier to accessing healthcare, due to the lack of comprehensible information about the existence of services and how to access them. If this can be successfully overcome, the difficulties in communicating and being understood in the clinical setting are then brought into sharp relief. For example, it has been shown that poorer communication in consultations with non-native speakers can lead to misunderstanding and non-adherence to treatment [4, 5].

The availability of professional translation services are therefore recommended to overcome language barriers in the clinical setting, but the situation in European countries seems heterogeneous. In the United Kingdom, most health services have policies to support the use of translation and interpreting services for individuals who have limited proficiency in English. Similarly, translation services can be found at least telephonically in Spain. In Switzerland, Bischoff and Hudelson [6] found that the use of an interpreter should be seen as a central and obligatory part of the consultation.

While the requirement to provide interpretation or translating services is not explicitly set out in European legislation, there is a legal framework that supports equality of access to healthcare, which places a public duty on health systems to ensure staff and service users are treated equitably and not discriminated against on grounds of ethnicity (notably the European Convention of Human Rights [7] which has been incorporated in legislation across Europe (Human Rights Act [8], the Equality Act [9] in the United Kingdom and the Spanish General Law [10] in Spain). Although there may be an obligation on services to provide translating services, in practice this may not occur either due to limited funding, failure to identify need or lack of availability of an interpreter who is proficient in the required language.

Conducting a clinical interview with the help of an interpreter can pose its own challenges, and guidelines to assist clinicians working with interpreters have been published (e.g. [11]). Fundamentally, it is recommended that interpretation should be carried out by someone who is competent to do so. It is rarely acceptable to rely on the patient's friend, relative or child to provide the interpretation service unless in true emergency, due to issues of confidentiality, impartiality and the quality and reliability of the translation. Patients have a more positive experience of the consultation when a professional interpreter has been used, and they report the perception that they have been helped more [12, 13]. In addition, it has been shown that the use of non-professional interpreters can lead to less disclosure of sensitive information by patients and can lead to errors in the interpretation of information obtained [12].

Before a consultation in which an interpreter will be used, it is recommended that adequate time is allocated for the interview; approximately twice as much time will be required as compared with an interview with a native speaker. The clinician should first meet with the interpreter to check that there are no conflicts of interests, such as any previous knowledge of the patient through family, social or business relationships. It is also recommended that the subject matter of the consultation (if known) will be outlined to the interpreter, to check that the interpreter will be able to proceed as the subject matter in forensic assessments may be shocking to those not normally working within this field. It is also recommended that "ground rules" are discussed with the interpreter to discuss how the interview will proceed, especially the requirement that everything said by both parties must be translated.

At the commencement of the interview, it is recommended that the interpreter is introduced and their role is clarified. The patient should be informed that the interpreter is independent and impartial and cannot advise them or provide support. They should be advised that they will translate everything they say and that they do not have to pay for the service.

The clinician is advised to carry out the consultation using simple words. Any medical or technical terms should be explained. It is recommended that a maximum of one or two sentences should be spoken before pausing for the interpretation. The language used should be specific and direct and should avoid inferences (such as "passed away" instead of died) or culturally specific phrases, similes, idioms or jokes that may not translate with the intended meaning. The clinician should speak directly to the patient as in a consultation without an interpreter, and the interpreter should reply using a translation of the patient's exact words. It is also important to continually ensure that the patient has understood by assessing their comprehension regularly during the consultation. Once the consultation is complete, the patients' language preferences and communication needs should be clearly recorded in the patient's record to ensure staff are aware of the needs of the patient.

8.3 Language Barriers in Forensic Psychometrics

Psychometric tools are a core component of forensic assessments, yet many tools published in English have not been translated to other languages. Furthermore, those translated into another language for use in another country may not have been validated for use with that population. It is imperative that the highest standards are upheld in selecting and administering appropriate psychometric measures and in interpreting the results in light of the known limitations of the instrument [14]. Those limitations may therefore be due to language, for example, that the instrument has been used with a non-native speaker or that the instrument has been translated but not validated for use in other populations.

The ethical standards for the use of assessment tools as articulated by the American Psychological Association (section 9.02) highlight the importance of using the tools

correctly on members of the population for which it has been tested on and appropriate to the individual's language preference and competence ("unless the use of an alternative language is relevant to the assessment issues"); if not, they should "describe the strengths and limitations of test results and interpretation" [15]. Only assessment instruments whose validity and reliability have been established for the particular population assessed should be used, yet forensic experts will invariably confront the challenge of assessing people who, by reason of ethnicity, culture, language or other factors, are not well represented in the normative base of frequently used assessment tools. In such circumstances, experts should interpret the test results cautiously, with regard to the potential bias and misinterpretation of such results [16].

Table 8.1 shows the translations available for IQ and personality assessments translated for common European languages. Several of the risk assessment instruments (Classification of Violence Risk (COVR) [17], Historical Clinical Risk Management (HCR)-20, [18] Level of Service Inventory-Revised (LSI-R) [19], Structured Assessment of Protective Factors (SAPROF) [20] and Violence Risk Appraisal Guide (VRAG) [21]) but not all of them, have also been translated into different languages. It appears that instruments that are frequently used in general psychiatry are more likely to be translated and validated for languages other than English compared with forensic instruments. Furthermore, specific training in the use of the instrument is frequently held in English, limiting the access of those professionals nonproficient in this language.

Nevertheless, even properly translated and validated psychometric measures may suffer as they may contain references to cultural idiosyncrasies. IQ tests and personality inventories may therefore be less reliable and valid with non-native English speakers, poorly educated individuals or those in non-Western cultures [22]. Furthermore, language barriers may not be appropriately compensated by

Table 8.1 Translations available for main forensic tools

Test/languages	German	French	Spanish	Italian
IQ measures				
Wechsler Adult Intelligence Scale-IV (WAIS-IV)	Hamburg-Wechsler-Intelligenztest für Erwachsene	Echelle d'intelligence de Wechsler pour adultes	Escala Wechsler de Inteligencia para Adultos	WAIS-IV
Personality inventories				
MCMI	MCMI	Inventaire clinique multiaxial de Millon	Inventario clínico multiaxial de Millon	MCMI
MMPI	MMPI	Inventaire Multiphasique de Personnalité du Minnesota	Inventario multifásico de personalidad de Minnesota	Inventario Multifasico della Personalità Minnesota
PAI	PAI	Inventaire d'évaluation de personnalité	Inventario de evaluación de la personalidad	PAI

using measures that do not require verbal instructions or responses [16]. Performance on non-verbal tests can vary significantly based on both cultural background [23] and educational level [24]. Indeed, the American Board of Professional Neuropsychology acknowledges that there are cases in which language barriers preclude valid test administration [25].

All of this highlights the dangers inherent in using psychometric instruments as a primary criterion in making critical decisions, ignoring the fact that they cannot possibly represent the individual as a whole being within his or her unique life context [26]. For the clinician, the most important thing to remember is that, while self-report measures have their place, they function best as screening instruments and should not be used in isolation as diagnostic instruments [27].

8.4 Language Barriers in the Criminal Justice System

Language barriers exist among those in contact with the justice system and have been described for both offenders and victims. The difficulties may be even more pronounced if mental health problems are involved [28, 29]. Concerns are particularly high among those whose competency is in question, as they may not even have the proper assistance of an appointed attorney and an accurate forensic assessment [28]. The European Committee on Crime Problems recognises that foreign offenders are more likely to be remanded in custody while awaiting trial and are more likely to be sentenced to terms of imprisonment after conviction than other offenders [2].

The increasing numbers of foreign inmates in European prisons provide a challenge in communication for those detained. In addition to the isolation for non-native speakers in prison, the European Council's European Committee in Crime Problems has stated that the "inability to communicate in the language most commonly spoken in a prison is a severe barrier to foreign prisoners' ability to participate in prison life". It is the root cause of many problems, such as isolation, lack of access to services, work and other activities, and an inadequate understanding of prison rules and regulations. Therefore, it is vital that prison authorities make every effort to facilitate communication and to enable offenders to overcome language barriers. The problem is exacerbated in those prisons that allow only one language to be used which could be considered against human rights. In fact, the European Court of Human Rights considered this aspect combined with the lack of personal space to decide that a Tajik inmate's detention conditions in Russia went beyond the threshold tolerated by Article 3 of the European Convention of Human Rights, prohibiting torture or inhuman or degrading treatment or punishment (European Convention of Human Rights 2005) [30].

Difficulties increase when several relevant aspects converge, such as suffering a mental health problem, having committed a crime and not sharing the common language. Furthermore, it has been suggested that poor language skills associated with an authoritarian system increase the likelihood of conflicts within the prison population [31].

8.5 Professional Language-Based Barriers: Communication with Colleagues

While non-native English speakers struggle to communicate effectively in English, native English speakers try hard to understand the many variants of non-native speakers, overcoming different accents and accepting the language mistakes inevitably made. Getting lost in translation is a problem for both sides.

At a professional level, a clinician's skills, expertise and knowledge can remain hidden by language due to difficulties in communication, which may also be a barrier to international mobility and collaboration. Professional experience outside one's own country is generally highly appreciated; professionals frequently decide to study or work abroad, and the amount of multilingual teams is increasing. Even research funding frequently highlights the importance of multinational studies to get a comprehensive picture of the phenomena studied. With the increasing development in collaborative work, lack of language skills inflicts a particular handicap on professionals wishing to work internationally. Due to the dominance of English in the scientific world, this can be harder for those whose primary language is anything other than English.

Regarding collaborative work, several studies have described language barriers in terms of lower social integration, reduced knowledge sharing or power-authority distortions [32]. It has been noted that language-related issues can significantly impact on the formation of trust within teams, with a perceived connection between language proficiency and the trustworthiness or competence of team members. It has been found that negative attributions are made about a colleague's competence based on their command of language, with a clear correlation between the magnitude of these negative attributions and the proficiency of their language [32].

Furthermore, there are "rules" that language is used in an expected and particular fashion in a given environment and context. If these expectations are not met, adverse attributions may be made as to the personality of the speaker who may inadvertently fail to conform to these rules [32]. In addition, less proficient speakers within a multilingual team may feel negative emotions, avoid native-speakers and switch to their mother tongue and group with fellow speakers, excluding others. Hostile stereotyping and emotional conflicts may then ensue, increasing miscommunication, uncertainty and anxiety [33].

Given the increasingly diverse nature of many forensic patient populations, multilingualism in forensic teams may be a future need, and therefore an awareness of the potential issues may help to mitigate problems.

8.6 Professional Language-Based Barriers: Professional's Mobility

Doctors frequently seek employment in countries other than where they trained. In 2011, Dr. Bollen Pinto, president of the Permanent Working Group of European Junior Doctors, stated that some regulatory bodies were "expressing concerns

regarding the language skills of migrating doctors and might push in the direction of mandatory language testing". He went on to say, "This issue is particularly evident in the UK, where recent cases of alleged malpractice with disastrous results by foreign doctors came out in the media. Communication problems between doctor and patient were pointed out as the cause of the problem" [34]. There is no uniformity for the assessment of language proficiency across Europe. Some regulators require a formal language assessment test post-registration, and some require no language assessment at all. Requirements by other regulators include a review of language proficiency by a panel, formal interviews, assessed discussion of a video, evaluation of the employers or a medical inspector or simply a declaration of proficiency by the individual [34].

Directive 2005/36/EC from the European Commission already provided for the obligation of professionals to have the necessary language skills. However, the review of the application of that obligation showed a need to clarify the role of competent authorities and employers, in particular in the interest of ensuring better patient safety. That Professional Qualifications Directive of the European Commission was updated in 2013, and several issues regarding language skills were modified [35]. It was made compulsory "for professions that have patient safety implications, a declaration about the applicant's knowledge of the language necessary for practicing the profession in the host Member State". The new Directive acknowledges "professionals benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practicing the profession in the host Member State". Therefore, after the recognition of a professional qualification, a Member State shall ensure that any controls carried out by, or under the supervision of, the competent authority for controlling compliance with this obligation shall be limited to the knowledge of one official language of the host Member State or one administrative language of the host Member State provided that it is also an official language of the Union. Controls carried out in accordance with the Directive may be imposed if the profession to be practised has patient safety implications, but they shall be proportionate to the activity to be pursued.

With regard to psychiatry, proficiency in the local language can be considered compulsory to practise. Evaluation of psychopathology, as discussed, is done to a large extent through observation of language use, which may be difficult to assess for a non-native speaker. Furthermore, specific communication styles may be especially complex: the use of sayings and proverbs can provide information with direct relevance to clinical assessment and even treatment, but they can be easily overlooked by non-native speakers.

8.7 English Dominance in the Scientific Field

Chinese, Spanish, English, Arabic and Hindi are the most widely spoken languages in the world by the estimated number of native speakers [36]. In Europe, the most widely spoken mother language is German, followed by Italian, English, French, Spanish and Polish (European Commission 2012) [1]. Nevertheless, English is the

most widely used "second" and "learning" language in the world and is the foreign language that Europeans are most likely to be able to speak (European Commission 2012) [1]. It is extensively used for international communication in business, finance, technology and, of course, science.

Whether language diversity leads to language barriers depends on the speakers' proficiency levels [32]. Governments in non-native English-speaking countries understand the relevance of this issue, and the majority of them have increased the extent to which students are required to learn foreign languages in the recent years. Indeed, learning English is mandatory in several European Member States within primary education; 93.7% of all European students in secondary education learn English as a foreign language [37]. On the other hand, the global popularity of English has had an adverse impact on native English speakers' learning of other languages [38], with the United Kingdom having the highest share of upper secondary school students not learning a foreign language (52%) [37]. Interestingly, this may damage the prospects of UK professionals in the employment market.

8.8 Language Barriers in the Dissemination of Knowledge

Language barriers may limit scientific discussions. At international scientific meetings, discussions are normally held in English in order to reach as many people as possible. No matter what language is being used, being a non-native speaker usually means less fluency of communication; limited vocabulary inhibits fast intellectual debate and may even prevent the non-native speaker from participating. This may cause frustration, but more importantly, it prevents ideas, experiences and knowledge from being shared.

Furthermore, scientific literature is predominantly published in English (including, as you have noticed, this text). A search of PubMed (one of the most popular bibliographic databases for published journal articles and citations) in October 2015 found there were over 21 million articles indexed. Of these, over 97% were in English, with only 1.5% in Spanish, 1.2% of articles in Chinese and only a handful of articles in Hindi and Arabic. Similarly, another international bibliographic index, Scopus, showed an overwhelming predominance of articles in English (over 98%) and only 1.2% in Spanish, 0.6% in Arabic and virtually no articles in Hindi. Global dominance of English is also found in forensic psychiatry. Figure 8.1 shows the number of published articles in the main European languages indexed in Scopus, containing the term "forensic psychiatry". Out of a total of 25,275, 84.5% were published in English.

Furthermore the best-rated journals are published in English according to the Scimago Journal Citation Index. In fact, there are no non-English medical journals ranked among the top 1000. It follows therefore that authors will reach a larger audience if they publish in English, and there is clear evidence that even non-native

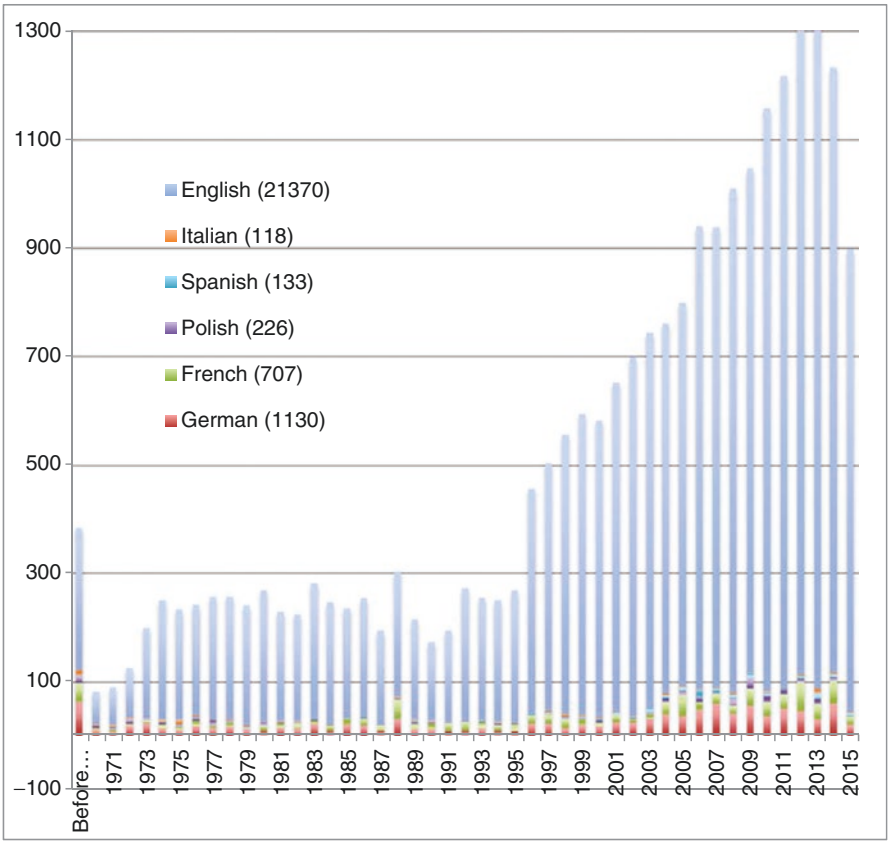

Fig. 8.1 Forensic psychiatry articles in Scopus by European languages

English authors chose to do this. According to the Scimago Journal and Country Rank reports, the English-speaking countries, the United States, Canada, the United Kingdom and Australia between them, accounted for 41% of published academic literature between 1996 and 2014, yet around 97% of scientific papers were published in English. It is evident therefore that authors from non-native English-speaking countries tend to publish in English; however, for others, it may prevent researchers and clinicians publishing at all, leaving important findings unpublished. Although non-native English-speaking authors may make an effort to publish in English, it does not necessarily follow that all of their non-native English colleagues are multilingual. Language barriers may therefore prevent professionals in a given country from accessing published information about research in their own country because it has been published in a different language.

8.9 A Spanish Forensic Psychiatrist in Wales

Wales welcomed me (Dr Esperanza L. Gómez-Durán), with open arms several years ago, despite the language difficulties. Having been born in the south of Spain, in an area of intense tourism, English can be considered obligatory and has always been in my life. However, when trying to develop yourself in the professional field in another language, you feel almost gagged. In addition to the logical pressure to adapt to a new environment, there is an obvious limitation to communicate as you wish.

The cultural differences between Spain and the United Kingdom can seem like an abyss when you approach your English colleagues in an excessively close, too direct and probably even impolite manner from the English perspective. This manner and sometimes a confusing speech is an obvious barrier. I remember surprising myself, offering an international referent the incomparable opportunity to collaborate with me, when in fact I was trying to ask for her appreciated supervision of my project. Fortunately, I always found understanding.

Cultural differences also act when you do not behave as your patients expect or you are unable to interpret their gestures or behaviour, something essential in psychiatry.

All this is surely more important than the difficulties with the content of the speech, but the content is also important. The fluency and rapidity of the reaction, the correct and measured choice of words and the mastery of the dialectic are of utmost necessity in clinical psychiatry but even more so in the forensic environment. Language as a tool of communication but also of analysis and management of the situation in psychiatry limits exercise in a non-native language.

From my perspective, practising as a forensic psychiatrist in an environment that communicates in another language and is culturally driven otherwise is an important limitation of the service you can offer. The same must be kept in mind when it is the patient who has to handle in a language and culture that is not his own. Our obligation is to provide a quality service; therefore, professionals must train, and the system must provide the necessary resources to save barriers, irrespective of the origin and language of the different actors in the process.

Conclusion

The inability to communicate effectively as a clinician, whether with patients or with colleagues, can provide an isolating experience for those involved. Incorrect and usually less favourable judgements and inferences may be made of those who cannot speak the native language by those who do. This can be particularly problematic and can have significant consequences for those involved in the forensic mental health or criminal justice systems. An awareness of this bias (including the limitations of clinical assessments and psychometric instruments in non-native speakers), and the imperative to provide adequate systems and resources to enable effective communication, may reduce the disadvantage that the non-native speaker experiences.

Take-Home Messages

- There is a bias towards incorrect and often unfavourable judgements towards individuals who do not speak the native language in a given country.
- The use of a professional interpreter is essential if patient and clinician do not share fluency in a common language; there may be a legal as well as practical and ethical imperative to do so.
- Administration and interpretation of psychometric tests must consider limitations of the test, such as whether it has been validated for the relevant population or used with a non-native speaker.
- Language can be a barrier to clinicians' international professional mobility, their ability to integrate with clinical teams and to communicate with patients. The dominance of English in the scientific community may also be a barrier to participate in scientific debate and dissemination of knowledge among non-native English speakers.

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Multi-agency Working

9

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9.1 Introduction

In some countries the increasing sophistication of forensic mental health systems has led to the development of multi-agency working. Traditionally, as in other areas of medical practice, decisions on patient care were largely taken by doctors and nurses. In recent years with the development of care in the community, the clinical and political focus on risk of harm to others and the recognised need to work beyond traditional health and social care boundaries and into other areas of public life, the concept and processes of multi-agency working have been developed [1, 2].

In this chapter we will define multi-agency working, provide examples of this within Europe, consider the pros and cons of multi-agency working and develop ideas for its future improvement [3].

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9.2 Definition

Multi-agency working in forensic mental health is defined as the coming together of people from different professional backgrounds, organisations and services, sometimes with varying primary purposes but with the common aim of improving public safety and decreasing an individual's risk of harm to others [3].

Examples of multi-agency working include the round table meetings in Germany, the multi-agency public protection arrangements in the United Kingdom, safety houses in the Netherlands and PSP (police, social services and psychiatry) cooperation in Denmark. Each is discussed in turn, and the first section contains a historical perspective which is largely applicable to all four countries.

9.3 Multi-agency Work: Historical Perspective

Working in forensic psychiatry is by definition and in practice an interdisciplinary and a multi-agency task. Treatment and rehabilitation have always been the work of several professions. Originally this was carried out by nursing and medicine, with nurses forming the backbone of the institutions and doing most of the work of treatment and control, and the few doctors employed making decisions on clinical care and taking overall responsibility. The two professions were dependent on each other and had a common goal and a common employer, so their work has to be considered interdisciplinary. In addition assessment and treatment of offenders always meant interaction with the judicial system. Final decisions on hospitalisation or release from hospital in the more serious forensic cases have never been made by nurses or psychiatrists but by courts or similar deciding bodies. These decision-makers belonged to a different system and quite often did not have the same goals as the medical system; still cooperation was necessary and had some features of multi-agency work. Several decades ago the system was clearly hierarchical in nature: final decisions being made by members of the judicial or political system and the treatment being organised by the medical profession within the framework of these decisions and carried out by the nursing staff.

In the second half of the twentieth century, a number of other professionals entered the treatment and rehabilitation process of forensic psychiatric patients such as psychologists, social workers, occupational therapists, arts therapists, pharmacists, activity specialists and teachers. The incorporation of the different professionals into a team with a common goal made interdisciplinary work more necessary and less hierarchical. It also helped to create forms and rules for cooperation and interdisciplinary work. Still the different professionals were employed by the same agency and by that forced to adhere to similar principals and goals. Institutions, however, had to cooperate with the education administration in order to find ways for the accreditation of their schooling and professional training, and this was a starting point into multi-agency cooperation.

In the late 1970s in many countries forensic psychiatry started to be more concerned with a continuation of treatment and rehabilitation after the release of

patients from secure hospitals and in transition management from inpatient to outpatient treatment. These developments made it necessary at times to include courts and probation officers in the management plans. This was initially done informally in most cases, based on personal contacts at least as far as the German-speaking countries are concerned. Eventually not only probation officers but also welfare organisations, which provided housing or work for disabled persons, were included into the management of released patients and also into the preparation for release. The agents of the collaboration were not only from different professional backgrounds but also belonged to different agencies.

When outpatient forensic treatment and transition management proved to be successful [4–6], the collaborations were increasingly formalised and even implemented into legal or administrative concepts. The formalisation of the collaboration also meant a shift from a more medical therapeutic principle to a more safety-orientated principle. This included an increasing involvement of the agents of the judicial system and the participation of police officers. When these collaborations started, the intentions of the protagonists from the different professions were varied: social workers had the well-being of the patient in mind, probation officers were concerned about prevention of recidivism and police officers focussed on the safety of the neighbourhood; some were more concerned about avoiding publicity or protecting their superiors from unpleasant questioning. In many cases, however, collaboration created mutual trust and understanding for the position and intention—and restraints—of the other professions, and it helped to speed up information exchange and decision-making and to improve tolerance and support. That again proved to be an effective strategy in preventing relapse and reconviction of former forensic patients. The interactions between the different professionals were guided much less hierarchically but more so by a set of rules which were either provided by laws or by administrative regulations.

These developments were most prominently and formally established in the United Kingdom with the introduction of MAPPA (multi-agency public protection arrangements) and in Germany with the “round table”.

9.4 The “Round Table” in Germany

The German “round table” involves formalised meetings, in which clinical outpatient services, probation officers and police are briefed on an individual’s package of care and consider whether additional measures need to be taken to improve the integration of the patient into the community and the safety of the public. Other professions (providers of housing, community social workers and sometimes lawyers or members of the judicial system) are invited to participate in these meetings as required.

The quality and effectiveness of this multi-agency approach depend on the participants, and at times this has been unhelpful. For example, a police officer informed a community that a released sex offender had been sent to a halfway house located in their neighbourhood. This caused public consternation and the refusal by the

housing department to provide accommodation at the time of release to a 72-year-old man. However, in spite of such incidents, systematic evaluation showed an improved outcome for forensic patients after the introduction of this multi-agency approach [7]. Relapse rates for violent re-offences by patients released from forensic institutions dropped from around 15% [8] to 6% [9] after the introduction of forensic aftercare and to 1.8% following the implementation of the round table into the aftercare of these patients [7]. All studies considered a time at risk of about 5 years.

Recognition of the communication difficulties between round table participants and the potential to learn from other professional groups lead to the development of interagency seminars involving police, forensic psychiatrists and psychologists and the development of common interests and goals [10, 11]. Seminar subjects included the use of psychiatric and psychological knowledge to improve the identification of offenders following a crime and crime scene analysis and integration of crime scene information treatment, risk assessment and risk management, employing a scenario analysis as a model for identifying the contextual variables which precipitate risk and the individual precursors of risk [12].

The development of multi-agency work has had two significant further advantages. Firstly, the feedback to the inpatient institutions led to a much more careful planning and preparation for release of mentally ill offenders from hospital in cooperation with the interdisciplinary aftercare team [13, 14]. Secondly, it leads to a greater focus on prevention. For more than 20 years, it has been acknowledged that forensic psychiatry is part of a system of crime prevention. Prevention however starts earlier than the hospitalisation of a mentally ill offender. It starts in general adult psychiatry where patients should be prevented from becoming forensic patients, and it starts with the young who should be prevented from becoming involved in antisocial behaviours. This is another field for multi-agency work and means collaboration with general adult psychiatry for risk identification and management and with schools in problematic neighbourhoods [15]. The experience with multi-agency work has lowered the threshold for forensic psychiatrists to actively engage with these activities.

9.5 Multi-agency Public Protection Arrangements in the United Kingdom

In the United Kingdom (UK), the multi-agency public protection arrangements (MAPPA) [16] were developed in England and Wales under the Criminal Justice and Court Services Act [17] and updated by the Criminal Justice Act 2003 (Sections 325–327) to manage the risk of harm to others by offenders. Under MAPPA the police, probation and prison services must work together to manage the risks posed by dangerous offenders in the community. There is a statutory duty

to participate in MAPPA for health, housing, social services, education, social security and employment services, the United Kingdom Border Agency, youth offending teams and electronic monitoring providers. MAPPA has three levels of response based on an individual's perceived risk level, media interest and complexity of management, in particular the involvement of multiple agencies in the coordination of care. Level one cases are managed mainly by one agency, whereas level two cases require active involvement of more than one agency meeting complex needs. Level three concerns a small number of very complex cases where the risk of serious harm is considered to be high, and/or there is high media interest. Levels one and two typically involve advice and checking of arrangements for the management of risk; whilst level three will involve a multi-agency public protection panel to review in detail the arrangements for an individual's risk management.

In 2015 there were 68,214 MAPPA-eligible offenders in England and Wales: 73% were registered sexual offenders, 27% violent offenders and less than 1% other dangerous offenders. Ninety-eight percent of cases were managed at Level 1. 222 MAPPA-eligible offenders were charged with serious further offences [18].

In Northern Ireland, a Multi-Agency Sex Offender Risk Assessment and Management (MASRAM) strategy was established in 2001 with voluntary agreements between agencies. The MASRAM arrangements were made statutory and renamed Public Protection Arrangements Northern Ireland (PPANI) under the Criminal Justice (NI) Order 2008. It is similar to MAPPA but has Local Area Public Protection Panels (LAPPP) and has two lay members of the public on its Senior Management Boards. In 2014–2015 in Northern Ireland, there were 1363 sex offenders and 697 violent offenders subject to PPANI: 1896 were on Category l, 142 on Category 2 and 22 on Category 3; 24 were being managed by the Public Protection Team [19].

The Management of Offenders etc. (Scotland) Act [20] established multi-agency public protection arrangements in Scotland. These required that the police, local authorities and Scottish Prison Service established joint arrangements to assess and manage the risk posed by sexual and violent offenders. The National Health Service (NHS) is involved where the sexual and violent offenders are also offenders with mental disorders. Its purpose is exactly the same as that in England and Wales, and its work is supported by the Violent and Sex Offender Register (ViSOR), a UK-wide computer database. In Scotland the National Health Service has developed an information sharing concordat with its MAPPA partners, set up a Forensic Network MAPPA Health Group and delivered training on risk and MAPPA processes through the School of Forensic Mental Health.

MAPPA was introduced initially for registered sex offenders in April 2007 and then for restricted offenders with mental disorders in April 2008 [21]. It also includes other offenders who are assessed by the Responsible Authorities as posing a risk of serious harm by reason of their conviction. In 2015 there were 4544 registered sex

offenders in the community or in custody subject to Level 1 MAPPA, 234 on Level 2 and 9 on Level 3; 3767 were in the community, 331 were reported for breaches of notification, 69 were convicted of a further violent or indecent offence and 11 were wanted (known to be avoiding police detection) [22].

9.6 Safety Houses in the Netherlands

In the Netherlands, the concept of safety houses has been developed to deal with complex issues and to reduce nuisance, domestic violence and criminality by multi-agency identification of problems and solutions and the joint implementation of the latter. These are partnerships involving the criminal justice system, mental health services and local authorities (municipal partners and board). A safety house is not a building but the name for the partnership between several agencies.

Nowadays there are about 40 safety houses in the Netherlands, but their number will decrease to 25 due to merging. Some partners participate in all of them: local authorities, police, prosecution services, child protection agency, probation services and welfare services. Some partners are not yet represented in all safety houses, such as general social welfare and addiction care.

Safety house participants deal with complex cases. These are defined by the following criteria: there are multiple problems in one or more areas of living that will result in criminal behaviour and/or nuisance or further social decline; cooperation between partners in multiple areas is required to achieve an effective approach; the problem is influenced by and has an impact on the family and social system and/or the immediate social environment (or is expected to have an influence on it); and there are severe local or area-specific safety problems, which require a multiple service response approach.

The major areas of work for safety houses involve juvenile offending, domestic violence, care packages for released detainees and recidivism. The Ministry of Safety and Justice developed a national framework to improve transparency and consensus about the work of safety houses but left room for local initiatives [23]. There are four components to the work of the safety houses:

Person-oriented: Adult repeat offenders, criminal youth and domestic violence offenders are given a person-oriented approach. On the basis of an individual plan that is drawn up jointly by the partners, the offender will get community service, a fine or imprisonment or a mental health disposal. The aim of this person-oriented approach is to detect violent offenders quickly, to punish them effectively and to monitor them closely. Partners, such as prosecution and youth care, investigate what is known about an offender. This allows the judge to impose conditional sentences tailored to specific conditions.

Territorial: Each of the 25 safety regions in the Netherlands have at least one safety house. Each municipality in this region can join the safety house. Due to this territorial approach, partners can easily anticipate problems in specific areas or neighbourhoods, such as tackling nuisance behaviour.

System aimed: Partners examine the system, such as the family or group, in which the offender operates. Interventions can be targeted to the family or group when appropriate.

Victim-oriented: Support for victims can be provided by provision of information, mediation or assistance in filing a written victim statement.

In 2014 a "Privacy Governance Guide to Safety Houses" was published [24]. This guide is a practical tool for the sensitive handling of personal data in and around the safety house. This processing of personal data may conflict with the right to privacy of the individual. The guide has limited advice on what is permissible as the legality of data processing is based on the individual circumstance in which it was done.

9.7 Denmark

In Denmark multi-agency working between the police, social services and psychiatry has been developed [25]. It is known as the PSP cooperation. This has been in place as a national system since 2009 but was originally developed by one police force in 2004 following concerns about their ability to handle vulnerable individuals who because of their social problems, mental disorders or substance abuse and multiple needs did not get the required services. The PSP cooperation is organised at a managerial and an operational level. Both involve one representative from the three bodies either at a managerial level or an experienced level, respectively. There is always a coordinator who is a member of the managerial group. The managerial group meets quarterly and has responsibility for the development of the overall framework and training. The operational group meets monthly, works on specific cases and coordinates actions between the involved bodies. Typically, in one area between 1 and 3 individuals were discussed at each operational group meeting. This system applies currently only to individuals over the age of 18.

Attendance by members is compulsory. Each meeting is minuted. The PSP cooperation pulls together information about vulnerable individuals and their situation in order to acquire the services of the most appropriate body. Actions will be designated for one body. Amendments to the Danish Judicial Code, to the Administration of Justice Act and Processing of Personal Data Act in 2009 have reduced concerns about professional confidentiality.

An evaluation of the PSP model was carried out using two qualitative studies between 2008 and 2010 [25]. It was found that the PSP cooperation reduced social disruption and crime in the vulnerable individuals identified and provided improved support. The bodies concerned identified improved service coordination, feedback and sharing of experiences as major benefits of the PSP cooperation. These findings are based on qualitative research rather than on specific data.

9.8 Elsewhere in Europe

The Ghent Group, an established cohort of forensic psychiatrists interested in education and research, was used as source of information in multi-agency working in other countries ([26]; www.ghentgroup.eu). No other structured system of multi-agency working was described. Many countries, for example, Switzerland, have a system whereby intermittently round table discussions do take place. Similarly, in Italy occasional meetings are held about individual patients between local mental health units and judicial services with the aim of tracking the patient, but this depends on individual and local sensibilities and availabilities. All countries, for example, Spain, described some form of probation service, but this is specifically for sentenced prisoners on release. Portugal has a Technical Committee within prisons that is responsible for advice on individual treatment programmes, appraising results and suggesting options, on any proposed changes to the courts concerning penal conditions, on the implementation of disciplinary measures to prisoners and on the matters that are brought to the attention of the judiciary. Some countries, such as Ireland, described joint working and established committees on policy between health and justice. This was not about specific cases. Some countries gave examples of specific multi-agency clinical initiatives such as a clinic for the "triply troubled" in Sweden with joint working between forensic psychiatry services, the Centre for Dependency Disorders and the Probation Services [27] or the Serious Offender Liaison Service in Scotland [28], but neither is available across their entire country.

9.9 Improving Multi-agency Working

These four examples of multi-agency working in Germany, the United Kingdom, the Netherlands and Denmark demonstrate some of the issues involved with this approach. The potential advantages of multi-agency working include a sharing of the burden of responsibility, particularly in the event of an adverse outcome; clarity on responsibilities, for example, a clear statement on which service and which individual will do what, within a specified timescale and at a specified place, with actions to be taken if this does not occur; engagement with difficult people that might otherwise be rejected by mental health services; a reduction in cost to society—for example, in Bavaria, violent recidivism reduced from 12% to 1.2% following the introduction of multi-agency working [7]; encouragement of informal collaboration and development of relationships; case review and broadening the perspective on a case from a particular professional standpoint alone; improvement in continuity of care; promotion of sharing of information on a proportional basis; and shared educational opportunities. Potential disadvantages include breach of confidentiality and sharing of information in a nonproportional way; continued intrusion into an individual's life; and cost of multi-agency

working both in terms of infrastructure financing and opportunity costs due to meetings.

Conclusion

It is our view that the advantages of multi-agency working out way the disadvantages but that more should be done to improve this. This should include educational visits between different agencies to improve understanding of their purpose, working methods and organisation; development of training in multi-agency working; creation of a multi-agency peer review system to examine services, issues and educational requirements; promotion of a statutory framework to multi-agency working; research to determine outcomes from multi-agency working; adequate resourcing; development of information sharing protocols including guidance on balancing confidentiality against information sharing to allow management of risk [29]; and establishment of rules of working such as duty to attend, time limits, role of the chair and clarity of purpose, that is, the reduction of risk of harm to others.

Take-Home Messages

- Multi-agency working in forensic mental health is defined as the coming together of people from different professional backgrounds, organisations and services, sometimes with varying primary purposes, but with the common aim of improving public safety and decreasing an individual's risk of harm to others.
- Specific systems for multi-agency working in Europe include the round table (Germany), multi-agency public protection arrangements (the United Kingdom), safety houses (the Netherlands) and police, social services and psychiatry cooperation (Denmark).
- Potential advantages of multi-agency working include a sharing of the burden of responsibility, clarity on responsibilities, engagement with difficult people that might otherwise be rejected by mental health services, reduced recidivism, encouragement of informal collaboration and development of relationships, case review and broadening the perspective from a particular professional standpoint alone, improvement in continuity of care, promotion of sharing of information on a proportional basis and shared educational opportunities.
- Potential disadvantages include breach of confidentiality, continued intrusion into an individual's life and cost of multi-agency working both in terms of infrastructure financing and opportunity costs.

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10 The Roles of Forensic Psychiatrists and Psychologists: Professional Experts, Service Providers, Therapists, or All Things for All People?

Thierry Pham and Pamela Taylor

10.1 Forensic Mental Health Professionals in Europe

The practice of forensic psychiatry varies between European countries, but our core values and recognition of its various possible roles have much in common. Where there is speciality recognition in the field of forensic mental health, other clinical professionals generally subscribe to a similar position. For forensic psychiatrists, the common ground is sufficiently great that the Ghent Group, an informal group of forensic psychiatrists from all European Union countries, readily agreed on a definition of forensic psychiatry (http://www.ghentgroup.eu/). This had to support the various roles in the speciality and acknowledge its medical roots and ethic. The extensive knowledge base required includes, but is not confined to, psychological medicine in all its aspects, relevant law, criminal and civil justice systems, mental health systems, and the relationships between mental disorder, antisocial behavior, and offending. The highly specialist skills required to encompass risk assessment and management, the giving of evidence in court and the management of care and treatment in secure settings. We recognize the developmental roots of offending and disorder (singly and in combination) in histories of victim experiences and failures of attachment and the relevance of these to the prevention of further victimization. The Ghent group definition of forensic psychiatry is:

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– A specialty of medicine based on a detailed knowledge of relevant legal issues, criminal and civil justice systems, and the relationship between mental disorder, antisocial behavior, and offending. Its purpose is the care and treatment of mentally disordered offenders, and others requiring similar services, including risk assessment and management and the prevention of further victimization.

Once it is acknowledged that care and treatment of offenders with mental disorder are at the heart of our work, then it is also apparent that in almost every role, there are tensions to be recognized and resolved if all relevant roles are to be taken up effectively and ethically. This is not unusual in medicine, since in any specialty, there are occasions when the well-being and wishes of the patient, generally the guiding principle for any doctor, cannot be the only consideration. Anyone with a highly infectious or contagious condition, for example, will require the best possible care and treatment for that condition but, on occasion, may have to be treated in isolation from others, whether s/he wishes to be or not, because of the seriousness of the condition should it spread to others. Perhaps the most often tension considered for forensic mental health clinicians is the interface between having a person in treatment as a patient and being requested to provide expert evidence to a court on some aspect of that individual's suffering or behavior. If an individual is taken into forensic mental health services, however, someone has to take legal responsibility for that individual's care and control and confinement—"the responsible clinician"—which means that s/he will be closely involved in defending continuing detention or petitioning discharge. To what extent can such a "custodian" also be a therapist? Then, by definition, forensic mental health professionals not only work within a multidisciplinary clinical team, where ethics and standards of behavior can generally be agreed with relative ease, but most also have an interagency role which works with the courts but extends far more widely too. This role relates most closely to public safety and membership of such groups and processes, such as the Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales, as described and regularly updated by the Ministry of Justice (www.mappa.justice.gov.uk), with professional guidance provided by the Royal College of Psychiatrists [1] or the Round Table in Germany [2]. Under such conditions, clinicians find themselves required to share usually protected clinical information, albeit the minimum necessary, with the police, housing bodies, and other community agencies with entirely different but no less valid concerns and ethical models than clinicians. Another aspect of promoting clinical safety is enshrined in duties to victims of the actions of offender-patients. In the UK, for example, roles in this respect are embedded in law—The Domestic Violence, Crime and Victims Act 2004. In the criminal justice system, victims and offender issues are explicitly covered by different people, but there is a disproportionately high likelihood that patients in forensic mental health services have attacked someone within their family, or close social circle [3] means that these roles can rarely be so neatly circumscribed, bringing an extra tension to them. Duties to inform the victim about review hearings and support them in giving evidence to these if they wish, generally fall to dedicated staff within the probation service, but the patient's responsible clinician must be satisfied that this

has taken place and cooperate with the necessary process. The victim may be allowed to specify conditions of release, such as limits to where the offender patient may live or travel, and the clinical team must abide by these too. In still further roles—and the tensions inherent in them—we have more in common than not with other clinical specialties, but still they have to be acknowledged and kept under review. Teaching and training, research, service development and management, standard setting and monitoring, and public advocacy for our service users and their services are all tasks at the core of good practice. While many of the tensions in these roles will be around time management—the balance between time given to reviews and time allocated to actual clinical care—we also have to be able to deal with such matters as confidentiality when outside agencies need good enough information to complete an adequate inspection. When people are in desperate need of services but in our considered judgment those services cannot be delivered effectively, when should we make this a matter of public debate? When should we walk away from trying to deliver a service that we have grounds for judging inadequate? These last are not idle questions for an exercise in debate. In England and Wales, for example, where a number of prison officers have been cut in the face of a continuing rise in the prison population and well-documented contemporaneous rise in suicide, self-harm and assaults, at least one forensic psychiatrist makes the decision to walk away from a service that she thought could not be delivered adequately rather than risk colluding in any pretext that the existing situation can be supported. Even the highest quality mental health services in prisons are dependent on adequate general prison staffing for ensuring appropriate and timely access to prisoners.

10.2 Psychologist Roles

Haward [4, 5] detailed the expert roles of psychologists as: "clinical," "actuarial," "advisory," and "experimental." For psychologists, even the most frequently requested role—the clinical—relies much more on formal testing than it would for psychiatrists. The psychologist would generally use tests with established reliability and validity of, for example, IQ, personality characteristics, or neuropsychological functioning, although, in some part, the training of clinical psychologists is now viewed as preparing them for the task of diagnosis [6].

Actuarial roles involve offering statistical probabilities of an event. While a plethora of risk assessment tools have been developed, investigated and reported in the literature, in the field of mental health, it is exceptionally difficult to use even these in real-life situations. Systematic reviews of research evaluation of these tools show the apparent limits to their predictive power in practice (e.g., [7]). Although hard to prove, this is more than likely due to the fact that when used in clinical practice, they are coupled with risk management. Perhaps in this context, we should be disappointed that these tools do not apparently seriously overpredict dangerous behaviors, but the low base rate of serious offending is another relevant explanation here. The great advantage of these tools is that they can produce improvements in transparency of how risk determinations are made, although a

potential problem is that any attempt to present information numerically—as risk scores—can give rise to implications about their scientific strength which are not justified. In other circumstances, in the UK, a pediatrician's use of probability estimates of the chances of "cot death" explaining the deaths of two babies was a major factor in their mother being convicted of killing them. The impressive sounding estimates were, however, wrong and led not only to a miscarriage of justice in this case but also in a series of similar cases. The Royal Statistical Society considered the matter and issued guidance on communicating expert statistical evidence in court [8].

The evaluation of competency provides an illustration of the evolution of forensic psychology and of how the advisory role has developed. Determination of competency is a court decision based on clinical opinion, and never, in law, a clinical decision. Nicholson and Kugler [9] conducted a review of comparative research on defendants tested for competency to stand trial before the criminal courts. They found 30 studies encompassing 8170 people between them. In terms of effect sizes, the strongest characteristics related to incompetency were (a) poor performance on psychological tests or interviews specifically designed to assess legally relevant functional abilities, (b) a diagnosis of psychosis, and (c) psychiatric symptoms reflecting severe psychopathology. To a lesser degree, traditional psychological tests, previous psychiatric hospitalization, previous legal involvement, marital resources, and demographic characteristics were also related to competency status. Thus, bringing together a mix of loosely structured and more rigidly structured assessments may be optimal.

Perhaps one of the most exciting areas in which psychologists have contributed to court work is that of relevant "experiment." Gudjonsson has taken a leading role in this field. While perhaps best known for his development of tests of suggestibility, which, in the UK have been so crucial in avoiding or helping to overturn miscarriages of justice (e.g., [10]), he has also shown how tailoring tests to the needs of individual cases can shed light on limits to competence or on relevant but highly specific deficits. An example of the former was to elucidate the extent of abilities of a young woman with intellectual disability to give accurate evidence to the court about her assailant; the defendant's lawyers introduced arguments that she was wholly incompetent, but tests devised for the specific circumstance showed that in crucial areas of, for example, visual identification, she could be accurate and have accurate recall [11]. In another case, a man had inexplicably attacked his wife; through detailed neuropsychological testing, he was able to offer an explanation which was accepted by the court [12].

In the domain of civil law, there is an increasing demand for clinical neuropsychologists to assess and testify on disability and individual injury in compensation cases. In the domain of domestic and family law, clinical forensic psychologists play is also expected to play a substantial role [13]. Furthermore, many jurisdictions allow expert testimony on whether a child has been the victim of sexual abuse, an area where Gudjonsson's work on suggestibility is also highly pertinent. Heltzel [13] outlined the extent of the legal system's "voracious appetite for information." Ireland's [14] work, which evaluated the quality of reports to the family court, provides

evidence of the importance of both qualifications as an expert and maintaining relevant experience if the quality of reports is to be sustained. She happens to be a university professor of psychology, so focused on psychology reports. Given the very personal hostilities toward her that this important work precipitated, it is perhaps unlikely to be repeated with psychiatrists, so psychiatrists must take these lessons from psychology for their own work.

10.3 Treating Clinician or Expert Witness?

While forensic psychiatrists may be called to give evidence in court as witnesses of fact, in which case, their duties are the same as for any other citizen, they are generally called as expert witnesses. An expert witness is defined by training and/or experience, with a requirement to assist the court in matters outside the knowledge or experience of the court. There are the same expectations of an expert in respect of relevant matters of fact relevant to their argument—to report truthfully and accurately—but the important difference between witnesses merely of fact and expert witnesses is that the expert is not only allowed to express opinions but expected to do so. An obvious concern that follows from this is that opinion is susceptible to conscious and unconscious biases and that a professional clinician who is treating the person for whom she/he is providing the report may have a quality of relationship with that person that renders bias inevitable. The next common assumption is that the bias will necessarily favor the individual; this is not necessarily the case. Any lengthy relationship between clinician and patient may lead to negative countertransferences as well as positive regard. Some authors, such as Strasburger et al. [15], have argued that the processes of psychotherapy and expert forensic mental health evaluation for the courts are fundamentally incompatible, and create an irreconcilable role conflict such that combining the tasks should be avoided whenever possible. Others (e.g., [13]) have argued to the contrary that there is no justifiable reason why a competent psychologist (or psychiatrist) cannot and should not conduct an objective and appropriate evaluation of a patient seeking clinical services as a basis for the treatment. In common law countries, the concern may be less about whether the expert is also treating the defendant or plaintiff and more about who has commissioned the report. The General Medical Council (GMC)—the UK's professional body for all doctors—warns:

"*You have a duty to act independently and must not be influenced by the party who retains you*" (GMC 2008) [16].

In the UK, a distinction is sometimes made between an expert witness and a professional witness, the latter, by definition having had professional clinical involvement with one or more of the parties involved in the case. Full transparency about the level of training and/or experience that qualifies the expert witness to take that role and about the nature and extent of any relationships pertinent to the case is seen as the most crucial issue. An important problem is that there are few empirical data on which to offer any guidance in this area.

Ghent group members came together to debate the issue, and this work was reported and supplemented by a systematic literature review and a survey of forensic psychiatric representatives from each EU jurisdiction [17]. Almost all published literature proved to be polemical and, thus, itself biased. The one directly relevant empirical paper showed good agreement on diagnosis between treating clinicians and independent experts, except in the case of the rarely diagnosed (in this context) anxiety disorders or the attribution of psychosis to substance misuse (kappa 0.3—significant but weak) [18]. The European expert survey highlighted differences in practice between countries, so the conclusion was:

On current evidence, either separation or combination of clinical and expert roles in a particular case may be acceptable insofar as there are national legal or professional guidelines on this issue, anyone practicing in that country must follow them and may safely do so, regardless of practice in their native country. The most important ethical issue lies in clarity for all parties on the nature and extent of roles in the case ([17], p. 271).

10.3.1 Some Notes on the Belgian Legal System

The Belgian legal system is inquisitorial. For further description of the inquisitorial system (and the adversarial system), see the chapter on Adversarial versus inquisitorial legal systems. This section will address the issue when a judge examining the case relies on a single expert clinical witness for guidance on the likely role of mental disorder in the offense and on clinical needs. There is no official list of experts in Belgium nor nationally accepted guidance on the style and content of expert reports. A project to devise and implement a mandatory form for them is, however, underway jointly between the Ministries of Justice and Health. The principle of separation between clinician and expert is at one end of a continuum, with "expert evaluation" and "treating" clinical teams in prison. The psychiatrist, surrounded by several psychologists, working in evaluation teams, is asked to assess personality, cognitive, and risk characteristics. All prison psychologists have a clinical background. Some have a specific forensic psychology background organized by several universities only, not all of them. Once engaged by prison authorities, all psychologists follow further specific training (e.g., dynamic risk assessment evaluations) co-organized by prison authorities. In the beginning of the 1980s, there were hardly any psychologists in Belgian prisons; today, there are 166 for a prison population of around 10,600. Since 2014, the average number of new receptions into prison annually has been just in excess of 400. The main tasks of these psychologists are to inform courts about individuals appearing before them, thus assisting the court to make sentencing decisions and, later, to provide reports for the prison authorities to help make release decisions. These clinicians also oversee interventions and rehabilitation programs for offenders while they remain in prison and have a so-called pre-therapeutic role. These psychologists prepare offenders for psychotherapy or rehabilitation and supervision in the community. However, there is no specific structure treatment nor transition programs in Belgian prisons.

Belgium differs from many European countries in that most people found not guilty by reason of insanity—called "internees"—are held in prison while they are supposed to be treated in secure hospitals.

Since 1930, Belgian government approved a law called "social defense" in order to "protect society against criminal behavior." Since then, "internees" who are severe mentally disturbed people, who have committed criminal acts, never get punished for their criminal acts but are criminally insane and in need of psychiatric care to prevent them from committing any further crimes. This law has long been the landmark to organize forensic psychiatric care in Belgium. However, after a number of cases heard before the European Court of Human Rights [19, 20], two new secure hospitals opened recently. For those prisons in Belgium which have a designated psychiatric unit, traditional multidisciplinary clinical teams treat offenders, most of whom committed their offenses while mentally ill and are internees. These professionals are involved in therapy and rehabilitation efforts and no social or clinical information passes between evaluation and therapy teams. This situation, designed to abolish the dual role conflict, has created some frustration between "evaluation" and "treatment" professionals and prisoner-patients alike. Indeed, "treatment" clinicians complain that assessments have to be repeated needlessly, while "evaluation" professionals complain about inability to access information on progress which would be relevant to release decisions. Inside the forensic "social defense" system, there is no strict separation between evaluation and therapy. From the beginning and until their definitive release, every 6 months, such people are examined before a court which considers evidence of mental state change and readiness for release into society. Although some [21] recommend a strict separation between the evaluation and treatment teams here too, the system rather supports the bringing together of evaluation and therapy efforts to maximize benefits for offenders and public alike.

Conclusions

When assessing or treating offenders who have mental disorders, lead clinicians often find themselves combining clinical and legal roles. Concerns about doing so seem to crystallize out most prominently in respect of giving evidence in court or to legal bodies—so much so that some countries proscribe the dual role. Experts are the only witnesses called to give evidence in a court of law who are entitled to offer opinions. This privilege should not be blindly extended to guidance on giving such evidence. It is possible to apply rigorous research to determining best approaches, given knowledge of the concerns which attend the potential complexities of the role, but difficult, not least because ethics committees still struggle to provide the necessary range of expertise to consider research proposals such a field [22]. Reasonable concerns have been cited in respect of, in effect, exceptional potential for offering biased opinion if the person providing the expert report is also the treating clinician. Less often expressed, but no less a concern, is that material which should perhaps properly remain confidential to the clinical relationship cannot it the treating clinician takes on expert roles. Research could identify the nature and extent of such biases, if any, and the nature and extent of harm, if any—to offender-patient or the wider public—when

the treating clinician draws on all information to write a report. The fact that different jurisdictions do operate different approaches to this dilemma suggests that there is no absolutely correct approach, which in turn should reassure ethics committees that there would be nothing unethical in a research comparison of the different approaches.

Take-Home Messages

- Most clinicians will at some point in their career find themselves acting in several roles in relation to a patient, but tensions in this fact are particularly likely to arise for those working between health and criminal justice systems.
- Professional bodies are increasingly providing guidance on how to manage such competition, and clinicians should always follow their professional code and guidance as far as possible, consulting with other clinicians in the field and/or legal advisors if there is any risk of breach.
- There is, however, almost no evidence base for many aspects of such guidance.
- This position could be changed, with interest from and determination on the part of the research community.

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Forensic Psychotherapy in Forensic Mental Health

11

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11.1 Introduction

In this chapter, we pay attention to the implications of speech and language in the forensic psychotherapeutic talking cure (§2). Especially in forensic mental health, the role of the committed crime is of central importance (§3). The institutional embeddedness of treatment in forensic mental health is discussed in §4 based on the experiences in the Netherlands. The rich historical development of this professional super specialism in the United Kingdom is outlined in §5. Its contribution to research is reflected in §6 and to teaching and training in §7. We conclude this chapter with attention for the international forum of forensic psychotherapy in §8.

11.2 The Role of Speech in Forensic Psychotherapy

Forensic psychotherapy is a talking cure. We ask our patients to talk about their offence, about their lives and about very intimate aspects of those lives, such as their romantic relations and sexuality. Moreover, we ask them to talk truthfully and frankly about these topics, frequently in the presence of other patients. This is a not an easy task. In addition, it is often assumed that offenders are not particularly good

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at this task because they have the tendency to minimalise their offence, to misrepresent the facts and to exaggerate the role of the victim [1, 2]. Such minimalising and legitimising is known as cognitive distortion and is used by offenders to waive their responsibility. The idea that 'Criminals do not think like law-abiding prosocial people' [3, p. 2] is taken as a fundamental idea in some types of treatment programmes for offenders. But how can we provide psychotherapy if we assume that the patient is not up for the task? How can we listen to the patient who we assume is distorting the truth? This will require us to question the role of speech in forensic psychotherapy. Let us start with an anecdote.

> *A man goes to a forensic psychiatric institution for an admission interview with the psychiatrist. He has prepared for this interview very well by reading through the information leaflet and checking the website in order to know as much as possible about how the institution functions. He is really motivated to start treatment. What scares him though is the fact that he will have to talk about his sexual offence to a group of patients. In order to make a good impression, he talks very honestly during the assessment interview; he talks about the offence and about his sexual attraction to children. The psychiatrist takes notes. When the man stops talking, the psychiatrist raises his head and says: 'So you deny your problem'. The man is astonished and asks the psychiatrist how he reaches that conclusion. 'You do not use the word paedophile to describe yourself, so you deny your problem'. The man responds that he is not a paedophile because that word literally means friend of children, and his deeds have nothing to do with friendship for children. The man is refused for the treatment programme.*

In our interpretation of this anecdote, the man and the psychiatrist reached an impasse because of a misunderstanding arising from their very different way of using words. The psychiatrist seems to have a set perspective and pattern of expectations about what he wants to hear from the patient. He seems to assume that 'paedophile' is the only correct way of describing the man and his crime. The sexual offender, on the other hand, seems to be investigating the meaning of words, deliberating which are best to describe himself and his deeds. The latter way of handling language is known in psychotherapeutic practice: an aspect of psychotherapy is about finding the words to describe yourself, your problems and others and constantly deliberating whether these words are both correct and specific.

The psychologist Jerome Bruner referred to this use of language as the narrative modus [4, 5]. The narrative modus refers to our use of language as a means of formulating the connections between events over time and trying to establish a sense of temporal continuity and coherence in the subjective experience; it relates to giving meaning to experiences through storytelling. Those stories are about 'human or humanlike intention and action and the vicissitudes and consequences that mark their course' [4, p. 13]. Stories represent what people want and how they want to reach this. Through narratives, we try to organise the complex and often ambiguous world of human intentions and actions in a meaningful structure.

In forensic psychotherapy, patients use a similar narrative modus. They talk about their experience in the present and past and try to give meaning to the events. A narrative is an act of interpretation because it provides an explanation of what happened and why it happened. In the process, individual experiences and circumstances are compared with broader social, cultural and moral frameworks of meaning. In the case of a person talking about something he or she did wrong—an

offence—the story emerges as a result of the ability to engage in a moral negotiation about what happened [6, p. 291], why it happened and what that means.

From this perspective, it is delicate to say that the tendency in offenders to minimalise and legitimise their crime reflects their personality; such 'cognitive distortions' need to be conceptualised as something people do rather than something people have as a psychological feature [7]. The use of cognitive distortions is no evidence for the fact that offenders think differently in comparison to prosocial people, but it illustrates that the person is trying to give meaning to what he did and who he is. The psychological literature on cognitive distortions establishes that taking full responsibility for every personal failure is not synonymous with healthy functioning—indeed such behaviour would be rather unusual and possibly a sign of mental illness [8]. Social psychology has demonstrated that people have the tendency to explain problematic behaviour in terms of external, uncontrollable and non-intentional causes [8]. To a certain degree, such explanations are adaptive because they give more resilience and self-confidence to people.

However, this does not mean that the speech of offenders should be taken at face value and that minimising and legitimising should be accepted. We would argue that the aim of forensic psychotherapy is to stimulate the narrative search for the meaning of the criminal offence, the meaning of the motives, the meaning of the aggression or sexuality implied in that act, the meaning of events from the past (traumatic and others) as precursors for the act and the meaning of the juridical label that is bestowed upon them. A particular challenge in this process is the fact that many of the topics that are subject of meaning-making in forensic psychotherapy are so difficult to formulate. As the crime often contains unconscious as well as conscious elements, the offender often has difficulty understanding the reasons that lie behind his or her crime, let alone the capacity to explain these to others. Consequently many offenders reach a point where their motivation to commit the offence is obscure to themselves. This is the moment when they will resort to psychological defensive manoeuvres such as rationalisation, denial, minimisation and blaming. The forensic psychotherapist, who is aware of the role of speech in therapy, will strive to provide the patient with a safe context to think and speak, will keep his own mind open to hear the patient and will help the patient to be curious about his own mind, motives and actions to a degree that the patient can tolerate [9].

11.3 Crime: Both a Meaningful and Meaningless Act

Within forensic psychotherapy, we assume that it is effective to talk to our patients about the crime they committed. This is because offences are not purely an expression of certain personality traits and situational determinants. Crimes and patterns of criminal behaviour have psychic determinants that are rooted within the unconscious mind. Crimes can be considered symptoms of unconscious conflicts, and their meaning can be unravelled and understood within treatment. These ideas stem from psychoanalytic theory and also apply to the treatment of non-forensic patients. Freud [10] pointed out that patients often find it painful to talk about the origin of

their symptom; rather they will act the symptom out. For example, a patient might not remember that he was defiant towards his parents' authority; instead, he acts defiantly to authority in his workplace. Freud viewed symptoms or actions as mnemic symbols which reproduced, in a repetitive way and in a more or less disguised form, elements of past conflicts in the present [11]. In Freud's words "A thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken" [12]. So rather than thinking that a patient's attitude is the expression of his personality, Freud saw it as the repetition of earlier elements in the patient's life. However, Blumenthal (ibid) notes that it is a characteristic of forensic work that what is forgotten appears, not in ghostly form but in action. The following anonymised vignette is provided as illustration.

> *A young man came to treatment for the possession of child pornography. After a number of misfortunes in his life, he had become depressed and had become heavily engaged in a clandestine online community of people who share pornographic imagery. What stood out of this period of illegal activities is one message he had send to all members in this community: 'Which daddy wants to hand over his child to me, I'll treat her very well?' Shortly after, he was arrested. During treatment, he talked about his childhood and how his parents hadn't been able to take care of him. He had resided in foster care for a number of years. It became evident that questions about why his parents had failed to take care of him and why they had handed him over to a foster family still troubled him unconsciously. Considering his life in retrospect, he came to see that his period of depression had brought these issues back into his mind. His crime could then be understood as a repetition, through acting out, of conflicts around this painful childhood experience. The question 'Which daddy wants to hand over his child…?' could be reformulated as 'What kind of daddy hands over his child to foster care?'*

So the crime had an unconscious meaning if we consider it from the perspective of his earlier life experiences and their legacy in the patient's internal world. In this case, it enabled us to orient the treatment to helping the patient work through the questions and conflicts in relation to his parents and parenthood that were troubling him. The unconscious meaning of the crime is highly specific to the individual and can only be understood within the broader context of the patient's life.

Although a crime has an unconscious meaning, there is always a meaningless aspect to it as well; meaning and lack of meaning are the two sides of a coin. The meaningless side of a crime relates to the sexual or aggressive drive behind the act. The primary forces of sex and aggression are buried so deep in our psyche that they are (partially) alien to ourselves. We might gain some understanding of these primary forces through psychoanalysis, in particular through the analysis of our dreams, but, for the most part, they are repressed from conscious awareness. These ideas originate in Freud's work described in his paper on 'Instincts and their vicissitudes' [13]. Freud posits that the sexual and aggressive drives are at the frontier between the somatic and the mental. In other words, as the drives are rooted within the body, they cannot be fully grasped psychically. The individual can develop a partial understanding of his sexual and aggressive drives, but there will always be a part that he cannot put into words.

Studies on the antecedents of crime have shown that committing an offence is preceded by certain negative life events [14, 15]. On the offence trajectory, there is a period where the sexual and aggressive drives start to manifest themselves in sexualised or aggressive feelings, thoughts, rumination, phantasies and behaviours. This period varies in length, but it is at the moment of the crime that these drives manifest themselves most clearly. This means that the offender is confronted with a part of himself that he neither knew nor probably wants to know. Since sexual and aggressive forces are related to the motives of the crime, it is particularly difficult for offenders to fully understand and disclose the motives underlying their offence [16]. That's the reason why very often, offenders produce unsatisfactory or even contradictory explanations about their offence: everything they say is in some respect beside the point. They lack the words to express what it's really about.

11.4 Forensic Psychotherapy Embedded in Forensic Mental Health Institutions

In the Netherlands, influenced by pioneers such as the criminal lawyer Willem Pompe, the criminologist Ger Kempe and especially the psychiatrist and lawyer Pieter Baan, in the second half of the last century as a reaction to and an alternative to strong custodial-based TBS hospitals (hospitals for treatment of mentally ill offenders under a special criminal law sanction), an emphasis on a more psychotherapeutic-oriented method came in vogue in Dutch forensic psychiatry [17]. The Utrecht Dr. H. van der Hoeven hospital was designed as a secure and controlled therapeutic environment. A few key elements were crucial in the therapeutic approach. Pieter Baan was strongly influenced by the ideas of Maxwell Jones who pioneered the use of small therapeutic group in his treatment model. The therapeutic community approach grew from dissatisfaction with both the strict medical approach to mental health problems and with the hierarchy of the organisation. Maxwell Jones prescribed a number of conditions that the community must meet in order to work as a therapeutic community, a reciprocal communication at all levels of the organisation, shared leadership and decision-making at all levels and consensus in decision-making and social learning through social interaction in the here and now. In addition to the Dr. H. van der Hoeven hospital, most other forensic hospitals embraced the therapeutic community model adopting key elements of this approach. The group is a central part of treatment; on a daily basis, the patient shares many of the experiences with the staff and fellow patients. The challenge for therapists in this treatment setting is to confront the detainees with external reality and the demands of everyday life. The hospital is considered as a protected and protective environment where residents can practice and experiment with new behaviour [18], a special and safe environment for re-education.

Contact between patients and their families is an important tool in the therapeutic approach, along with opportunities for work, education, sport, education and leisure activities. In recent decades, the original model of the therapeutic community has given way to a grafted environmental therapy, which has incorporated some

principles of cognitive and behavioural therapy [19, 20]. The Dr. H. van der Hoeven Hospital is now recognised as the forensic psychiatric centre where the most far-reaching group therapeutic approach has been implemented. In his contribution, 'The forensic psychiatric hospital as a therapeutic tool' Blankstein [18] concisely describes the position of the hospital. 'But a hospital is more than the sum of a number of treatment moments. There is a specific emotional climate, which is reflected in the attitude of all practitioners and other hospital staff. This climate is also fuelled by formal and informal rules and codes of conduct, which both have impact on the staff contacts with the residents as well as to the handling and methods of collaboration between staff members. This climate pervades all treatment contacts and often transcends the power and influence of a particular treatment sector or practitioner. This emotional climate, with its translation into rules and codes is supportive for certain approaches, but can neutralise or even fundamentally disempower other approaches'.

Van Marle [21] in his dissertation entitled *Een gesloten system* ('A closed system'), describing a psychoanalytical frame of reference for the care and treatment of TBS patients, emphasises the importance of the therapeutic milieu as a holding and containing environment. In this perspective, the psychiatric ward is perceived as a substitute for the family. Due to the many restrictions and constraints necessary in a forensic institution, patients' transference feelings come to the fore strongly and are often directed at therapists or socio-therapeutic workers. Also the concept of the hospital as a substitute mother has a meaning that goes far beyond the mere idea of a building where patients are being treated. Van Marle's description is based on the Dr. S. van Mesdag Hospital in Groningen, a forensic psychiatric hospital for treatment of TBS patients. Although its psychodynamic roots can still be traced in daily practice in the hospital, nowadays cognitive and behavioural approaches are dominant.

The TBS measure for treatment of mentally ill offenders requires that, within the secure environment of the hospital, the detainee should be able to 'experiment' with other behaviour. Changing one's own behaviour is difficult for the offender and is often met with both conscious and unconscious resistance; however, effecting change is even more of a challenge when it is required by the criminal court. Treatment as part of the TBS measure starts in the closed protected and protecting environment of the hospital. Inherent to the treatment process in the TBS system is that the treatment team gradually facilitate increasing amounts of freedom and leave for the offender under strict security safeguards and risk management protocols. Within the TBS system, security and treatment are closely interlinked so that successfully increasing the patient's freedom of movement is seen as marker of treatment progress but only occurs if clinically justified and requires robust and vigilant risk management [22, p. 179].

There is often a tension between restricting a patient's movement and the patient's wish for freedom. In recent years, partly because of public discussions following several serious incidents, an emphasis on security as oppose to treatment has permeated the patient management within the TBS hospital. This shift has been reinforced by the development of more risk-adverse societal attitudes. Some have argued that

this pendulum swing towards security has compromised the detainee's rights. The incorporation of a mentalisation-based approach into the therapeutic programme of the forensic psychiatric hospital at Assen [23, 24] has helped enhance acceptance of the regime and the rules and increases motivation for treatment as shown in recent research. Within a mentalisation approach, a mentalising stance requires the clinician to prioritise and be curious about the patient's state of mind, as oppose to his behaviour, and explore and make explicit differences in perspectives [25]. This approach is entirely in accordance with the theory of *procedural justice*. The concept of procedural justice deals with the conditions in which people experience authority, regardless of the outcome of specific decisions. Important conditions are that people feel heard, trust the authorities, feel that they are treated with respect and have the feeling that decisions are made impartially. In the context of the forensic system, it will mainly depend on the quality of the relationship whether the requirements of procedural justice can be met. Good contact between the staff and detainees, where one can communicate with openness and trust to some degree (however, tricky this can be in a closed institution), has a positive effect on the experienced *safety* [26].

11.5 The Historical and Conceptual Roots of Forensic Psychotherapy in the United Kingdom

In the United Kingdom (UK), the discipline of forensic psychotherapy has developed mainly within the National Health Service (NHS), as opposed to the Criminal Justice System, and was pioneered by psychiatrists and forensic psychiatrists, many of whom were also psychoanalysts and group analysts. Although there were several pioneers who worked independently in prisons and secure forensic units, the institutional cradle for the development of the discipline was the Portman Clinic, part of the Tavistock and Portman NHS Foundation Trust, London. The clinic grew from the idea of a small group of psychoanalysts who wanted to establish that there was a better way of dealing with offenders rather than incarcerating them in prison. Thus, forensic psychotherapy developed from psychoanalysis, psychodynamic psychotherapy and forensic psychiatry and psychology and refers to the application of psychoanalytic principles and treatment in the service of understanding and managing mentally disordered offenders, irrespective of whether these individuals are in secure NHS units, prisons or the community. In other words, forensic psychotherapists not only provide treatment but also apply psychodynamic thinking to the complexities and dynamics within staff teams and institutions treating these individuals [27]. One of the unique selling points of forensic psychotherapy is that central to its work is a psychoanalytic consideration of the unconscious mind and the internal world of the patient. This contributes an additional dimension to understanding the mind, criminal acts and ongoing risk of the offender [11, 28–31].

Forensic patients have highly disordered and fragmented internal worlds. They rely on primitive unconscious defence mechanisms in an attempt to stabilise their inner world. Aspects of the patients' internal world can be projected into staff and

evoke reactions in both the staff and the institution that arise either from the unconscious response of staff to the projected aspects of their patients' internal world or from mobilisation of the unconscious defence mechanisms of the staff and the institution to reduce internal anxiety. If left unattended, these processes result in staff teams becoming 'split' and reenacting aspects of the patients' intrapsychic and interpersonal situation within the professional network. The therapeutic potential of the environment is decreased along with the effectiveness of the particular therapeutic task, irrespective of whether this is one of containment, assessment or treatment [32]. The understanding that forensic psychotherapists can bring to the intrapsychic function and the interpersonal consequences of such splitting for both their patients and the systems in which they work can significantly contribute to assessment, treatment and risk management [33]. However, to achieve this, it is crucial that forensic psychotherapy is a team effort [34] and, as such, embraces inter-professional, interdisciplinary and interagency working. The impetus for the further development of forensic psychotherapy came from two drivers: one creative and the other tragic.

To further multi-professional expertise in forensic psychotherapy and to encourage the growth of the discipline beyond psychoanalytic departments and clinics in the United Kingdom, Dr. Estela Welldon established the first training course in Forensic Psychotherapy in 1989 which was accredited by the University of London and run at the Portman Clinic. This was an innovative and highly successful course; however, it could be argued that health service policymakers and the bastions of forensic psychiatry did not fully appreciate its worth.

Tragically it took several public enquiries before policymakers and the secure institutions, which sit at the heart of forensic psychiatry, realised what forensic psychotherapy could offer. In the 1990s, Ashworth Hospital (at Maghull, Merseyside, UK), one of the four high secure hospitals in the United Kingdom, was the subject of two public inquiries because of concerns about staff behaviour towards patients. The first Ashworth Inquiry found evidence that some staff had been physically abusive to some patients [35]. The second found evidence of serious boundary violations by staff who had either colluded with patients on the hospital's personality disorder unit or turned a blind eye to their behaviours such as 'the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material on the Unit' [36]. As a result of the 1992 enquiry, the first Consultant Forensic Psychotherapy post, recognised by the Royal College of Psychiatrists in the United Kingdom, was established at Broadmoor High Secure Hospital and resulted in the development of a forensic psychotherapy service. The second enquiry recognised that clinical decision-making lacked the capacity to formulate and understand the patients' internal world and acted as an impetus for the Department of Health to fund a small number of training posts in forensic psychotherapy, so psychiatric trainees could be trained in both psychoanalytic psychotherapy and forensic psychiatry. The rationale was that these dually trained doctors would be better 'equipped to enhance multidisciplinary teams awareness of the often unconscious dynamics arising from patients' early experiences and to consider the reverberating emotional impacts which determined relationships between patients and professionals on the wards and in other mental health settings' [37].

In the United Kingdom, forensic psychotherapy has developed mainly within the shelter of the NHS; its growth in prisons has been slower. Early models for the application of forensic psychotherapy in the male prison estate included the 'visiting psychotherapist', where the psychotherapist is added on to a traditional system [38], or the 'whole institution approach" used in prison-based therapeutic communities [39] with male prisoners at HMP Grendon. This model is geared towards providing a specific and therefore narrower treatment approach for offenders with a diagnosis of personality disorder. In the Corston Report [40], Baroness Corston argued that equal outcomes for women required different approaches; arguably this policy initiative allowed forensic psychotherapy thinking and practice to cross over into women's prisons. The Report paved the way for community mental health teams (CMHTs) to be based in prisons, where the prison is the community, and some of these teams now include forensic psychotherapists.

A recent policy initiative, the Offender Personality Disorder (OPD) pathway is a joint National Offender Management Service (NOMS) and NHS strategy for violent male and female offenders with personality disorder and has driven the development of more joined-up services for this offender group across the Criminal Justice System, the NHS and into the community [41]. The OPD supports a variety of treatment interventions including cognitively based offending behaviour programmes; however, the initiative has also drawn heavily on forensic psychotherapy principles, psychodynamic theory, attachment theory and its developmental legacy, the capacity to mentalise [42], to shape its treatment interventions. As part of this, initiative psychologically informed planned environments (PIPEs) have been set up in prisons and in the community to provide personality-disordered offenders with progression support prior to or post treatment. PIPEs provide mentalising environments where the affective and cognitive meanings behind actions are thought about in relation to the self and others and where offenders can think about their antisocial identities and choices. Although forensic psychotherapy is in its infancy within the prison system, it is encouraging that in the UK prisons see the provision of psychological therapies as a legitimate part of their remit.

As a super specialism, forensic psychotherapy always faces a particular problem, namely, how to achieve an impact on and develop clinical practice across a wide and varied forensic mental health system with a relatively small number of practitioners—this challenge has been addressed in the United Kingdom by a variety of approaches outlined below.

11.6 Therapy at the Edge: Two Initiatives for Mentally Ill Offenders in Belgium

In the Netherlands, the United Kingdom and Belgium, community care policies have been implemented in order to move mental health care from institutions to local treatment services within the patients' social environment. Existing places in residential facilities are reduced, and patients are stimulated to progress more quickly towards return in the community. A number of people with complex and

chronic mental health issues, who traditionally would be in long-term residential care, are struggling to find their place in this changing world. Especially in cases where the psychiatric difficulties go together with issues of aggression or drug abuse, patient might be considered 'therapy resistant.' In Belgium, several local initiatives are established for these patients, of which we will mention two. Within the psychiatric ward of the prison of Antwerp, mentally ill detainees are invited to participate in a number of therapeutic activities on a voluntary basis [43]. Many of these detainees have complex and long-standing psychiatric histories, including psychotic symptoms, personality disorders and substance abuse. The therapeutic activities consist in a range of creative activities, sport, psychotherapy and open group activities (listening to music, discussing the news, etc.) that are offered on a voluntary basis. There is also a project involving prison radio (radio made by and for prisoners). The high amount of routine and structure, and the low amount of pressure on the detainees, helps to create a safe environment in which people who would otherwise withdraw from social activities start to engage with the group and the therapists. In Ghent, the project 'Villa Voortman' provides a meeting place for people with a dual diagnosis of substance abuse and psychosis [44]. This meeting place is situated in an ordinary house in the city, which is open during the day. Creative activities are organised during the day, and people are free to come in and spend their day in the house.

Although very different in setup, both initiatives share some basic therapeutic principles. On the basis of the Lacanian theory on psychosis, it is assumed that psychotic subjects tend to engage in fusional and aggression-laden relations. As a consequence, the therapeutic professional may come to be perceived by the psychotic subject as someone who takes over or threatens their personality. The risk is especially high when the professional addresses the psychotic directly, for instance, with a therapeutic demand. In order to avoid the development of a psychotic transference, the abovementioned initiatives put no pressure on the patients to engage in the treatment. A range of activities is offered, and patients are invited to participate. Those who don't participate are not excluded or forgotten but 'kept in mind' during the staff discussions. The therapists are available for the patients, either within the setting of a consultation room or just for a chat in the corridor. The idea is that these little, casual interactions are as therapeutic as the interactions within a scheduled therapy session. Patients are also able to work out their own treatment programme. In accordance with the therapeutic community approach, much value is given to the group. The group of patients are given a degree of autonomy to take decisions in relation to practical issues that arise within the institution. The aim is to organise authority horizontally as much as possible, rather than vertically.

11.7 Impact on Practice: Through Research and Scholarship

As clinicians and academics, forensic psychotherapists have greatly extended psychoanalytic thinking and scholarship in a wide range of areas, too wide to do them all justice here. However, there are certain domains where forensic psychotherapy has made particular contributions extending psychoanalytic theory and thinking and

applying these ideas to treating patients in the contemporary complex systems where our patients are contained and managed. Forensic psychotherapy is intimately concerned with triangulated and oscillating dynamics between the patient, the psychotherapist and society, often represented by the Criminal Justice System as well as triangulations commonly found when working with forensic patients when they adopt roles such as the victim the perpetrator and the bystander [45].

Ubiquitous to our clinical work are the acts of violence that our patients perpetrate, and a fundamental principle of forensic psychotherapy, as noted earlier, is that the offence has a meaning to the offender, a meaning that often contains unconscious elements [28], and the actuality of the individual's offence needs to be kept in mind within the therapeutic work [11, 46]. The forensic psychotherapist is well placed to anticipate and articulate links between the internal and external worlds of the individual and can therefore make a critical contribution to the understanding of violence, including seemingly random violence, the containment of violence and the management of risk [29, 31, 47–50].

Clinicians and authors have also greatly extended psychoanalytic thinking providing a model of female perversion [27, 51] and the psychoanalytic mechanisms underlying women's crimes of violence towards their partners or their children [52, 53].

Forensic psychotherapy can provide a way of thinking that helps staff understand the less conscious communications of their patients and supports staff in their work with highly disturbed individuals and helps us manage the anxieties and internal disturbance such work engenders [54–56]. Supervision and the provision of reflective space can shed light on how patients' psychopathologies unconsciously influence the system that contains them, whether this is at the interpersonal level or within the institution as a whole.

Two of the challenges facing forensic psychotherapy are, firstly, to develop reliable clinical tools that help teams have a systematic approach to examining and formulating the patient's difficulties from a psychodynamic perspective and, secondly, to evidence what we do through qualitative and quantitative research methodologies. With respect to the first challenge, a group of UK forensic psychotherapists have developed the Interpersonal Dynamics (ID) Consultation model [57]. Based on the work of the Operationalized Psychodynamic Diagnostics (OPD) Task Force [58, 59], which has been widely used in Germany, the ID Consultation provides clinicians with a systematic way of mapping and formulating the patient's core relationship patterns and helps the multidisciplinary team develop a shared understanding of patterns of dysfunctional relating. The ID draws on psychoanalytic concepts of transference-countertransference which become enacted between patients and staff members involved in their treatment. Such a shared understanding offers the possibility of improving unit dynamics, treatment concordance, offering protection against boundary violations and managing risk [60].

Core to the work of forensic psychotherapists, and indeed to forensic mental health professionals, is the examination of the index offence; however, there has been no systematic way of examining and formulating the patient's offence narrative or investigating whether the way in which a patient represented his offence was predictive of progress. Using methodologies arising from the field of attachment

research and examining the patients' capacity to mentalise especially around their offence, the Index Offence Representation Scales were developed [61] which were shown to be predictive of both subsequent violent behaviour and treatment engagement.

One of the major treatment advances of the last two decades has been the advent of new theoretically driven psychological treatments for individuals with a diagnosis of personality disorder especially borderline personality disorder. However, a sense of therapeutic pessimism has remained in the hearts and minds of clinicians in relation to treating those patients with a diagnosis of antisocial personality disorder (ASPD). Of these treatments, mentalisation-based treatment (MBT) has been of particular interest to forensic psychotherapists as there is a growing evidence base for its use in the treatment of some individuals with ASPD [62, 63]. A large-scale, national multisite RCT comparing MBT with other services offered by community-based probation is now underway in the UK to evaluate MBT's effectiveness in reducing aggression and offending behaviour and improving health and well-being in comparison to 'probation as usual'.

11.8 Impact on Practice: Through Training

The legacy of the Ashworth and other enquiries led to a small number of national training posts being established for medical trainees in forensic psychotherapy; however, two problems remained. First, with funding pressures on NHS trusts and commissioners, it was clear that this small number of trainees would never increase to reach a critical mass of skilled clinicians who could have a wide impact within forensic services. Second, there was no established career pathway or mechanism of training for 'would-be' forensic psychotherapists who were not medically qualified. Pathways have now been developed which lead to both academic and professional registration through the British Psychoanalytic Council. Completion of the Forensic Psychodynamic Psychotherapy course at the Portman Clinic, the iteration of the original Portman Course established by Estela Welldon, is accredited by the British Psychoanalytic Council (BPC) and equips its graduands to work as independent practitioners.

The 2-year MSc in "Psychotherapeutic Approaches in Mental Health" is a collaboration between the Forensic Psychotherapy Department at West London Mental Health NHS Trust, the Department of Psychotherapy in the Belfast Health and Social Care Trust in Northern Ireland and New Buckinghamshire University in the United Kingdom. Establishing this training in Belfast provides a model of how to develop a multi-professional forensic psychotherapy training in a periphery of the United Kingdom in which there is a relatively modest provision of psychoanalytically trained clinicians. MSc graduates are eligible to apply for British Psychoanalytic Council (BPC) registration as psychodynamic practitioners in mental health (general or forensic). A further clinical training of 2 years leads to BPC registration, as a forensic psychodynamic therapist, with full membership of the forensic psychotherapy society. All of these courses offer training for multidisciplinary

professionals working across a range of forensic settings and community settings and a range of different organisations such as the NHS, as well as for individuals working in the NHS, the Criminal Justice System and the third sector organisations such as charities and voluntary organisations.

11.9 Impact on Practice: Through Communities of Practice

As a relatively small group of professionals, the International Association of Forensic Psychotherapy (IAFP) acts as an umbrella to link and bring together practitioners across the world. The IAFP has strong European and UK roots. It was formed in 1991 in Leuven, Belgium, by Estela Welldon and colleagues who in the field of law and mental health wanted a forum to think about the difficulties they encountered in psychotherapeutically working with forensic mental patients. Today, the IAFP encourages and supports the sharing of practice, research and new developments in forensic psychotherapy and through annual international conferences and national meetings enables professionals in the field to present their clinical work and extend their skills.

Take-Home Messages

- Crime is both an unconsciously meaningful and meaningless act for the criminal: its meaning can be deciphered by considering the act in the context of a life story, and its meaningless aspect can be situated in the aggressive or sexual drive that motivates the crime.
- An offender's use of rationalisation, denial, minimisation and blaming does not reflect an antisocial personality; they are an offender's attempt to engage in a moral negotiation about what happened and provide valuable input to work with in forensic psychotherapy.
- The institution where forensic psychotherapy takes place presents an important environment that has a crucial impact on the therapeutic and work climate for all those involved.

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Part IV

Teaching and Training

Teaching Forensic Psychiatry and Psychology in Europe

12

Sheila Howitt and Lindsay Thomson

12.1 Introduction

Working within the fields of forensic psychiatry and psychology requires an effective combination of knowledge, clinical skills and professionalism which must be developed through academic learning and clinical experience. Whilst a general expertise is developed through core psychiatry and clinical psychology training, those working in forensic services must have detailed knowledge of risk assessment and management, criminal justice services and the role of a medicolegal expert. Furthermore, experience must be gained in a range of clinical environments including secure psychiatric facilities, prisons and outpatient settings.

Most clinicians working as either forensic psychiatrists or psychologists will have a role in the teaching and supervision of trainees and may also be involved in undergraduate teaching.

They may also have a role as teacher in the courts or legal systems [1]. In this chapter, we aim to discuss the teaching of forensic psychiatry and psychology across Europe and to outline the range of teaching methods that may be employed. Specialist training in forensic psychiatry and psychology will be discussed in detail in the next chapter.

Additional challenges that the forensic practitioner must be prepared and equipped for arise from the paradoxical political and public misconceptions that, on one hand, those with mental disorder pose a risk to others and should be infinitely detained, and conversely that due to their offending behaviour they are less deserving or in need of care or resources. This may be amplified in developing countries

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where there may be a more limited understanding of mental disorder and limited resource. It is our belief that those working in the field of forensic mental health have a role, not only as teachers but to act as ambassadors and to reduce mental health stigma.

12.2 European Routes to Practising in the Professions of Forensic Psychiatry and Forensic Psychology

The pathways to becoming a practitioner working in the fields of forensic psychiatry and psychology vary across Europe, but there are commonalities in the training and skills required. As specialist training will be discussed in detail in the next chapter, here we aim to provide an overview of the process to undertaking specialist training and outline the key components of this training.

Prior to undertaking specialist training in most European countries, forensic practitioners undertake an undergraduate degree in medicine or psychology.

12.2.1 Psychiatry

Undergraduate medicine curricula include psychiatry, but there are significant variations in the quantity of teaching and experience of forensic mental health within this both nationally and internationally. Some institutions, for example, the University of Edinburgh, include teaching on mentally disordered offenders and the structure and provision of secure care within its undergraduate curriculum. Some but not all students have the opportunity to undertake clinical placements in forensic settings. Following completion of an undergraduate medical degree, psychiatry can be selected as a career pathway. This will involve clinical training, assessment of competencies and in some countries postgraduate examinations.

In the UK, psychiatric trainees wishing to receive specialist accreditation in forensic psychiatry must undertake 3 years of training in forensic psychiatry following completion of core psychiatric training. This is overseen by the Royal College of Psychiatrists who has developed a curriculum and learning outcomes which must be adhered to and award a European Certificate of Completion of Training (CCT).

Accredited training in forensic psychiatry resulting in a CCT is also available in Ireland, Germany, Switzerland and Sweden. In other European countries, such as Denmark, Belgium, Austria, Finland, Norway, The Netherlands and Spain, university or official medical bodies run a diploma course in forensic psychiatry and psychology [2].

12.2.2 Psychology

In the UK, after undertaking an undergraduate degree in psychology, those interested in working within the field of forensic psychology must undertake a postgraduate degree. It should be noted that there is a clear divide in those that train to

become clinical psychologists and work in forensic mental health services and those who train to become forensic psychologists and work mainly with the police or in custodial settings focussing on criminal profiling and altering offending behaviours. In Germany, there are three universities with master's programmes exclusively focusing on psychology and law. In the Netherlands, there are three accredited academic master's programmes in forensic psychology which is delivered by Maastricht University, the University of Amsterdam and Tilburg University.

12.2.3 Components of Training

As will be discussed in the next chapter, the length and structure of specialist training vary across Europe; however, there are commonalities in the components and content of this training. Firstly, specialist training can be conceptualised as comprising both formal teaching and apprenticeship. Formal teaching includes lectures, courses and problem-based learning and is the main mechanism through which theoretical knowledge is imparted to trainees. These teaching formats will be discussed in more detail later in this chapter.

Alongside formal teaching, trainees in forensic psychiatry and clinical psychology undertake apprenticeships, that is, clinical placements working under the supervision and guidance of experienced practitioners. Here, trainees will develop expertise in the assessment of treatment of mental disorder, risk assessment and medicolegal work. Clinical skills are developed in tandem with professional skills, and trainees receive formal supervision from their mentor. Trainees will also gain experience in the administration of psychological theories to both individuals and groups, which is of importance not only for the development of therapeutic skills but also for the professional skill of maintaining boundaries.

Trainees should receive regular feedback from their supervisor over the course of a clinical placement with a formal review on completion of the placement. Clinical and professional competencies should be assessed against a defined curriculum and supervisor's reports supplemented by workplace assessments and, in some countries, professional examinations.

12.3 Education Beyond Specialist Training for Forensic Mental Health Clinicians

Accreditation of completion of specialist training in forensic psychology, clinical psychology or psychiatry does not signify an end to educational requirements. Clinicians require ongoing training to both maintain and enhance existing knowledge and skills. Evolving research and policy necessitate changes in practice, and even the most experienced clinicians will require training in legislative changes and new methods, e.g. a new risk assessment tool.

One of the challenges of training forensic mental health clinicians is that, due to the level of specialisation, there is a relatively small body of practitioners who may be spread over a large geographical region. This can make the delivery of training

and teaching irregular and not cost-effective. One strategy to overcome this is to make training multidisciplinary and national rather than regional, as exemplified by the School of Forensic Mental Health in Scotland.

The School of Forensic Mental Health (SoFMH) [3] was established in 2007 coinciding with a time of change within the country with new mental health legislation, new initiatives and the development and opening of new forensic facilities. There were major training requirements following these changes, but training in forensic mental health was uncoordinated and unidisciplinary, and access was subject to a geographical lotters. SoFMH was developed to meet these needs and is a virtual school with an administrative centre but delivering training usually on a multidisciplinary basis across Scotland using a variety of teaching methods. The school organises a range of multidisciplinary training events, clinical forums and special interest groups, coordinating research and teaching across the country.

There is a short programme course, postgraduate qualifications such as a master of science degree in forensic mental health delivered electronically which has four core online modules, namely:

- Mental disorder and the law and treatment and interventions for mentally disordered offenders
- Problem behaviours
- Risk assessment and risk management
- Evaluating evidence to develop research and inform practice

In addition, SoFMH has an active research programme linking to its educational remit.

One teaching resource developed by the SoFMH is the 'New to Forensics' teaching programme. 'New to Forensics' is a learning tool developed between the National Education for Scotland (NES) and the Forensic Network. It is suitable for clinical and non-clinical staff and is multidisciplinary and multiagency in approach. A mentor, who is an experienced forensic mental health worker from within the multidisciplinary team, supports a student through 15 chapters over a 6-month to 1-year period. It includes patient case scenarios in a variety of settings, from high-secure psychiatric care to community. To date, over 1000 individuals have undertaken the programme.

12.4 European Educational Initiatives

Although specialist training varies across Europe, there are a number of pan-European organisations which exist to share and learn from each other's experience including the European Association of Psychology and Law (EAPL), the European Federation of Psychiatric Trainees (EFPT), the European Psychiatric Association and the Ghent Group. These bodies will be described more fully in the chapter 'International Associations', so here we will focus on their important role in education and training by organising events, disseminating knowledge and developing guidance.

12.4.1 The European Association of Psychology and Law (EAPL) [4]

The European Association of Psychology and Law (EAPL) was founded in 1992. Its aims are as follows:

*The promotion and development of research, improvements in legal procedures, teaching and practice in the field of psychology and law (*e.g. *legal psychology, criminological psychology, forensic psychology) within Europe, and the interchange of information throughout the world aimed towards an international cooperation.*

They have a publication *Psychology, Crime and Law*, which is issued eight times a year, and organise an annual conference. There is an active student association, and their website provides fact sheets on a range of forensic issues which summarise current literature into short (two page) documents. Topics include psychopathy, criminal profiling and risk assessment. They also publish a series of articles focusing on the 'controversies' in psychology and law and provide information on forensic psychology courses across Europe.

12.4.2 European Federation of Psychiatric Trainees

In 2009, the European Board of Psychiatry published 'European Framework for Competencies in Psychiatry' [5] which was developed in collaboration with the European Federation of Psychiatric Trainees (EFPT) and involved consultation with patient and carer organisation, national psychiatric association and the European and World Psychiatric Associations. They identify seven key roles of the psychiatrist as:

1. Psychiatric expert/clinical decision maker
2. Communicator
3. Collaborator
4. Manager
5. Health advocate
6. Scholar
7. Professional

The aim of these objectives is to be used as a reference for national associations and other bodies to develop or review curricula for postgraduate training. The document also provides guidance on how competencies can be assessed and lists three key principles to guide the assessment process.

- Assessment should be transparent.
- Each competency must be assessed.
- Competency assessment must be triangulated.

The document then goes on to outline a range of methods of assessment divided in three domains – knowledge, competency and performance. Knowledge assessments are written examinations (WE) and oral examinations (OE). Competency assessments are clinical examinations (CE) and assessment of simulated clinical encounter (ASCE). Performance assessments, also known as workplace-based assessments (WPBA), are directly observed practice (DOP), multisource assessment of performance (MSAP) and document-based discussion (DBD).

12.4.3 European Psychiatric Association (EPA) [6]

Founded in 1981, the European Psychiatric Association has active members in 88 countries with a stated mission to improve psychiatry and mental health care in Europe. It provided a number of different educational opportunities including a summer school, courses and e-learning programmes. For early career psychiatrists, they run a 'Gaining Experience Programme' offering short observership placements in psychiatric institutions across Europe and run a specific early career psychiatrists programme at the annual European Congress of Psychiatry.

12.4.4 The Ghent Group

The Ghent Group is a European network of forensic psychiatrists which aims 'To support aspects of training, which will facilitate the practice of forensic psychiatry across national boundaries in Europe, to meet and develop ideas, to make recommendations about training and to support the development of professional groups in countries developing new services' [7].

A regular topic of discussion within the group has been the optimum model for teaching and training for specialisation. Multidisciplinary training, including trainee lawyers, has been proposed to enhance understanding of legal issues relating to mentally disordered offenders. Through discussion, the group also concluded that trainees themselves should be involved in discussions to develop best practice in training and teaching, and consequently a training seminar for both consultants and experienced trainees was developed.

The Ghent Group holds training seminars on an annual basis in Kloster Irsee in Bavaria with 25 delegates attending (trainees in forensic psychiatry and young consultant psychiatrists) from across Europe. The format is a mixture of lectures and case vignettes to follow the offender journey from committing a serious offence to release into the community. Participants work in groups of six to consider each stage of the journey in each of the participant's country comparing and contrasting national positions. One member of each group then presents their group's discussion to the whole delegation to allow further discussion and debate. Through this process, the pathway, and role of the forensic psychiatrist and psychologists within it, was clarified for each country furthering the participant's understanding of the system of other countries as well as their own.

12.5 Key Teaching Themes

In addition to the skills and knowledge acquired during general psychiatry and psychology, training those working in the field of forensic mental health requires additional expertise in the following fields.

12.5.1 Mental Health Legislation and the Interface Between Mental Health and the Law

Mental health legislation varies across the European Union, and the competent forensic clinician must have a sound understanding relevant to their role of the laws and legal tests in their jurisdiction. This is important both for clinical practice and for undertaking medicolegal work. In order to gain the required knowledge and experience in this area, trainees require specialist teaching and supervision. Firstly, they must develop an awareness of the relevant legislation, and this is most simply delivered via lectures and then further self-directed learning. Once a theoretical knowledge of relevant legislation has been acquired, the trainee must further their understanding by undertaking appropriate medicolegal work under supervision. Ideally, this should involve consultation prior to the patient being assessed, supervision of assessment (at least initially) and review and discussion of draft report. Only by undertaking such work will the trainee develop an understanding of the legal tests and become familiar with the correct terminology. The supervision of such work also provides the trainer with an opportunity to assess progress and provide feedback.

12.5.2 Risk Assessment and Management

For those working within forensic psychiatry and psychology, risk assessment is paramount to identify and manage risk of harm both to the patient and to others. There are a variety of tools in which practitioners can undertake training and can utilise to recognise and classify risk including actuarial tools like the Risk Matrix 2000 [8] and Structured Clinical Judgement tools like the HCR-20 V3 [9]. The 2007 Briefing Document ‘Giving up the Culture of Blame. Risk Assessment and risk management in psychiatric practice’ [10] concluded that interventions may decrease risk in one area only to increase in another and that risk cannot be eliminated. They also concluded that a perfect risk management system would have only a modest impact on rates of homicide by the mentally ill and may influence debate from a position where the greatest good may be done to the greatest number of people. For this reason, trainees must have guidance and teaching not only in identifying risk but in conceptualising it and being able to manage personal and professional anxiety associated with informed risk management.

12.5.3 Professionalism and Ethics

For psychiatrists working within the field of forensic mental health, the four moral principles of biomedical ethics recognised by Beauchamp and Childress [11] must be considered. These are the following:

1. Respect for autonomy – respecting the patient's right to make decisions around their own care
2. Beneficence – acting in the patients best interest
3. Non-maleficence – doing no harm
4. Justice – fairness concerning the distribution of resources and who gets what treatment

For forensic practitioners, the pursuit of these ethical standards is complicated not only by having to consider both the general public and the individual but also in some countries by the dual roles of providing care and treatment whilst providing expert opinion and evaluation to the court, often via third parties. As discussed by Arboleda-Florez [12], this raises the question of whether forensic practitioners should identify with a 'welfare paradigm' or a 'justice paradigm'. As result of the justice paradigm, treatment without consent and breaches of confidentiality may be required and indeed be considered best practice. Whilst most experience in this field will be acquired through practice under supervision during training, formal teaching may be of benefit. The Madrid Declaration on Ethical Standards for Psychiatric Practice 1977, most recently updated in 2011 [13], sets out an internationally applicable ethical code on which to base practice and teaching. This declaration devised by the World Psychiatric Association (WPA) also provides guidance concerning 16 specific situations of which the following advice is of relevance to forensic practitioners.

No 2. Torture

'Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.'

No 3. Death penalty

'Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.'

No 15. Dual responsibilities of psychiatrists

'These situations may arise as part of legal proceedings (i.e. fitness to stand trial, criminal responsibility, dangerousness, testamentary capacity) or other competency related needs, such as for insurance purposes when evaluating claims for benefits, or for employment purposes when evaluating fitness to work or suitability for a particular employment or specific task.

During therapeutic interactions conflicting situations may arise if the physician's knowledge of the patient's condition cannot be kept private or when clinical notes or medical records are part of a larger employment dossier, hence not confidential to the clinical personnel in charge of the case (i.e. the military, correc-

tional systems, medical services for employees of large corporations, treatment protocols paid by third parties).

It is the duty of a psychiatrist confronted with dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the triangular relationship and the absence of a therapeutic doctor-patient relationship, besides the obligation to report to a third party even if the findings are negative and potentially damaging to the interests of the person under assessment. Under these circumstances, the person may choose not to proceed with the assessment.

Additionally, psychiatrists should advocate for separation of records and for limits to exposure of information such that only elements of information that are essential for purposes of the agency can be revealed.'

Working with mentally disordered offenders can evoke strong feelings within the professional team providing their care. This is something for which general training can leave trainees underprepared to manage their own feelings and complex team dynamics when the perpetrator of a particular offence, for example, murder or sexual child abuse, requires treatment. Attending a Balint-style case-based discussion group may be helpful in understanding and managing some of the complex emotions generated and allow consideration of the countertransference evoked [14, 15]. In a traditional Balint group, named after psychoanalyst Michael Balint, participants meet regularly with a leader and discuss a clinical case brought by one of the participants. Discussion focuses on the doctor-patient relationship and is useful for discussing cases where strong feels have been evoked in the clinician. Non-case-based reflective practice groups also have a role in allowing forensic trainees a forum to discuss and consider the challenges and implications of working within restrictive environments and the emotions this generates. Typically these sessions take place on a weekly basis and are facilitated by someone out with the clinical team. Themes include discussion of the complex dynamics of working within institutions and multidisciplinary team.

12.5.4 Clinical Expert/Witness Training

As previously discussed, one role of forensic clinicians is to provide an expert opinion on an individual's mental health to courts or other legal bodies. This evidence can be written or verbal. Giving verbal evidence in court can be an anxiety-provoking experience for which trainees should receive guidance, training and support. This will reduce anxiety and improve the impact of evidence delivered. Key components are as follows:

- Training on the content of the written report which forms the basis for any examination
- Knowledge of court proceedings and etiquette
- Advice regarding delivery of evidence
- Practice in undergoing cross-examination

Such teaching can be delivered on an informal basis, such as during a supervision session, or in a more formal environment. Some bodies and agencies provide specialist training in this field, for example, the Swiss Society of Forensic Psychiatry. Attending court to observe experienced psychiatrists given oral evidence can also provide a valuable training experience.

12.6 Teaching Methods

As stated earlier, much training in forensic psychiatry and psychology is done through an apprenticeship model during clinical placements. There are a number of traditional and modern methods which can be utilised by teachers of forensic mental health, each with its own advantages and limitations as outlined below.

12.6.1 Lectures

The most traditional of teaching methods is the formal lecture. This format continues to maintain a place in undergraduate and postgraduate teaching curriculums due to its advantages over more contemporary methods as outlined below [16].

Advantages of Lectures
- Allow large volumes of basic information to be effectively delivered
- Cost-effective, allowing information to be disseminated to a large number to students at the same
- Provide an overview and/or framework for further learning or activities
- Generate a curiosity and interest in a topic
- Allow teacher to retain control of material covered to ensure important learning points are covered

Difficulties with Lectures
- Not suitable where large quality of detailed information is to be imparted as this is unlikely to be retained
- Communication flows primarily from teacher to student
- Limited opportunity to check learning or to gain feedback of effectiveness of teaching
- Poor student engagement with students adopting passive roles

These difficulties can be overcome or at least minimised by integrating interactive techniques such as asking questions and reviewing. Lectures may be appropriate in forensic psychiatry and psychology where a basic theoretic information needs to be delivered, for teaching of undergraduates about the provision of forensic mental health services or presenting new research at conferences or seminars.

12.6.2 Problem-Based Learning

Problem-based learning is a teaching method in which small groups of students explore their existing knowledge, identify areas for further learning, perform independent research and then return for group discussion. Learning centres around a clinical case or problem and meetings occur in the presence of a facilitator. As with lectures, there are advantages and disadvantages to utilising problem-based learning [17].

Advantages
- Development of generalisable skills, e.g. self-directed learning
- Experience of small groups highly relevant to working with teams
- Increased motivation of learning
- Development of extensive, flexible knowledge base
- Improved communication and psychosocial skills
- Can be used flexibly across curriculum

Disadvantages
- Anxiety and uncertainly during initial phase of skills acquisition
- Increased resources required
- Clinicians concern that students lack knowledge
- Costly
- May be more suitable for mature students
- Unfamiliar to teachers and other staff

This method may be useful in forensic mental health not only as a method for current trainees to develop knowledge and the habits of self-directed lifelong learning but through discussion of interesting and complex cases to inspire students and junior trainees to pursue a career in this field [18].

12.6.3 Utilisation of Technology

Over the last 20 years, education has evolved to include a range of technologies in developed countries. This can range from the use of Microsoft PowerPoint in lectures and tutorials to online e-learning modules. When used effectively, technology can improve engagement and enhance the learning experience, but when used ineffectively can distract from learning and feel misplaced.

1. Podcasts

   Podcasts, that is, audio or video file downloaded via the Internet onto a computer or a mobile device, are especially useful in providing specialist information that can be accessed at a convenient time to recipients across the globe. These

allow for quick dissemination of recent updates in research and case law and are particularly valuable in geographical regions with a small number of forensic practitioners where specialist local teaching is not feasible.

2. Use of videos

   Video cameras offer a cheap and readily available opportunity to record interviews with consenting patient. When used in case presentations, they offer the audience an opportunity to assess the mental state of the patient and increase engagement. Case presentations provide the opportunity to teach others about themes or topics that arose in a particular case and to generate ideas and opinions regarding diagnosis, care and treatment from colleagues. Videos are also useful during the teaching of clinical and research tools, for example, the Hare's Psychopathy Checklist-Revised (PCL-R) 2003 [19], as an adjunct to case information. This can allow demonstration and practice in the use of the tool and generate discussion to improve inter-rater reliability. Policies must be in place to ensure full consent is acquired prior to a video being made, videos are appropriately stored and videos are destroyed when no longer required.

3. E-learning modules

   In many European countries, continued professional development (CPD) is required by employers and to maintain membership of professional bodies. This often requires clinicians to record time spent training and at conferences. Attending such events, especially for those working in small or remote departments, can be costly and time-consuming. Electronic learning modules (e-learning) are a cost-effective way of undertaking core or additional learning at a convenient time. Such modules are best suited to theoretical learning but are also useful for facilitating consideration of ethical and legal issues. In the UK, the Royal College of Psychiatrists has a range of CPD-accredited online modules related to forensics from the assessment and treatment of sexually abnormal behaviour to people with intellectual disability in custodial settings. These forensic modules are found amongst a large collection encompassing different psychiatric specialities, clinical skills, professional skills and ethical issues.

12.6.4 Role Play

Although anxiety provoking for participants, role play can be an invaluable teaching method for forensic clinicians. In Scotland, forensic psychiatric trainees in the national training scheme attend monthly teaching sessions, with one session devoted to giving evidence at a mental health tribunal or in court. Prior to the session, the trainee supplied an anonymised report to a consultants forensic psychiatrist who reads the report and then takes the role of a lawyer and cross-examines the trainee upon it. The court or tribunal environment is simulated by other trainees taking the role of judge and other members of the court and the trainee having to adhere to court etiquette.

12.7 The Role and Responsibility of Teachers in Forensic Mental Health to Reduce Mental Health Stigma

Despite improved understanding and awareness of mental health issues, mental health services remain underfunded [20] compared to physical health equivalents, and stigma continues to affect an individual's likelihood to present for help in a timely fashion. Due to limited public understanding, particularly of psychotic disorders like schizophrenia, a culture of fear prevails and there are misconceptions that those suffering from mental disorder are more likely to be perpetrators of crime than victims. It is the authors' belief that those clinicians working within the field of forensic mental health have a role of educating not only trainees but the wider public to reduce this stigma.

12.8 Promotion of a Career in Forensic Mental Health

Reiss and Chamberlain [21] estimated that only half of UK medical schools provide clinical placements, workshops, seminars or specialist study modules in forensic psychiatry, and this is likely to be replicated across Europe. Even psychiatric or psychology trainees may not have had exposure to forensic mental health with Reiss and Famoroti [22] finding that a significant proportion of psychiatric trainees had not visited a prison. Lack of awareness and exposure to the speciality is likely to affect recruitment. Ensuring able candidates attracted to forensic practice has been one of the considerations of the Ghent Group. Practising clinicians can play a role in promoting careers in forensic mental health through attendance at careers fairs and by organising work experience placements or 'taster weeks' for interested individuals.

Conclusions

Despite different routes to practice in forensic mental health across Europe and variations in legislation, there are common skills and expertise which are required by all forensic practitioners. Alongside national training, our European context offers the additional opportunity for clinicians to learn how neighbouring countries address universal problems and to further understanding of our own practice.

As outlined in this chapter, there are a number of traditional and evolving teaching methods which can be used to develop knowledge and enhance expertise. Forensic clinicians should consider teaching and training as a core component of their occupation and endeavour to impart their skills and expertise.

As international links develop and evolve, forensic clinicians have the opportunity to share and learn from each other's experiences. This will influence both practice and policy necessitating additional training and teaching. Through sharing of knowledge and ongoing research, forensic psychologists and psychiatrists across Europe can work together to improve both standards of teaching and of patient care.

Take-Home Messages

- Forensic psychologists and forensic psychiatrists require expert knowledge and skills which must be gained through formal learning and apprenticeship.
- Training is optimised by utilising a range of teaching techniques.
- Forensic mental health is an evolving field, and it is essential that practitioners engage in lifelong learning.
- Pan-European bodies offer the opportunity to improve training and education by facilitating the exchange of ideas and experiences.

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Specialist Training in Forensic Psychiatry in Europe

13

Norbert Nedopil and Pamela Taylor

13.1 Differences and Common Ground in Legislation and Practice

Forensic psychiatry is no longer seen as restricted by the national and jurisdictional differences in the legislation and customs of individual countries. Specialisation, training and certification are, however, not universally established—and comparatively new in the field. International exchange of knowledge is advancing, evidenced in part by the growing numbers of systematic literature reviews in the field. Although, when treated as a single nation, the USA still tends to dominate in terms of research quantity, collectively Europe is playing at least a big part in research in the field. In a systematic review of mental illness rates among prisoners, for example, Fazel and Seewald [1] reported that they had identified studies from 24 different countries published between January 1966 and December 2010; 14 were from European countries, treating Scotland as a separate jurisdiction within the UK. It is thus important to acknowledge that there are relevant differences, not only in legislation but in details of social climate which could have a significant impact on interpretation of findings from one country in another. Worldwide, it is important even to take demographics into account, especially age and ethnic distributions [2]. In Europe, this may be less of an issue, and diagnostic habits are more consistent, but still countries face different illicit drug-taking problems and different habits in relation to alcohol consumption and have different approaches to how specialist

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services are organised [3, 4]. Although such systems have developed differently across the member states of the European Union (EU), however, it seems likely that we have more common ground than not in philosophies of treatment of offender patients [5]. Forensic psychiatry is a growing field, with increasing numbers of patients in forensic hospitals, increasing obligations for psychiatric experts in court and in society and—luckily—increasing knowledge about how best to treat and manage offenders with mental disorder.

Medical practitioners who are recognised as specialists in one country of the European Union (EU) are entitled to practise that specialty in all other member countries, subject to having appropriate language skills. Criminals or forensic psychiatric patients may also move freely within the EU, and certainly some do so. It is, therefore, important that they can be assessed and treated by forensic psychiatrists outside their home country and there is sufficient knowledge and understanding of systems in each country to be able to advise on transfers of sick prisoners or manage patient movement when necessary.

There is a long history of ideas and initiatives on how to overcome the difficulties brought about by differences between jurisdictions. First, there was the idea of harmonising criminal law and thus also forensic practice in the different countries of the EU [6]. This proposal was quickly dropped but was followed by resignation and stagnation. Forensic psychiatry had few European platforms for furthering transnational discussions. Within European psychiatric organisations, like the European Psychiatric Association (EPA), forensic psychiatry played only a marginal role. Since about 2000, forensic psychiatrists have taken the initiative to overcome this stagnation and to build networks of professional exchange within the European framework, both within the EPA and independent from it. The most important of these is the Ghent Group, which provides an informal network for such tasks. Its members have been trying to improve collaboration since 2004 (www.ghentgroup.eu). It focuses mainly on teaching, training and providing specialist education in forensic psychiatry, with a focus on EU countries but routinely including Norway and Switzerland. The name ‘Ghent Group’ derives from the place of its first meeting—Ghent, Belgium, in 2004.

13.2 Towards a Common Definition of Forensic Psychiatry

One of the first tasks for the Ghent Group was to agree a definition of forensic psychiatry. This had to capture the following:

- The range of knowledge required—medicine (including, but not confined to, psychological medicine in all its aspects), relevant law, criminal and civil justice systems, mental health systems, the relationships between mental disorder, antisocial behaviour and offending
- The aims and purpose of the work—assessment, care and safe treatment of mentally disordered offenders, including the skills required to achieve this—risk assessment and management and the prevention of (further) victimisation

Contrary to the position of the American Academy of Psychiatry and the Law (AAPL), which, in 2005, adopted special ethical guidelines for the practice of forensic psychiatry (http://www.aapl.org/ethics.htm; see also [7]), which suggested that somehow a duty to the court may override the medial ethic, the Ghent Group agreed on the primacy of the medical ethic, even when duties include medicolegal reports. It defined forensic psychiatry as 'a specialty of medicine based on detailed knowledge of relevant legal issues, criminal and civil justice systems, mental health systems and the relationship between mental disorder, antisocial behaviour and offending. Its purpose is the assessment, care and treatment of mentally disordered offenders and others requiring similar services; risk assessment and management and the prevention of further victimization are core elements of this'.

13.3 Knowledge and Skills Needed in Forensic Psychiatry

Forensic psychiatry, then, holds clinical skills in common with general medicine and psychiatry and is perhaps distinguished from them in degree rather than nature by the range and depth of other knowledge and skills required. It follows too that some level of forensic psychiatric skill may be needed by all medical practitioners. All may, for example, be called upon to provide expert evidence in court, and all will at some stage have to make judgements at some level about a patient's risk of harm to others as well as to himself/herself. Forensic psychiatry training should, therefore, be a core part of any medical curriculum—at both undergraduate and postgraduate level. The forensic psychiatric specialist will then need specific skills which include running specialist health facilities in which the different kinds of security must be used therapeutically, the capacity for long-term treatment of treatment-refractory patients can be sustained and, for the most serious and persistent offenders, accurate decisions on the timing and conditions for release are made, taking account of victim needs. All these skills require a higher level of training. At best, fully trained forensic psychiatrists should be among the most committed beyond the more routine continuing education to regular peer review and reflective practice. To take this idea one step further, the members of the Ghent Group reflected on the skills and competencies needed in forensic psychiatry. According to Gunn and Nedopil [8], Nedopil et al. [9, 10] and Taylor et al. [11], these include the following:

- Medicine and psychological medicine in all its aspects
- Organisation of mental health systems
- Criminology and criminal psychology
- Legal concepts of competency and responsibility
- The legal statutes and the principles outlined in the Conventions of the United Nations and the European Council
- The organisation of court systems and the code of conduct in court
- Accurate and ethically appropriate communication within and outside the medical profession, including the legal profession, police, prison and probation staff,

and with a range of helping agencies (such as housing or relevant charitable bodies), the wider public - whether as jurists, victims, concerned citizens who live close to specialist units, and also the press; in addition, ensuring clarity of communication with our patients/service users is a specialist skill in itself;
– Methods of treatment for all relevant disorders and also perhaps applying therapeutic approaches to the offending per se
– Interdisciplinary and multiagency work

Accepting this as the minimum range of skills required, one has to come to the following conclusions:

– If there are distinct qualities to the skills and competencies of forensic psychiatrists, then there must be distinct training to ensure that those are in place.
– If there are some tasks for which forensic psychiatrists are uniquely well qualified, then completion of a specialist training ought to lead to specialist recognition.

Anyone who delivers treatment services for offender patients would consider the task to be possible only in the context of sound multidisciplinary practice. This, however, is only possible if each contributing discipline recognises and is trained for, although not necessarily confined to, specific roles within the team. This, in turn, requires role clarity in the other professions and perhaps specialist training there too. Given the breadth of knowledge and skill required to become a specialist in forensic psychiatry and the number of other specialties it touches, it may be important from the very earliest stages of career planning—even while people are still in secondary education—to be clear about the career pathway [12].

13.4 Special Training

Currently, four countries offer training in forensic psychiatry which leads to a certificate of completed *clinical* training (CCT) in the specialty which would be recognised throughout the EU. These are Germany, Sweden, Switzerland and the UK—and until recently, Ireland. Belgium has now recognised forensic psychiatry as a subspecialty of psychiatry. Most other EU countries have some recognised training, but no board approved specialist *clinical* certification, while some, such as Austria, Denmark, Finland, the Netherlands, Norway and Spain, rely on universities or official medical bodies to run relevant diploma courses. The situation is, however, quite fluid. In 2014, in Austria, a task force of forensic psychiatrists created new curricula and training courses, with a requirement that trainees attend nine 2-day seminars over 1 year and receive a certificate of attendance. This may be a stepping stone to further developments in clinical training. In some countries more than in others, there are fears about specialisation in forensic psychiatry, and there has even been hostility to specialist recognition [13, 14]. In part, the sibling rivalry is about resources, in part about the rather different approaches to major mental illness. At

least as perceived by forensic psychiatrists, their general adult peers operate a predominantly crisis intervention model, whereas the forensic drive is to maintain mental health once restored or improved. Intervention at crisis point is too late when serious harm to others may be associated with deteriorating mental state.

13.4.1 Training in Forensic Psychiatry as a Recognised Clinical Specialty

Training in forensic psychiatry in Germany started independently in five different institutions in the 1980s. At that time, there was still rivalry between forensic psychiatrists in different universities, who adhered to different schools of psychiatry. These differences, which were equally present in general psychiatry, were only overcome in the 1980s and 1990s. The first national interdisciplinary training courses came in 1990, and certification in forensic psychiatry was first granted by the German Psychiatric Association (DGPPN) with a structured training programme and regulations in 2000. In 2003, the German Medical Association (Deutscher Ärztetag) agreed to recognise forensic psychiatry as a subspecialty of psychiatry. There are currently two overlapping ways to qualify in forensic psychiatry: certification by the DGPPN and approval as a specialist by the State Medical Association. One of the requirements for certification by DGPPN is 36 months of training in an accredited institution, of which 12 months may be obtained during general psychiatric training; at least 6 months of the training must be in the treatment of mentally ill offenders either in special hospitals or in prison.

The skill mix required for qualification in forensic psychiatry in Germany includes ethics; relevant criminal, civil and social welfare laws; psychotherapeutic treatments; evaluation of the ability to stand trial; evaluation of culpability/responsibility; risk assessment; ability to act as a professional witness; and thus both to write reports for courts and give oral evidence. There are around 230 certified forensic psychiatrists in Germany, although the demand is increasing because of new laws demanding more expert reports—estimated to exceed 300–350 specialists.

In *Switzerland*, the curriculum, requirements and qualifications are similar to those in Germany, often adopted from them, but adapted to meet the requirements of the Swiss legal code.

In *Sweden*, after qualifying in medicine, a 2-year internship includes 3 months in psychiatry for everyone. Of those who choose to specialise in psychiatry, 90% go on to become general psychiatrists or child and adolescent psychiatrists, each of which has its own certificate of specialist clinical training requiring a minimum of 5 years. Those who wish to become specialists in forensic psychiatry may start training only after certification in one of these. It then takes a minimum of a further 2 years to become a certified forensic psychiatrist; 1 year is focussed on learning to do court-ordered assessments and 1 year on training in treatments. Retention on the specialist register requires participation in continuing medical education courses.

In the *UK* and in *Ireland*, until the early 2000s, postgraduate clinical training in psychiatry was devised and inspected by the Royal College of Psychiatrists. In the

UK, this then passed through the Postgraduate Medical Education and Training Board (PMETB) of the medical licencing body, the General Medical Council (GMC), where it now rests. When the College of Psychiatrists of Ireland was established in 2009, postgraduate clinical training development and oversight passed to this body, and forensic psychiatry is not for the time being recognised as a separate specialty there, although it is hoped that this will change.

There remain strong similarities in forensic psychiatry specialist training between Ireland and the UK. In both, after qualifying as a doctor, it is first necessary to complete 3 years of general professional training in psychiatry and pass all sections of the respective college membership examinations. The trainee is then eligible to enter advanced/higher training. In the UK, this could be in any one of six psychiatric specialties: general psychiatry, psychiatry of learning disability, old-age psychiatry, forensic psychiatry, child and adolescent psychiatry or medical psychotherapy; there are also three recognised subspecialties of substance misuse psychiatry, liaison psychiatry and rehabilitation psychiatry. There are a few training schemes left which allow for dual specialty training, for example, in child and adolescent forensic psychiatry or forensic psychotherapy. While single higher specialty training generally takes 3 years, dual training takes four.

Higher training in forensic psychiatry in both Ireland and the UK is a competency-based training. The core competencies are knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. These must be developed through experience at all levels of secure hospital practice as well as prisons, courts of all kinds, including criminal and civil tribunals, court diversion schemes, outpatient clinics and some related special institutions including forensic learning disability clinics, adolescent and child clinics, victim work and work with homeless people. Details for Ireland are at http://www.irishpsychiatry.ie/Postgrad_Training.aspx and for the he UK at http://www.gmc-uk.org/Forensic_submission_July_2016_GMP_mapping_FECC_approved_page_numbers_added_July_2016.pdf_67176891.pdf.

Training schemes are inspected periodically. There is no further examination in the subject for higher trainees, but in order to gain the relevant registration, each trainee must maintain a structured portfolio of evaluated experience, reviewed annually by trainers to ensure that progress is satisfactory. Once registered in a clinical specialty, this must be maintained through 5-year cycles of revalidation, which requires satisfactory annual approved peer appraisal of continuing professional education and development.

13.4.2 Other Higher Training in Forensic Psychiatry

It is impossible here to cover all training schemes and styles in Europe, so we have chosen a few which are more familiar to us to illustrate the range of training experience offered.

In *Belgium* forensic psychiatry is now a recognised subspecialty of psychiatry. There are four Flemish universities which run a diploma course in forensic

psychiatry and psychology. Together these universities provide a 2-year part-time course, one emphasising work with sex offenders, but none particularly clinically centred. Assessment is based on attendance at lectures or seminars. A Walloon university also has a course in forensic psychiatry, mainly to teach expertise in court work. People interested in recognised training in forensic psychiatry would expect to complete 5 years of clinical training, one of which would be based with a forensic psychiatric team and then spend an additional year specialising in some form of clinical forensic psychiatric, although it is possible to complete 5 years of general psychiatric training and follow this with 2 years in forensic psychiatry. At present, recognition is either for preparing expert reports for the courts or running clinical services, but not both.

In *Denmark* there is a strong interest in forensic psychiatry among general psychiatrists, and it is now recognised as a subspecialty. There is no formal forensic psychiatry training programme, although forensic psychiatry is one of the eight mandatory 3-day courses for all postgraduate students, and clinicians who would practise forensic psychiatry are encouraged to take on extra training, including training in a country which has recognised specialty clinical training in the field.

There is no recognised clinical specialist training in forensic psychiatry in the *Netherlands*, partly following from concerns that if these are developed, forensic psychiatry would separate from general psychiatry. This may also relate to the nature of organisation of services for offenders with mental disorder, split between the ter beschikking stelling (TBS) system of specialist services run by the Dutch Ministry of Justice (e.g. [15]), principally directed at prevention of recidivism of serious crimes, and a separate healthcare system within prisons also run by the Ministry of Justice as well as some regular health service provision. Both the former are under the Dutch criminal code. The specialist care offered within the health service under mental health law—for those who have impaired responsibility for their criminal acts but are not deemed so dangerous—is more limited. There are special conferences where forensic psychiatrists may learn material more specific for their work, and attendance at a course on being an expert witness is mandatory before presenting expert evidence in court.

In *Spain*, training developments have grown out of a long-standing division between legal training in medicine and clinical and organisational training [16]—so people wishing to specialise in work with offender patients must train in legal matters as they relate to medicine (not specifically psychiatry) and in clinical matters (not specifically relating to offender patients, most of whom are treated in a prison setting). As such, there is a tendency for courts to require opinions on offender patients from doctors with legal training who may have no expertise in psychiatry at all. The Spanish National Commission for Specialisation has considered allocating subspecialty status to forensic psychiatry, which would mean 1 additional year of specific clinical training after 3 years of general training in psychiatry; this has not happened yet but may do so in the foreseeable future. A non-clinical master's degree of 1–2 years in forensic psychiatry is available, such as the ones offered by the Universitat Internacional de Catalunya, the Universidad Complutense de Madrid or the Universidad Nacional de Educación a Distancia.

13.5 Uniprofessional or Multidisciplinary Training?

In a specialty which relies strongly on multidisciplinary work, it seems logical that the different professions should be learning from each other. There is real benefit in bringing many clinical disciplines together given that offender patients have complex problems and need the wide range of skills that this can bring. It is thus important that each discipline brings unique skills to the clinical team and is secure in them. This can only be realised by effective within-discipline training, but there is an argument that complementing this with additional multi-professional training could bring further advantage. In *Scotland*, the School of Forensic Mental Health (SoFMH) was established in 2007, to improve the quality of response, care, treatment and outcomes for people with mental disorder who come into contact with the criminal justice system or whose behaviour puts them at risk of contact with it. It emphasises care and treatment delivered on a multidisciplinary and multiagency basis and offers multi-level and progressive provision of learning across the college and university interface. An example of an SoFMH programme is a self-directed learning programme, supported by mentors, which provides basic information on patients' 'journeys' through the forensic system, with case examples, questions, a reflective diary and a bibliography for each of its 15 'chapters' [17].

A wider professional training issue is raised by the growing acknowledgement of the importance of interagency work—as in the UK multiagency public protection arrangements (MAPPA) for discharged patients considered to have the likelihood of posing some continuing risk to some others under some circumstances (for England and Wales: https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf; for Scotland: http://www.gov.scot/Publications/2016/03/6905). Agencies such as the police, probation and housing authorities have very different goals, ethics and codes of practice from clinical practitioners, and it is important to be able to understand each other. To date, most related training tends to be within-discipline and interdisciplinary efforts more informal.

13.6 International Training

Since 2010, the Ghent Group, through collaborations between the universities of Munich, Cardiff and Antwerp and the Max Planck Institute for Foreign and International Criminal Law (Freiburg, Germany), with substantial support from Danish forensic psychiatrists, the UK Royal College of Psychiatrists and Bildungswerk Irsee in Bavaria (Germany), has been bringing together forensic psychiatry trainees and consultants from many European countries into a 4-day seminar, led by an experienced international team, including an academic lawyer specialising in international law. The format of the seminar mixes lecturing and case work on relevant themed topics. Making constant comparisons between national positions, the participants follow the paths of any given offender from

the moment he or she committed a serious crime, through the criminal justice system of each country, their committal to the relevant institutions and on to consideration of their release back into the wider community. So far the themes have been:

- Pathways of offenders in the different countries of Europe and the role of the forensic psychiatrist
- The role of psychiatrists within the criminal justice system in different countries of Europe
- Offenders with personality or other developmental disorders
- Research and its impact on the practice of forensic psychiatry: exploring the extent to which practice in each country is truly evidence based
- Patients who clinicians find difficult to manage—how do they compare across Europe?
- Individual cases who have significantly influenced legislation and jurisdiction
- Assessing and managing asylum seekers, refugees, other immigrants and other people from different cultural and ethnical backgrounds

After some introductory, theoretical sessions, participants work in groups on the case vignettes provided. One member of the group is then asked to present the deliberations of the group to the plenum, for discussion and challenge by the other participants and the trainers. The work is made more naturalistic by giving participants only one phase of the case at a time, with more information being released as the case 'progresses'. From this exchange, pathways into and through the criminal justice system and the role of the forensic psychiatrist can be determined for each country. A frequent comment at the end of each case is that participants had not only learned about other systems but also understood their own legal system much better. Being required to explain one's own system to people without any experience of it at all, while being used to managing a range of offending or psychiatric problems, means that no one can shelter under the cover of assumptions of knowledge. Also, participants discover new ways of dealing with offender patients within their national context and how to understand better the interaction between themselves, the offender/offender patient and the court. As participants get involved in the role-play, which is a key part of the seminar experience, they learn also about feelings, prejudices and disappointments that they encounter from all parties involved in criminal proceedings and how to share these appropriately and deal with them.

Conclusions

The proximity of European countries and the fact that they share core values relevant to work with offender patients while having different laws and legal systems make them uniquely well placed to unite in training efforts and in research. In all countries, forensic psychiatry has some unique features that are not shared by most other medical disciplines:

1. Forensic psychiatrists have to translate medical knowledge into terms which other professionals, such as lawyers, courts, public agents and other decision makers and sometimes even the public and the media, can understand and use for their decisions.
2. While general psychiatrists must be ready to weigh their responsibilities towards the patients with those towards public safety, including actual or potential victims, forensic psychiatrists must constantly do so and ensure that their patients understand this position.
3. More than in other medical disciplines, work of forensic psychiatrists is integrated in a multidisciplinary and multiagency approach, which does not only include other empirical sciences but also law, policing and welfare organisations.

These unique features require special teaching and training methods, which exceed the acquisition of knowledge and the practice of medical skills. They include communication and the understanding of many professional roles and narratives and how to cooperate effectively with nonmedical personnel who have a different professional ethic while always maintaining medical standards and the ethical foundation of their own profession [18].

We do not yet have much similarity in our training systems or the extent to which forensic psychiatry is fully recognised as a specialty, but we have learned how much we can learn from each other and how necessary and important that is to being able to interpret and use much of the research data from each other's countries.

Take-Home Messages

- Forensic psychiatry is, across European countries, variously a specialty, subspecialty or development within medicine. The medical ethic applies at all times, and great weight is placed on the prevention of harm and service provision.
- In addition to clinical knowledge and skills, specialists in forensic psychiatry need special knowledge and skills pertaining to legal concepts of competency and responsibility, of wider ethical issues including the statutes of the UN and the European Convention on Human Rights, of communication with nonmedical professions and of interdisciplinary and multiagency collaboration.
- To achieve the knowledge, skills and competence, some European countries have established specialist clinical training. Others have tended to rely on attendance at courses, but these are primarily effective in knowledge transfer. Skill development and competence emerge from supervised experience.
- European countries have started to exchange knowledge and to find common ground for teaching and training in forensic psychiatry. The Ghent Group promotes this.
- People collaborating in residential Ghent Group seminars report that these have substantially improved their knowledge of their own country's practices as well as those in other European countries.

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Impact of Service Organisation on Teaching and Training

14

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14.1 Introduction

In this chapter, we will set out what we believe are the most universal or typical structures that characterise service organisation in forensic mental health and then discuss specialist teaching and training required to meet the needs of such services for forensic patients. Models of service organisation for forensic mental health should be continuously revised as the theory and practice of delivering such services develops. Traditional service models were often documented in eighteenth-century textbooks on hospital architecture, emphasising a static concept of lifelong care (Kirkbride 1880; Burdett 1891). These authors had much to say about the selection, training and roles of staff in such hospitals. This was followed by doubts about the asylum system (Stanton and Schwartz 1954), then sociological critiques (Goffman 1961), careful consideration of the position of the mentally ill person in the asylum (Goffman 1963), increasingly radical attacks on the concept of mental illness itself (Szasz 1961), reasoned studies of long-term hospital patients (Wing and Brown 1970), politicisation of psychiatry (Foucault 1967), the politicisation of concepts of disease, health and medicine (Foucault 1973) and the politicisation of prisons (Foucault 1977). There were successful refutations of such critiques (Clare 1976), while the historical failings were accepted (Hunter and McAlpine 1974; Clare 1976;

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Bynum et al. 1988). The post-modern attempt to deconstruct medicine and psychiatry itself has been reconsidered from a sociological perspective (Collins and Pinch 2005) and sometimes from both a satirical (Sokol and Bricmont 1998) and self-critical perspective (Skrabanek and McCormick 1992). Only recently has culture in psychiatry (Littlewood and Dein 2000) and in secure care (Bartlett 2016) been studied from an academic perspective.

Service organisation progressed to decarceration (Scull 1977, 1979, 1981; Bynum et al. 1988), and the provision of services almost exclusively in the community (Hall and Brockington 1991; Murphy 1991) though this occurred in different decades in different jurisdictions; Italy was an early adopter with Ireland a recent example, while in some jurisdictions, there has been some reconsideration [1].

The next stage in the development of mental health services saw the emergence of trans-institutionalisation [1], with a growing recognition of the need to make mental health services accessible to homeless mentally ill people, mentally ill prisoners and those in need of long-term supportive services in the community (Torrey 2008).

This model in turn has developed into a nuanced range of services with an emphasis on individual care plans (Thornicroft and Tansella 1999) and a recovery orientation [2] (Drennan and Alred 2012). Modern policy-oriented writing often omits any mention of forensic mental health pathways, hospitals or services. A comprehensive service for any defined population includes therapeutically safe and secure services that are provided as part of a life-stage pathway tailored to the needs of the individual at a particular stage in their life. Such highly specialist services are selective supports for the larger general adult services. These provide for districts or regions, and typically service populations of three to five million.

This development of specialist forensic mental health care as an integral part of comprehensive mental health services will develop continuously over time and will take different forms in each jurisdiction, shaped by the boundaries between community, hospital and criminal justice services, processes and legislation [83]. In Germany, The Netherlands and in England and Wales, patients can be detained because of personality disorder; by contrast, in Ireland and France, the law excludes detention on the grounds of personality disorder. Training for the skills to provide such services must therefore be flexible and must emphasise the acquisition of the ability to take an overview and a critical understanding of the social and cultural influences that shape forensic mental health in each place and in each era.

In order to consider the impact of service organisation on education and the research that underpins training, this chapter will first outline the most common structures and processes of forensic mental health services now. We will then briefly describe the skills required to deliver the range of services that can be described as forensic mental health, having constant regard for the commonality and overlap with the mainstream of mental health services. Next, we will describe the diverse roles of the mental health professions practicing in forensic mental health and the training specific to each, having regard to the importance of multidisciplinary and multi-agency work. We will briefly discuss the necessity of specialist knowledge and training in law and ethics for practitioners in this challenging field. We will also

describe briefly the training relevant to communicating assessments and opinions in legal tribunals and hearings with particular reference to court decisions regarding forensic mental treatment orders and release decision-making.

14.2 Forensic Mental Health Services Now: Structures and Processes

14.2.1 Prison In-Reach and Court Diversion

Pathways into mental health care and treatment can be described as planned and appropriate or unplanned and dysfunctional. The planned pathway consists of a person or their family and carers seeking help through primary care and being referred where appropriate to secondary mental health services. Where necessary, secondary mental health services may refer the person to highly specialised tertiary services such as forensic mental health. Unplanned or dysfunctional pathways occur when, because of an unmet mental health need, the person presents through some other route. Homeless services, addiction services, schools and occupational health services are intermediate community-based routes back to primary care or mental health services. However, contact with the criminal justice system because of the consequences of unmet mental health needs may be regarded as dysfunctional. In effect such a person has fallen through the 'help-seeking' route designed to connect mentally disordered people with appropriate mental health care. Therefore, many jurisdictions have clinical services and legal processes designed to screen for mental disorder amongst those coming before the courts or remanded into custody. The aim is to divert them to the most appropriate mental health care whether that is in the community, in a local hospital or in a forensic hospital. Street level liaison and diversion, police station screening and diversion, courthouse screening and diversion and prison in-reach systems for screening and diversion all represent approaches to this problem. In practice, court diversion systems are usually highly dependent on support from psychiatric in-reach and screening services in remand prisons [3, 4]. The only system demonstrated to meet the needs of all those remanded in custody is the remand prison in-reach screening system [5].

14.2.2 Stratified Therapeutic Security

All psychiatric services, like all health services generally, are organised into different levels of intensity of care and treatment and are designed to match different levels of need. This is fundamentally a system-oriented approach to managing the risk of adverse events and outcomes in the broadest sense (Adams 1995). Those with acute, subacute and rehabilitation needs each need different levels of care. In forensic practice, therapeutic security represents levels of care and can be described in terms of environmental or physical security, procedural security and relational security (Kinsley 1998) [6]. Relational security divides into quantitative relational security, the ratio of staff to patients; and qualitative security, the extent to which staff know their patients and have a strong working alliance with patients.

Accordingly the hospital, a ward within a hospital or any part of a service including community housing can be high or medium or low in physical or procedural or relational security with any combination being possible. Clinicians require the skill to assess the individual patient's need for levels of therapeutic safety and security and to place the patient so as to match those needs. Few will need the highest levels of physical and environmental security, but relatively many will need the highest levels of relational security and specialist treatment programmes. This corresponds to a nuanced version of the risk-need-responsivity principle (Andrews and Bonta 2006). In practice, it is the seriousness of risk and not the probability of risk [6–11] that matters most. The work of forensic rehabilitation and forensic community teams and the levels of therapeutic security that can be provided in the community has had limited but valuable preliminary research [12, 13].

14.2.3 Active Management of Length of Stay

The greatest risk facing a patient admitted to hospital including forensic hospital is to have a very prolonged stay. This may arise because clinicians and review boards are risk averse. Under some circumstances, economic pressures may lead to a shortage of beds and pressure to discharge prematurely. The period spent at any given level of therapeutic security, whether high, medium or low is therefore the result of many competing considerations. Under these circumstances, there is a necessity for objective evidence-based criteria. Triage criteria based on the seriousness of harm, which are distinct from treatment outcomes are good predictors of length of stay [14]. There is evidence that the dynamic items in risk assessment instruments such as the HCR-20 predict failed transfers to less secure places and failed discharges [15]. There is also evidence that the response to a range of treatments best thought of as multimodal treatment predicts moves to less secure places and conditional discharge [16, 17]. Similarly, change in measures of forensic recovery predict moves to less secure places [18] and conditional discharge [16–18]. Ensuring that appropriate treatments are delivered therefore becomes an essential element of actively managing length of stay. Ensuring that response to treatment and recovery is systematically and regularly measured and reported is also an essential element of the active management of length of stay [9, 19].

14.2.4 Governance Structure

It is common for policy decisions to require that all forensic clinicians should be trained in the use of the latest risk management instrument. In practice, this is futile unless the training includes a system for using such instruments as aids to the decision-making process. One professional may use the new instrument and its related skills almost randomly whenever he or she thinks of it. A group of clinicians may pass the instrument around, and each will use it differently and for different purposes. Only some consistent governance structure can derive the reliability and validity claimed for such instruments and such skills.

It is not enough that structured professional judgement should be applied to assessing the need for therapeutic security or assessing and managing risk. A judgement support framework is also required. A fair and just triage system requires that a consistent governance structure is applied to triage and the management of waiting lists (Daniels and Sabin 2002). In practice, this requires both the use of a validated set of criteria, monitored by means of validated assessment instruments, and a well-organised governance structure such as an admission panel to decide on the allocation of patients to the appropriate level of therapeutic security whether that be admission to a forensic hospital, admission to a locked psychiatric intensive care unit, an open ward or an outpatient appointment [8, 20].

Similarly, once admitted, the active management of length of stay outlined above requires that the routine outcome measurements are systematically reported to a governance structure where decisions are made about movements from high to medium, medium to low security or to the community. In practice in most jurisdictions (Canada, The Netherlands, Scotland), this decision-maker is a statutory, independent review board or tribunal. It is for the hospital governance structure, for example, a clinical director to decide on a standard format for reporting to this tribunal or board. Such reports should never be considered complete unless they include a summary of serial routine outcome measurements over time [19] such as the HCR-20, DUNDRUM-3 programme completion and DUNDRUM-4 forensic recovery [15–17]. Decision-makers should demand such objective data as the basis for opinions and recommendations placed before them.

14.2.5 Prison to Community

Mentally disordered persons leaving prison typically find themselves homeless and no longer in touch with primary care or secondary specialist mental health services. Accordingly, a system is essential for planning in advance of discharge to arrange for aftercare. Typically such pre-release planning is one of the functions of prison in-reach teams. Social workers often take the lead in this role because of their ability to coordinate probation, housing, primary care, social welfare benefits and secondary mental health services.

14.2.6 Forensic Hospital to Conditional Discharge

There is remarkably little research concerning criteria for both safe and successful conditional discharge. Readmission to forensic hospitals following conditional discharge is increasingly common. The majority of readmissions are because of relapse or recurrence of problem behaviours, substance misuse or relapse of symptoms though without serious offending. Serious offending however does occur. There is very little evidence concerning which treatments not only reduce the risk of reoffending but reduce the seriousness of reoffending. Efforts to devise and validate routine outcome measurements calibrated in meaningful units of change are however promising [21]. Measures of functional neurocognitive ability [22]

increasingly show that those with severe and enduring mental illnesses have significant impairments leading to disability [23, 24]. It is not surprising therefore that the goal of discharging all patients from medium or low security to the community will lead to demands being placed upon the individual for self-care and autonomy that are beyond the abilities of some. Increasingly, the emphasis must be on assessing the level of biopsychosocial supports required in order to avoid relapse, reoffending or readmission and achieve a satisfactory quality of life. Forensic mental health legislation commonly bestows powers for conditional discharge, a power that is rare in civil mental health legislation. The matching of the conditions attached to discharge with the psychosocial supports required for stability and recovery represents a particular advantage of forensic mental health pathways.

14.3 Structured Therapeutic Day and Treatment Programmes

In northern European countries, the number of forensic secure beds has increased steadily at a time when both prison places and general psychiatric hospital places have reduced [25]. Some countries follow a radically different policy. For example, in Italy, Law 81/2014 requires that referral to security beds must take second place to any attempt to provide a care pathway in the community network. Elsewhere, there is a widely accepted principle of the least restrictive option whereby patients should be detained in no greater a degree of therapeutic security than is necessary for safe care and treatment and for no longer than necessary. The Italian law also requires that time spent in a forensic setting shall focus on the timely provision of treatment aimed to discharge patients to lower levels of therapeutic security. This is sometimes stated as the ethical principle of reciprocity [26] according to which those deprived of their liberty by law are entitled to restorative treatment or at the very least they are entitled to a quality of life that ensures dignity. To reduce the risk of very long periods of detention in hospital, it is necessary to start rehabilitation programmes soon after admission. While providing effective treatment programmes is essential to achieve these goals, promoting quality of life is also an essential component of achieving recovery goals. Patients in secure forensic hospitals often complain of high levels of inactivity. A national study conducted in Italy on approximately 80% of the forensic population found that structured activities accounted for only 10% of the daytime hours [27], and these were mainly working activities. In the next section, we will consider active means of addressing this.

14.3.1 A Balanced Day and Quality of Life

In order to maintain a safe and therapeutic environment in which to deliver specialist treatment programmes, great attention should be paid to the milieu in which patients live and in which patients and clinicians work together. For these purposes, milieu can be thought of in the same way as therapeutic security: environment, relational and procedural aspects of communal living. The Quality Network for Medium

Secure Services of the Royal College of Psychiatrists in London sets as a target that each patient should have 25 hours of structured activities a week. The use of these 25 hours has never been further quantified though it might reasonably be expected that a therapeutic day should consist of a balance between formal treatments in the mornings, individual or group; meaningful work in the afternoons, education or occupation; and sport, creativity and leisure in the evenings. For many patients, the provision of the simple regularities of communal living emulates the caring and supportive structures of family life; rising at a regular time in the morning, eating meals at regular times, preferably with trusted others; moving from living to working spaces in the course of a day, all of which are experienced as safe and supportive; and retiring to a personal space at night which is safe and individual [85] (Newman 1972), all with access to fresh air, daylight, exercise and as much personal choice and autonomy as are compatible with safety. While landmark studies by Goffman (1961, 1963) on the anthropology of total institutions were succeeded by further studies suggesting that excessively regimented and rigid hospital routines and deprivation of personal property and personal space led to so-called institutional neurosis (Wing and Brown 1970), in succeeding years the so-called institutional neurosis has been reframed first as the negative symptoms of severe mental illness [28] then as the neurocognitive impairments of neurodevelopmental disorders including schizophrenia [23, 24]. Under these circumstances, a degree of structuring is supportive for those who lack the capacity to maintain their own minimum regularities, in order to tend to their physical and mental health unaided.

14.3.2 Treatment Programmes

The conventional view of the 1990s that treatment programmes should follow clear guidelines, operationalised and manualised wherever possible in order to ensure fidelity and effectiveness has been qualified in recent years. A recent overview indicates that while specific and manualised treatments can be shown to have positive effect sizes, it is the more general aspects of treatment such as positive working alliance, frequency, intensity and duration that have the largest measurable treatment effects [29]. Similarly, for violence reduction programmes, a comprehensive review suggests that multimodal approaches to treatment once again with an emphasis on frequency and duration of treatment are most likely to be effective rather than single specific and targeted interventions (McGuire 1995, 2002) [30]. The important qualities of the individual therapist [31] represent a particularly difficult challenge for research and training. Under these circumstances, Kennedy et al. [9] using a Delphi style process have described seven pillars of care for people with severe mental illness detained in forensic hospitals with the goal of enabling such patients to be cared for in progressively less secure placements. These seven pillars of care are:

- Physical health
- Mental health
- Substance misuse interventions

- Problem behaviour interventions
- Self-care and activities of daily living
- Education, occupational and creativity
- Family and intimate relationships

Each of these is delivered in preliminary short-course interventions consisting mainly of psychoeducation [32], full programmes which may last a minimum of 26 weeks and may have to be repeated a number of times until effective, and a third phase of maintenance or self-maintenance. The content of each programme is not prescriptive since best practice will evolve continuously, and individualisation will always be necessary. Patients can be assessed for progress in each of these seven programmes using scales calibrated in meaningful units of change from an initial stage which may consist of lack of readiness for movement to a less secure place through to readiness to move from a high or acute level of care to a subacute or medium level of therapeutic security and then a move to low security followed by movement to supported community placements and eventual achievement of full autonomy. Operational criteria are given for each unit of meaningful change. These can in turn be related to five paradigmatic theories concerning treatment and change (Table 14.1).

For each patient, an individualised care and treatment plan can be constructed from the elements of these treatment programmes. This treatment plan will evolve in repeated cycles of care planning, for example, at 3–6 monthly intervals. Change will occur according to the readiness and motivation of the individual patient. Each revision of the individual treatment programme should be supported by the active engagement of the patient with the multidisciplinary team so that it is the patient who is the co-producer of the individual care and treatment plan. The patient is placed at the centre of the care pathway in accordance with recovery theory [33]. This is thought to be essential in order to regain hope and a sense of personal agency. In addition to therapeutic engagement, goals include risk reduction and mental health recovery more generally. Richter et al. [21] have recently shown that progress in the seven treatment domains above can be related directly to reduction in dynamic risk of violence. Individual treatment programmes must be pragmatic, taking account of strengths, vulnerabilities and motivations in the individual person. Protective and resilience factors are increasingly recognised as of equal importance to vulnerability factors [34, 35]. However, there is also a growing emphasis on the need to identify proximate causal factors as targets for treatment.

Finally, recovery goals such as an increased sense of personal agency, co-production of care and treatment goals and plans and hope are all valid outcome measures when related to increased use of leave and return to the community [18]. The restoration of functional mental capacities and legal competencies should also be regarded as relevant outcome measures and goals (Grisso 2003) [36]. Functional mental capacities are conceptually difficult to understand without clinical training and clinicians commonly mistake the ability to understand information for the ability to reason using that information [37].

14.3.3 Quality of Life Programmes

Quality of life may be difficult to measure and may seem a paradoxical concept for those deprived of their liberty while detained in hospital or in a prison, but quality of life is an essential precondition for successful treatment, whether short term or long term [38]. Respect for personal dignity must always involve guaranteeing quality of life in terms of the living environment (Hickman 2013), interpersonal relationships as well as professional relationships [39] and procedures to ensure that these are sustained reliably over time [40]. Those who are unable to progress in treatment due to treatment-resistant mental illnesses or impairments of neurocognition or social cognition are nonetheless entitled to dignity and quality of life in accordance with the principle of reciprocity even when risk needs responsivity requires high levels of therapeutic security for prolonged periods of time. For many patients, providing the quantitative and qualitative relational supports necessary to achieve Maslow's basic needs is the buttressing which permits impaired and disabled patients to nonetheless achieve Maslow's higher goal of self-actualisation. It is increasingly also recognised that the need for human contact can be fulfilled through passive or active membership of the community even when that is a highly selected community of fellow service users. Once again, supporting the basic needs for human interaction may permit the achievement of some degree of self-transcendence, for example, by engaging in voluntary charitable work and other contributions towards the social capital of the group. There are examples of excellent practice, for example, in units for long-term forensic care within the TBS system in the Netherlands (Pompe Kliniek Zeeland) and particularly in New Zealand, for example, the Mason Clinic. The emphasis here is on providing those patients who require very long periods of detention in conditions of high security with opportunities for work that is known to have prosocial effects outside the hospital in the broader community while at the same time contributing to communal activities within the secure setting as well as self-actualisation through various forms of creative self-expression [41, 42] and cultural consciousness raising.

14.4 Forensic Mental Health Services and Specialist Skills

Mental health services generally, including forensic mental health services, are best delivered by multidisciplinary teams, according to many policy statements. It is also generally accepted that addressing the biopsychosocial needs of a mental health patient will involve the coordination of many agencies beyond mental health services including housing, welfare and occupational rehabilitation. In forensic contexts, a variety of criminal justice agencies and more specialised housing and welfare agencies may be involved including police, probation, specialist services for personality disorder, sex offenders, arsonists and other niche arrangements. An overarching skill for senior clinicians is to plan, coordinate and sustain complex treatment plans and pathways. In some jurisdictions, the role of case management has been taken on by third-party state sponsored purchasers and commissioners of

complex care packages, for example, NHS England or the TBS system in the Netherlands. This is in contrast to the judicial role of review boards in Canada and mental health tribunals elsewhere. The specialist skills required to fulfil such roles remain largely unstudied. An awareness of social policy and social institutions, criminal justice services and legal processes, service evaluation, audit cycles and quality improvement would all be required at a governance level.

In this chapter, there will be insufficient space to deal with highly specialised topics such as services and skills for psychopathic disorder, forensic intellectual and developmental disorders, forensic child and adolescent mental health services, services for the elderly offender, dual diagnosis services for substance misuse, acquired brain injury and other 'niche' needs including sex offenders, arsonists or others. Instead, this chapter will concentrate on the larger common aspects of forensic mental health practice.

14.4.1 Risk-Need-Responsivity and Skills

The general principle that those presenting the highest risks should be allocated to the highest levels of care translates into a series of practical steps each requiring specific skills. Treatment and where necessary detention in conditions of therapeutic security should be regarded as a dynamic process. An individual patient may need to move between the community and high, medium or low levels of therapeutic security at different times in the course of a career. These dynamic assessments fall under the general heading of needs assessment and cannot readily be mapped onto risk assessments as generally understood. The factor mainly determining the need for therapeutic security is the seriousness of the risk rather than the probability [6–8, 10, 14, 20]. From the point of view of governance and the clinical director of services providing forensic mental health pathways through care, it is important that there should be well-organised systematic admissions panels for consistency amongst those clinicians assessing need. Needs assessment should be informed by evidence based and validated structured professional judgement tools. The use of such tools in itself requires systems for training and regular refresher exercises to ensure consistent inter-rater reliability and the avoidance of drift.

14.4.2 Triage and Urgency Assessments for Admission

Assessing the level of therapeutic security to which a mentally disordered person should be admitted is a core skill for forensic psychiatrists and forensic hospital governance systems. Remarkably, little research has been published on this topic. Eastman and Bellamy's [43] Admission Criteria for Secure Services Schedule (ACSeSS) was the first to set out criteria for assessing need for therapeutic security and in effect postulated the use of clinically meaningful units of measurement—since then other instruments for measuring need for therapeutic security have mostly

followed the same scoring system with '4' for high security, '3' for medium security, '2' for low security, '1' for open settings in hospital or the community and '0' for independence. Eastman and Bellamy's scheme set out seven domains relevant to the need for therapeutic security including the gravity of recent or past violent behaviour, the immediacy of any risk of violent behaviour in the community or in hospital, psychopathology that 'predicts' the above, specialised psychopathology that specifically determines anti-social behaviour (specialist forensic need), the likely duration of the admission, unpredictability and lastly how the case would be perceived by a criminal justice agency—a 'political' factor that might determine admission to a higher level of security than other factors might indicate. There are no published validations for this scheme. Kennedy [6] described definitions for levels of therapeutic security, then went on to define needs for therapeutic security as triage criteria; these were predominantly static and patient centred, so that a triage recommendation could be formulated in the course of a pre-admission assessment using the sort of information normally considered for such reviews. Shaw et al. [44] published an instrument using visual analogue scales to measure patient-centred factors such as security needs, dependency needs, treatment needs, 'political' considerations and likely length of hospital stay. Kennedy [6] balanced the static nature of these admission criteria by adding definitions for the levels of therapeutic security and also by adding criteria for assessing the dynamic readiness for moves to less secure settings. Subsequently, other instruments for needs assessment were published, intended for cross-sectional surveys. Sugarman and Walker [45] published the HoNOS-secure, a mixture of severity items and physical, staffing and procedural items; Collins and Davies [46, 82] published the Security Needs Assessment Profile (SNAP) containing mainly security-centred institutional factors such as physical security, relational security and procedural security with detailed item definitions. Security-centred instruments or items are to some extent circular in their reasoning—asking clinicians what height of wall or level of nursing care a patient needs is itself the answer to the question, not a measure of the patient-centred factors determining that need. An actuarial tool was tested as an assessment of triaged need in an English high-secure hospital [47]; this was based on risk factors which contained only one item reflecting seriousness of violence and perhaps for that reason had a moderate receiver operating characteristic and modest predictive power [47]. Kennedy et al. [9, et seq] built on Kennedy's [6] paper to describe the Dangerousness Understanding Recovery and Urgency Manual (DUNDRUM toolkit). This is a series of structured professional judgement instruments describing patient-centred factors and some victim-centred factors influencing need for therapeutic security, urgency of need when on a waiting list, a set of measures of response to seven treatment domains or 'pillars' representing multimodal treatment programmes and operationalized criteria for recovery in a forensic context as well as a set of self-report criteria co-produced by service users [14, 18]. These have been extensively validated both by the authors and in other jurisdictions including England, The Netherlands and New South Wales [5, 7, 8, 14, 16–18, 20, 48, 49] (Adams et al. 2018). The DUNDRUM handbook says that the item content was arrived at by a Delphi process of distilling the collective experience of clinicians

who had worked in many jurisdictions. The handbook describes these items as intended not only for assessing individual cases but also as training material for forensic clinicians.

14.4.3 Risk Assessments

Risk assessment is considered a core skill for forensic practitioners. Not all members of a multidisciplinary team (MDT) require the same risk assessment tools to fulfil their roles, and different members of the MDT may require different types of knowledge and expertise in the use of such instruments. There is evidence in the literature that the clinical and risk scales of the HCR-20 [50] (Webster and Hucker 2003) can predict those forensic patients who will be violent when discharged from medium security [51, 52] and those who will be recalled following transfer to a less secure placement [15]. Accordingly, risk assessment instruments should be incorporated more systematically into the processes of decision-making, for example, in reports to review boards and tribunals [19] and should therefore be part of the training of treating clinicians and experts giving evidence and of the members of such decision-making bodies. However, such risk assessments have also been criticised because of their high false-positive rate when the 'base rate' incidence of violence is low [53] though this criticism itself may fail at the system level [54].

Short-term risk assessment instruments such as the Brøset [55] and DASA [56] are proximate and causal in their content rather than distal and indirect 'risk' factors. For this reason, short-term risk assessments such as the Brøset and DASA lend themselves to immediate interventions such as de-escalation and are typically used by nurses and other ward-based staff. While the interventions to ameliorate proximate causal factors are directly linked to the content of such instruments—engagement, distraction, time-out, the interventions necessary to reduce static and dynamic risk factors identified in longer-term instruments such as the HCR-20 may be less clear. The risk management companion guide (Douglas et al. 2001) is in this respect a beacon of light for clinicians drafting individual treatment plans and a guide for future clinical research and service development. However, much more research is needed to make risk assessments directly relevant to treatment and rehabilitation [12].

There is some evidence that very general indicators of ability and well-being such as the Global Assessment of Function are almost as good predictors of inpatient violence in forensic patients as formal risk assessments such as the HCR-20 [57]; while new instruments assessing protective factors also perfume as well as risk-vulnerability assessments [34, 58]. This raises interesting questions about the nature of risk assessment instruments as a way of achieving an empathic understanding of the patient and their risks [59]. The content of a risk assessment may be the most appropriate way of selecting a specific tool when identifying remediable problems relevant to violence.

There is worrying evidence that risk assessment instruments may be relatively insensitive to change [60] though there is new evidence of sensitivity to change in the earlier stages of treatment [21]. While 'treating violence' remains central to the

perceived purpose of forensic mental health services (Maden 2007), the actual evidence that treatment reduces risk or the severity of risk is relatively new [21] and requires much more research.

14.4.4 Treatment and Recovery Measures

Structures for multimodal treatment have been described above. The coordination and delivery of such programmes in a sustainable cycle over time requires multidisciplinary coordination within hospital pathways and community pathways or within prisons. Part of the skill in doing this involves a regular review of the best evidence concerning effectiveness [29, 30]. At the moment, this evidence largely rests on systematic review (McGuire 1995, 2002) [30]) with little evidence available at the standard of meta-analysis because of the paucity of randomised controlled trials. Where randomised controlled trials exist, there is little consistency concerning the nature of the control condition or 'treatment as usual'.

Against this background, it remains possible to use general outcome measures such as the Clinical Global Impression Scale [61, 62], the Global Assessment of Function [63], Social and Occupational Functional Assessment Scale (SOFAS), Global Assessment of Relational Functioning (GARF) [64] and a range of other measures of need including the Health of the Nation Outcome Scales (HoNOS) and Camberwell Assessment of Need (CAN) [84]. All of these are best rated by multidisciplinary teams in the course of regular cycles of case conference and care planning so that serial measurements can be compiled. However, the general nature of these assessments means that they may offer limited reassurance regarding treatment and recovery outcomes specifically relevant to risk (probability) of serious violence. A specific specialist skill therefore consists of identifying relevant treatment goals and the means of measuring the extent to which they are achieved.

Some measures of the need for therapeutic security already referred to such as the HoNOS-SECURE [45] or the SNAP [46] may provide measures of progress towards needing less therapeutic security, but in so far as these ask circular questions ('does the patient need to be detained behind a 3.5m fence'), they are not really measures of progress in a relevant treatment. Only the HCR-20 and the DUNDRUM-3 programme completion and DUNDRUM-4 forensic recovery scales have published validated studies showing that they predict moves from higher to lower secure settings and conditional discharge using scales composed of patient centred items. There is also evidence [21] that reliable and meaningful change in measures of programme completion can be related to reductions in measured risk of violence though much more needs to be done to establish chains of causation. It can be shown also that neurocognitive impairment has an adverse effect on change in programme completion scores [21].

Recovery as a concept may seem difficult to reconcile with systematic therapeutic security, but there is evidence that working alliance [39] and recovery principles generally are fostered and practiced in forensic settings [33, 65–67].

14.5 Mental Health Professionals Practicing in Forensic Mental Health

Forensic mental health services are distinguished from other parts of a comprehensive mental health service in both qualitative and quantitative ways. Quantitatively forensic mental health services provide a carefully structured range of levels of therapeutic security at levels much higher than are required in general adult services. Qualitatively, the emphasis on risk of serious violence with the means of addressing this is a distinguishing factor. In practice, the importance of positive working alliance, service user engagement and a recovery orientation all underline the similarities between general and forensic mental health services for people with mental disorders. In this context, it has always been possible for practitioners to move between general adult and forensic services. However, it would be wrong to underestimate the importance of specialist training and cumulative experience over the course of a career when assessing, advising and treating mentally disordered offenders and liaising with the many agencies involved in their pathways through care and custody. For each of the professions involved, there is a progression from studying a formal curriculum of basic sciences through training in clinic skills on to the acquisition of expertise. Expertise is variously defined as both the use of deliberative judgement and over time the acquisition of what appears to be a mixture of deliberative and intuitive judgement [59, 68], while a more formal definition of expertise would distinguish between the interactive expertise of journalists and lawyers and the contributory expertise of highly skilled and experienced practitioners who are capable of generating new knowledge in their field [46, 82]. Interactive experts commonly overestimate their expertise. Contributory expertise is undervalued in so-called health economies. Research training and continuing clinical and research experience are required in order to achieve the highest levels of expertise. This is particularly true amongst those who are responsible for undergraduate and postgraduate professional training and for those who are responsible for translating research and scientific advances into policy and service development.

14.5.1 Psychiatrists

In many jurisdictions, higher training in psychiatry is common for all sub-specialties. In some jurisdictions, higher training can lead to registerable specialist recognition as a forensic psychiatrist. After medical qualification in the UK and Ireland, a 3-year competency-based basic specialist training in psychiatry is followed by a 3-year specialist training in forensic psychiatry, and a curriculum for this is published by the Royal College of Psychiatrists in the UK. In North America, after medical qualification, a 3-year specialist training in psychiatry is followed by a 1-year fellowship in forensic psychiatry. The competencies outlined typically include a knowledge of the uses of therapeutic security, risk assessment and risk management, the organisation and delivery of prison in-reach and court diversion mental health services and community-based forensic rehabilitation and recovery services.

In most jurisdictions, psychiatrists are required by law to lead a multidisciplinary team and to bear legal responsibility for the care and treatment of psychiatric patients, particularly in hospital settings. Exceptions exist in some jurisdictions (England and Wales, The Netherlands) where psychologists may take legal responsibility for the care and treatment of patients with personality disorder or intellectual and developmental disorders. As the leader of the multidisciplinary team, the psychiatrist must be able to fill the role of chair, standard setter, goal setter, negotiator, consensus builder, limit setter, expert in relation to medical matters, facilitator in relation to the specialist skills of other disciplines, narrator, interpreter and formulator in relation to biopsychosocial understanding of the patient (Osler 1913, 1926). The psychiatrist must also take responsibility for maintaining a positive therapeutic relationship and working alliance with the patient, the patient's family and carers and the entire team [29]. The relationship of a psychiatrist with their patients is often a long-term relationship. Under the circumstances, the therapeutic relationship itself becomes central to achieving successful outcomes in the domains of treatment and programme completion, quality of life and the protection of rights and dignity. The psychiatrist as team leader has a particular responsibility to act as advocate for services, resources and rights for their patients. As outlined below however the ethical position of the consultant psychiatrist in forensic practice is often complex. The careful balancing of a patient's individual rights, responsibilities, autonomy and dependency needs and the need to maintain the safety of the patient and those who come in contact with him or her is a matter for constant reflection and review. The ability to express decision-making in plain language and to explain an opinion in transparent terms based on good clinical evidence will regularly be subject to cross-examination in forensic settings. An ability therefore to present evidence both in writing and orally is one of the essential skills for a forensic psychiatrist.

14.5.2 Nurses

Forensic mental health nursing [69] demands a constant balancing of custodial, parentalistic and behaviour-changing care and interactive, relational and personal quality-dependent care [70]. Nurses in mental health practice may have been trained specifically in psychiatric nursing in some jurisdictions, while in other jurisdictions, they may have had a general nursing training with postgraduate specialist qualifications in psychiatric nursing. Formal training in forensic nursing [71] is usually provided at postgraduate level. In mental health settings generally, nurses have a responsibility to ensure that patient experiences are positive. Typically, the nurse who takes on the role of primary nurse will have daily contact with the patient and will have responsibility for engaging the patient in their care planning and recovery processes. In hospital settings, ward-based nurses have the responsibility for ensuring the ward environment is physically safe, clean and healthy and also that the ward environment is caring, supportive and friendly. In a forensic setting, attention to quantitative and qualitative relational security is particularly important [72]. Relating staff to patient ratios to indices of need is well developed for physical dependency needs but

less well developed as yet in relation to therapeutic safety and security [6] though there is some evidence that qualitative relational security helps prevent violence [40]. Limit setting in a way that is fair, respectful, consistent and knowledgeable and shows empathic engagement is recommended from qualitative research [73, 74].

In forensic settings, nurses and nursing assistants or social therapists typically will all be trained in the prevention and management of violence and aggression. The emphasis falls heavily on short-term risk assessment leading to de-escalation designed in order to minimise the use of intrusive, restrictive or coercive practices such as restraint, seclusion and forced medication [75]. Where these are used, it should be possible to demonstrate that their use is proportionate.

In prison in-reach settings, nurses and social workers who are typically trained to Masters level may be involved in screening and triage and have a significant role in arranging alternative placements necessary for court diversion schemes. In forensic community rehabilitation and recovery teams, mental health social workers and community mental health nurses working with the supervising psychiatrist and operating in accordance with assertive community treatment principles may take on an enhanced role in relation to reporting to courts or review boards and using the conditions attached to conditional discharge as a means of ensuring long-term stability and quality of life.

14.5.3 Social Therapists

There are a variety of roles for health-care assistants and social therapists at various stages in the forensic care pathway. In inpatient settings, social therapists contribute to skills mix. This often involves taking a direct role in the physical care of patients who may need support and assistance with activities of daily living. More generally, social therapists may bring life experience to the hospital setting enabling them to communicate and relate directly with those from a variety of backgrounds, often with appropriate cultural matching and sensitivity. Social therapists typically have postgraduate qualifications at certificate or diploma level and may also have undergraduate qualifications in health care, psychology or social work. Graduates in psychology, social science, health science and other academic disciplines may elect to work as social therapists in order to acquire clinical work experience prior to undertaking formal professional training in one of the allied health disciplines, or they may be engaged in a primary career or in a midlife change of career. For those recruited in midlife, bringing life experience from entirely different walks of life can be particularly enriching in relation to education, occupation and creativity and the humanising of ward atmosphere [38, 76, 77].

14.5.4 Psychologists

Clinical psychologists bring two specific skill sets to the multidisciplinary forensic mental health team. The first concerns neuropsychometric and neuropsychological testing in accordance with validated and reliable measures. The recent progression

from traditional measures of academic ability such as the Wechsler Adult Intelligence Scales to measurement of functional neurocognitive abilities such as the Matrix Consensus Cognitive Battery [22], which includes a measure of social cognition, has to some extent led to a reappraisal of schizophrenia and other severe and enduring mental illnesses as neurocognitive and developmental disorders [23, 24, 78] in which impaired mental capacity arises from neurocognitive impairments rather than simply arising from delusions and hallucinations. It is becoming increasingly obvious that delusions, hallucinations and violence arise from neurocognitive impairments rather than vice versa [79] and that these neurocognitive impairments are relevant to violence [79].

Clinical psychologists also bring training and expertise in a range of evidence-based psychotherapies. Bearing in mind the increasing recognition of neurocognitive impairments [80], these may commence with cognitive remediation therapies, progressing when the patient is sufficiently able, to metacognitive therapies which are seen as preparatory to individual and group forms of psychoeducational, motivational and cognitive-behavioural therapies. While these may be directed towards symptoms of mental illness, the group and individual approaches to cognitive behavioural therapy may also address specific problem behaviours including anger, violence, negative attitudes to women, fire-setting behaviours, sexual offending and a range of other specific problems. Where there are enduring problems with dispositions and personality traits, therapies may also be directed towards longer-term structured transference-based approaches such as cognitive analytic therapy where there is sufficient evidence to support this.

Counselling psychologists typically are trained in a wide range of evidence-based therapies including all those mentioned so far, as well as dialectic and metalizing therapies and other evidence-based therapies as appropriate.

Forensic psychologists often find a specific role in relation to prison and correction settings where their skills in risk assessment may inform the organisation and management of prison regimes. ‘Forensic’ psychologists working in these settings may have to think carefully about the differences between clinical ethics and security ethics where there is actually no ‘dual role’. This problem would not arise when working in a prison hospital, where clinical ethics has the usual balancing role in dual obligations.

Psychologists in any forensic setting may assist other disciplines in managing acute threats of violence through designing behavioural management plans orientated around identifying individual antecedents, individual behaviours and the consequences which may reinforce repetitive dysfunctional behaviour so that alternatives to violence can be rewarded while unintended rewards for violent or aggressive behaviour are removed.

Psychologists may also have a particular role in relation to trauma-informed care and the psychological treatment of post-traumatic stress and attachment disorders.

14.5.5 Occupational Therapists

Occupational therapists have specialist skills in assessment and rehabilitative therapies concerning motor and process skills relevant to self-care, activities of daily living, work and leisure activities [81, 86]. Typically such assessments and

rehabilitative programmes are orientated around a model of human occupations. As the understanding of neurocognitive and social cognitive impairment in severe and enduring mental illness and other mental disorders becomes clearer, the importance of process abilities in achieving rehabilitation and recovery goals is emerging as central to good outcomes in mental health and particularly in forensic mental health.

14.5.6 Social Workers

Social workers combine training in sociology, social anthropology and social institutions with a knowledge of individual case work and advocacy. Child protection in statutory contexts, and victim liaison concerning the rights of victims are also within the special expetise of social workers. The increasing importance of care pathways in mental health and particularly in forensic mental health can be traced to this academic and intellectual field. Social workers typically focus on the person in their family, community and social network. In many jurisdictions, social workers have an independent role in relation to mental health law orientated towards assisting or supporting the statutory roles of next of kin, family and careers while at the same time having an advocacy role in ensuring that the least restrictive option is found and made available when choices must be made regarding the use of legal measures or placement in secure and restrictive settings. Social workers may find themselves in the role of social supervisors either in forensic mental health social work or in probation work. As in other aspects of forensic mental health practice, this role almost always commences with the engagement in a negotiation regarding a voluntary contract so that the service user accepts legally binding conditions as an aid to stability, recovery and progressive autonomy.

Social workers may also take professional or legally defined roles in relation to advocacy and decision-making variously defined in law as guardianship, guardian ad litem, social supervisor or a range of other such roles. Social workers also commonly take a lead in family interventions.

A number of related roles may work closely with social workers including housing support workers, welfare officers and youth workers.

14.6 Training in Law and Ethics for Clinicians

14.6.1 Ethics in Forensic Mental Health Practice

Ethics is to law as physics is to engineering. An education in ethics therefore commonly forms part of the undergraduate or basic training in each of the mental health disciplines described above. Treating mentally disordered patients who may have impaired decision-making capacity presents special difficulties due to conflicting principles when those patients are formally detained and deprived of liberty. Forensic patients are usually subject to treatment without consent at least for a time during their pathway through forensic services. Treatment may at times include personally restrictive and intrusive practices such as seclusion and restraint.

Education and training is required in the ability to think critically and to balance the patient's best interests and the public interest. Reasoning about the necessity to maintain a safe environment in order to provide restorative care and treatment is part of the preparation for ethical professional practice. Scepticism about the more fashion-bound and media-amplified trends in psychiatry is essential (Hacking 1995). An awareness of international ethical conventions such as the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities and an understanding of how these are interpreted is an essential skill. The ability to understand the distinction between ethical processes and value judgements is a prerequisite for maintaining the positive therapeutic regard which is one of the necessary preconditions for successful treatment. The distinction between processes and values is also necessary for maintaining a hospital culture in which therapy prevails over custody. At the same time, the ability to maintain sufficient objectivity to be aware of risks and to safely manage risks is part of a broader ethical obligation to maintain professional and personal boundaries. All of this arises both from formal education and from professional training with experienced role models.

14.6.2 Mental Health Law for Clinicians

Some clinicians choose to take specialist postgraduate qualifications in mental health law. This is by no means central to the practice of forensic psychiatry or other forensic mental health professions. Curricula that are sufficiently broad to include an awareness of human rights can bring an enlightening awareness of legal concepts of mind and legal concepts of causation (Hart 1977; Hart and Honore 1985) which often sit uneasily with scientific concepts. Studying the extent to which they are compatible or otherwise can be of great benefit when writing medicolegal reports and giving oral evidence before courts or review boards. Studying the extent to which legal and scientific concepts of mind and causation are or are not compatible can be enlightening (Kenny 1989) provided clinicians do not succumb to the glamour of rhetoric (Marjoribanks 1950; Schopenhaur 2012). In many respects, the role of the forensic psychiatrist in court is similar to the role of the liaison psychiatrist in a general hospital. Finding a common language is a greater challenge, and the onus is on the psychiatrist to communicate in jargon-free language and to make no assumptions about the acceptance of universal scientific principles. In this context, the logical language of the legal draftsman and the clarity of written judgements by senior judges (Dworkin 1977; Posner 2008) contribute greatly to our modern understanding of functional mental capacity, of free will and responsibility and of basic principles of fair process, a right to be heard and freedom from bias. When acting as leader of a multidisciplinary team, these principles of natural justice which arise from the humanities rather than from the sciences are valuable ways to ensure that constructive criticism is welcomed in the best interests of good decision-making (Peay 2003, Posner 2008, Prins 1980). It is the courts who decide who is an expert, often with surprising latitude (Briskman 1988). The study of the subject of expertise itself is perhaps one of the most important formative subjects for forensic specialists [46, 82].

14.6.3 Communication Skills: Writing Reports

Clinicians coming to the end of a scientific and clinical training commonly find themselves in difficulties when trying to express thoughts clearly. The skills involved require practice and supervision. A structured court report should include within it a psycho-biographical history that contains relevant facts upon which an expert opinion may be based. The supervision of an experienced trainer and cumulative experience over time is essential.

14.6.4 Communication Skills: Oral Evidence

It is always possible with training and experience to learn to write a clear and well-reasoned court report. Assisting the court by giving clear oral evidence is however more than a skill. The ability to understand an audience, to hold their attention and to engage them was regarded in classical times as an essential skill for any educated person. When giving evidence before a jury, there is the constant danger of rhetoric that appeals to emotion and to lower forms of argument (Marjoribanks 1950; Schopenhaur 2012) rather than the unbiased presentation of facts followed by reasoned presentation of opinion within matters of expertise. There is however no obligation to be popular or to please—on the contrary, the expert witness has an obligation to be truthful (Said 1993) and to assist the court.

14.7 Summary

An emergent theme has been the need to equip professionals with the general and specialist education to continue to acquire new skills over a career. There is also a need to educate those clinicians with so-called contributory expertise [46, 82] who will ensure that translational research and clinical research and development will continue as the basis for service improvement and the regular updating of training curricula and continuing professional development. Those with ‘interactive expertise’ acquired through contact with the ‘contributory’ expert clinicians include managers, lawyers and journalists. It is essential that there is a mutual understanding of these distinct roles and a mutual recognition of the limits of each. It is also essential that there is a harmonious division of leadership roles between the two. Where a choice must be made, it is in general better for expert clinicians to take on the ultimate leadership role in accordance with ultimate responsibility, with the support of business managers rather than the reverse.

This chapter has addressed the impact of service organisation on teaching and training. It is apparent that teaching and training must be grounded in research and development. Actually, there is a need for centres of excellence where both research and teaching can occur. Not every forensic centre needs to be a teaching hospital with cutting-edge research, but every jurisdiction needs at least one, and those centres of excellence need to be networked internationally. This fundamental

characteristic of medical services has to some extent been marginalised by the attempted culture shift towards managerialised health services. All forensic mental health services need to maintain a continuous culture of learning so as to be open to new developments. Journal clubs, case presentations, Balint groups, private reading, external courses and international conferences are all necessary to achieve this. But excelence in forensic mental health services can be guaged from published research and in particular from the ability to peform randomised controlled trials and other forms of continuous innovation leading to improvement of outcomes for patients and the public.

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Evidence-Based Treatment in Forensic Settings

15

Norbert Schalast, Conni Lebbing, and Birgit Völlm

15.1 Introduction

In the medical field, guidelines of good practice are meant to provide concise state-of-the-art information on treatment approaches for diseases and disorders, based on empirical evidence and/or expert consensus. Where available such guidelines should be based on the systematic review and meta-analysis of high-quality research evidence on a particular topic. Proponents of guideline-based provision of care argue that they improve quality of care by ensuring consistency and allowing individual practitioners to keep abreast with the latest evidence in their field. Critics contend that the strict following of guidelines undermines individual decision-making, deskills practitioners and might lead to the needs of individual patients not being met.

Following guidelines is not mandatory; they are one out of many tools to improve the quality of care and cannot replace individual clinical decision-making [1]. However, not following guidelines and hence best practice might lead to legal challenge if treatment is not successful or leads to harm, and the practitioner might have to explain reasons for diversion from the available evidence.

In comparison with general medicine and psychiatry, forensic psychiatry is lagging behind regarding the development of evidence-based treatment guidelines. This clearly is the case in Europe, where only researchers and practitioners from a minority of countries are involved in the professional debate on these issues. The degree of standardization of treatment programmes within forensic settings varies across European Union member states [2]. On the one hand, diverse standardized

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and evidence-based treatments are available for a large variety of mental disorders and offences, as is the case in Great Britain or the Netherlands. On the other hand, there seems to be a lack of data for the psychological treatment reality in most European forensic mental health institutions. The same heterogeneity seems to be evident in the training of psychological and medical professionals. Most states do not require staff of forensic mental health institutions to be especially trained for the work with delinquent patients. Also, a shortage of suitable candidates for the work with mentally disordered offenders (MDOs) may lead to the paraprofessional implementation of psychotherapeutic interventions (ibid.).

15.2 Legal Issues

The therapeutic scope can be specified by the respective legislation of a state [3]. In Germany and Austria, for example, the law allows for offenders with substance-related disorders to be treated in specialized facilities. The growing number of substance abusers in forensic settings (e.g. [4]) emphasizes the importance of specialized treatment and concepts of relapse prevention to reduce recidivism in this group. Nevertheless, some countries, e.g. the UK, specifically exclude individuals with substance abuse disorders from compulsory psychiatric treatment. Similar variability exists with regard to personality disorders. In addition, some countries require decreased criminal responsibility as entry criterion for admission to a forensic institution, while others may admit fully responsible or even non-offending patients to forensic care (see, e.g. [5]).

While scientific papers and conferences do reveal efforts to improve the quality of treatment and care in forensic psychiatric institutions, Italy has closed down all six remaining forensic inpatient hospitals, characterized as "seriously insufficient" by Barbui and Saraceno [6]. Whether the alternative small residential units will be successful in aiding the recovery of their residents remains to be seen. Economic and public pressure may limit their effectiveness. A parallel debate on abolishing the concept of legal incapacity may indicate a singular way to handle the challenging problem of treating mentally disturbed offenders in special institutions. Even more mentally ill offenders in the regular prison system may be a consequence.

15.3 Relevant Concepts

The authors of this chapter do not have the authority to conceive general guidelines of forensic treatment, but we aim to highlight concepts which, in our view, need to be considered in a respective debate. One such concept is the *risk–need–responsivity* model (RNR; [7]), which has been a frame of reference for the development of therapeutic programmes and assessment instruments over many years [8]. One may add that this refers most notably to the Anglo-American part of the world. On the European continent, educated forensic staff has prevailingly taken notice of the

RNR principles, though these have not always been translated into guiding principles of treatment.

The *Risk principle* of the RNR model requires practitioners to match the level of programme intensity to the offender's risk level (i.e. no expensive treatment for low-risk offenders, most intensive treatment for high-risk individuals). The *Need principle* calls to target "criminogenic needs", i.e. dynamic factors linked to the risk of reoffending (like antisocial peers and attitudes, drug abuse, impulsiveness); treatment providers are discouraged from focusing on non-criminogenic needs, such as discontent, low achievement motivation, anxiety or other symptoms of mental disorder. The *Responsivity principle* refers to the matching of treatment style and mode to the offender's learning style and abilities. According to Andrews and Bonta [9], interventions in accordance with the three principles are associated with significant risk reduction, while others are not or may even cause harm.

While the relevance of the three (RNR) principles is widely accepted, the delivery of RNR-based treatment programmes in the correctional system is criticized. According to Gannon and Ward [10], there are three reasons for the popularity of RNR: (1) participation in RNR programmes may reduce recidivism. (2) The RNR principles are simple and can be implemented to large groups of offenders within highly structured cost-effective treatment programmes, frequently delivered by less qualified staff. (3) The focus on risk reduction complies with the priority of security issues in the correctional system. The authors criticize the stringent manualization of treatment programmes, along with a risk of overreliance of therapists on a specific manual, thereby disregarding patients' needs and focusing too much on public safety measures instead of therapeutic goals [10].

The good lives model (GLM) has been suggested as an alternative or rather an extension to the RNR model. It stresses the similarity between the needs of offending and non-offending individuals and the crucial difficulties of offenders to fulfil their normal primary needs or goods in a socially compatible way. According to the model, there are 11 areas of primary goods: life (healthy living and functioning), knowledge, excellence in play (recreational activities), excellence in work (including mastery experiences), excellence in agency (autonomy, self-directedness), inner peace, relatedness (including intimate, romantic and family relationships), community (connectedness to wider social groups), spirituality, pleasure (feeling good in the here and now) and creativity. The GLM approach focuses on individual needs and the increase of the patients' ability to live a fulfilling, satisfactory life. In contrast to RNR, GLM considers the fulfilment of basic needs to be sufficient to (naturally) reduce criminogenic needs [11]. However, Andrews et al. [12] argue that the specific points and apparent changes suggested by the GLM are already covered by the RNR concept. They do, however, content that the strength-based focus of the GLM may be a positive addition.

There is little evidence clarifying which role the GLM plays in the practice of forensic treatments in Europe. In Germany, two papers have recently informed about the model in a major forensic psychiatric journal [13, 14]. There is considerable interest in the approach, reviving an individualized psychotherapy approach within forensic settings. This receptivity may have its origin in the strong

psychodynamic and psychoanalytic traditions in countries like Austria, France and Germany [15].

Specific treatment programmes discussed in the literature may be differentiated regarding their closeness to the RNR and the GLM concept. RNR-oriented programmes are generally cognitive behavioural by nature and highly structured and manualized and have a strong focus on risk factors and on later risk management. There are programmes for individual, group and aftercare outpatient settings. In the UK, multiple highly structured treatments are available and accredited [16]. Specific training may be required to deliver programmes, and ideally programme implementation and delivery will be monitored on an ongoing basis and staff supervised. The highly structured nature of these programmes, alongside their manualization, means that training may be specific to the programme, while no degree in a particular subject (such as psychology) or general psychotherapeutic education may be required to become a treatment programme facilitator.

15.4 Programmes in Practice

There is a multitude of treatment programmes claiming to fulfil RNR criteria. Among the empirically well-evaluated programmes are the Reasoning and Rehabilitation (R&R) programme and the sex offender treatment programme [17]. The R&R programme, introcuded by Ross, Fabioano and Ross in 1974 [18, 19] targets cognitive processes such as reasoning, atributions, self-evaluation, expectations, appraisal of the world and values, in order to enhance the client's competencies to cope with everyday problems and challenging situations. The effectiveness of the R&R approach has been evaluated in Canada, the USA, the UK and Sweden, and it has been found to achieve a moderate but significant reduction of reoffending rates [20, 21]. For example, in the study of Tong and Farrington, the relative risk of reoffending was reduced by 14% in the first year after discharge from the institution. However, it was pointed out that there is limited evidence regarding the effectiveness of cognitive skills programmes like R&R with mentally disordered offenders. In a randomized controlled trial, Cullen et al. [22] demonstrated that R&R completion had a positive effect on patients with severe mental illness. But a high rate (50%) of noncompletion presented a problem, discouraging too optimistic conclusions.

The sex offender treatment programme (SOTP) is an evidence-based group treatment programme in forensic settings and was originally developed for the implementation in prisons in the UK [23]. SOTP was designed to address the sexual offence and treat patients using cognitive behavioural techniques, in accordance with the prevailing research on sexual offending. The programme has been adapted to serve the needs of forensic psychiatric patients as well as subgroups of offenders (such as those with intellectual disabilities and, more recently, deniers) and has been implemented in other European countries, such as Germany [24]. However, there are numerous interventions targeting sexual offending, ranging from cognitive to medical approaches (such as chemical castration). Prominently, the relapse prevention approach, which was originally developed for drug abuse, is used and has been

adapted to reduce the risk of relapse. Schmucker [25] suggests complementing this approach with the humanistic goals of the GLM, in order to generate a more positive therapeutic atmosphere. Sex offender interventions have been subject to a great number of effectiveness studies and numerous meta-analyses summarizing their findings with some concluding that the effect of these programmes is absent or minimal and others producing more promising findings. The most recent meta-analysis of interventions [26], reviewing 11 other meta-analyses, concluded that sex offender treatment showed promise in reducing reoffending with effect size of about 10–20% and larger effects for treatment for adolescents compared to adults, surgical castration/hormonal medication compared to psychological interventions and community compared to institutional treatments.

The ongoing research activity surrounding sex offender interventions has allowed adjustments in line with research findings. For example, the prison SOTP in the UK has recently de-emphasized the focus on victim empathy after a number of studies have found that its inclusion in the programme is not only inefficient but potentially harmful [27]. Instead Mann et al. [28] identified the following criminogenic needs as targets for intervention: sexual preoccupation, deviant sexual interest, offence-supportive attitudes, emotional congruence with children, lack of intimacy, lifestyle impulsivity, poor cognitive problem-solving, resistance to rules, grievance and hostility and negative social influences.

A variety of violent offender treatment programmes (or similar, e.g. [29, 30]) have been implemented and proofed useful, though the empirical evidence regarding these programmes is somewhat more limited than for sex offender programmes ([31]; for a recent review see [32]).

Programmes more related to the GLM approach put more weight on the therapeutic relationship as an effective factor of treatment and are less rigidly manualized and less focused on risk factors. They do show more overlap with general psychological treatments [10]. According to the literature, RNR-based and cognitive behavioural programmes preponderate clearly in correctional and forensic settings, but in practice, general psychotherapeutic and even psychodynamic approaches still play a significant role. These approaches generally comply with the GLM demand to give interpersonal factors special attention.

A number of psychotherapeutic approaches, usually delivered on a 1:1 basis, but sometimes group based, or a combination of both, are in use in forensic settings which will be briefly described here, though it is important to note that there is virtually no evidence for their effectiveness in forensic settings and that, mostly, they have not been adapted specifically for use in such settings.

Psychodynamic therapy is characterized by its individual patient focus and in-depth search of the biographic and emotional roots of maladaptation and behavioural problems. The general efficacy of psychodynamic therapy approaches has been demonstrated empirically [33, 34]. Traditionally, psychodynamic therapy in forensic settings has had its place in Austria, Germany, France and the UK, though less so recently in the latter [15], in addition to other therapeutic approaches.

Transference-focused psychotherapy (TFP) constitutes a newer form of psychoanalytic therapy, designed to deal with severely personality distorted patients and to

accommodate current directions in psychotherapy research. There are specific recommendations for the use of TFP in forensic settings available, such as dealing with the dual relationship problem (emerging from two sets of norms associated with community protection versus fostering the patients' well-being) and its possible effect on the therapeutic process [35, 36].

Schema-oriented psychotherapy (SOPT) is an adaption of Young's schema therapy [37] to suit the needs of (forensic) patients with personality disorders. It is composed of a three-step programme, which is delivered in a group setting though it is sometimes used individually or in a group and individually in parallel. Ultimately, the goal of this therapy is to modify maladaptive coping strategies, in terms of working through identified "schemata" of thinking and responding by use of techniques such as role play and chair dialogue. In a recent study by Elsner and König [38], forensic patients who participated in a SOPT programme showed more improvement regarding self- and staff assessment and objective measures (like progress in the institution's phased plan) than a matched control group. Notably, the use of this approach in the treatment of patients with high psychopathy scores, a group of offenders very difficult to reach therapeutically, is also currently explored.

As a large group among violent and sex offenders have experienced severe deficits of early attachment, attachment theory has also become an inspiration to offender treatment [39]. Fostering clients' capacity for "mentalization" [40] is proposed to improve their behavioural control and affect regulation as well as strengthen their competence to manage everyday problems and reach a more fulfilling life.

Last but not the least, dialectical behaviour therapy (DBT), as introduced by Linehan et al. in 1991 [41], clearly fulfils the demands of the GLM concept. It is a broad, evidence-based cognitive behavioural approach originally developed for the treatment of (para)suicidal female patients with borderline personality disorder. It has been adapted for the use in forensic settings [42]. DBT is implemented in forensic settings, especially in Anglo-Saxon countries [43], but has also been found efficacious in outpatient forensic treatment of patients with a borderline personality disorder in the Netherlands [44] and Germany [45].

15.5 Discussion

Empirical evidence may hardly give last answers to the question which treatment approaches should be considered state of the art in forensic and correctional settings, certainly not in relation to a specific patient. Empirical evidence demonstrates that, when comparing two groups treated in different ways, significantly more patients have a positive outcome in one of the groups. But there is commonly a rather small share of clients whose adjusting may be specifically attributed to a specific intervention. Psychosocial programmes, when rigorously, evaluated show prevailingly, at most, small effects. We are still not close to answering questions like "what works for whom, in what contexts, under what conditions, with regards to what outcomes, and also why" [46, p. 2].

What also justifies some restraint is that studies evaluating model projects interventions instead of routine practice and rather small instead of large samples tend to find larger effect sizes, as well as studies run by researchers affiliated to the programme at stake (ibid.). It has also been stated that being able to benefit from a standard treatment programme rather indicates a less severe rather than a severe and complex disorder [47]. In addition, positive effects of a programme may not only indicate a direct impact of the programme, like modifying directly clients' attitudes. Programme delivery may also have an indirect effect through positively affecting staff–clients' communication and the institution's social climate (which would be a most valuable effect!). All together, there is no single approach which may be acknowledged "state of the art", but these critical observations should not dismiss the fact that there is support confirming the utility of concepts like RNR, GLM and programmes based on their principles.

Take-Home Messages

Against the background outlined above, the following conclusions should be considered when debating guidelines of treatment in forensic psychiatric settings:

- Forensic and correctional treatment programmes should give special attention to dynamic risk factors related to clients' recidivism; these factors need to be focused on in treatment planning and implementation and in aftercare.
- Clients' individual needs and goals must be considered and acknowledged, not least as this might motivate them to co-operate. One should not expect offenders to reach a stable social adjustment just by training them to avoid and control antisocial behaviour; positive "turning points" of life have proven to be closely linked to consistent desistance from crime [48], providing rather strong confirmation for a "good lives approach" in working with mentally disturbed offenders.
- Clients suffering from severe emotional instability may benefit from cognitive behavioural interventions and treatments explicitly fostering their skills to manage anxiety and anger, like DBT-F or schema therapy. Findings from attachment research need to be considered, which may foster therapists' awareness of relationship issues [39].
- Inpatient secure treatment settings should be closely linked to aftercare programmes providing support, coaching to cope with the challenges of daily life and some degree of control.
- Medication was not a topic considered in this chapter, yet may be essential in managing critical dispositions of behaviour, severe mental disorders and addiction. General psychiatric guidelines are relevant in this regard.

Postscript: At present, Europe is struggling with a welter of problems. At times, the European community seams closer to breaking apart than solving these problems. Whenever issues of forensic care are discussed in the (regional) public, "security" is a primary focus. Debating standards of correctional and forensic psychiatric care is very low in the European political agenda.

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A European Perspective on Risk Assessment Tools

16

Michiel de Vries Robbé and Vivienne de Vogel

16.1 Violence Risk Assessment

Accurately evaluating the likelihood of violent reoffending increases the knowledge of professionals working in forensic practice; ensures the most justified treatment efforts and risk management for the patient, client or offender; and ultimately enhances the safety of society. For mental health professionals in (forensic) psychiatry, risk assessment offers guidance for their treatment practice. Judicial authorities and probation workers utilize risk assessment in their risk management planning and release decision-making (for an overview of different risk assessment tools, see Tables 16.1 and 16.2). However, formulating judgements regarding the possibility of future violent behaviour is a difficult task, which should be done with caution as the outcome of the risk assessment may have major implications. Underestimating the level of violence risk could lead to an unjustified low intensity of risk management or wrongful early release, which may present a missed opportunity for successful intervention, may pose a danger to society in terms of potential new victims, may lead to rearrests and financial burden for the judicial system and could be neglectful to the further treatment needs of the patient. Overestimating one's level of violence risk may prompt clinicians and courts to impose unnecessary lengthy or intensive interventions, which are costly for society in terms of financial burden and costly and unethical for the patient in terms of loss of liberties and unjustified treatment intensity.

From clinical experience and empirical studies in the past century, it has become clear that without the aid of risk assessment instruments, our best clinical judgement

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Table 16.1 Actuarial risk assessment tools commonly used in Europe

Tool	Reference	Type of risk assessed
LSI-R/LS/CMI	Andrews and Bonta [7]; Andrews et al. [8]	General offending
YLS/CMI	Hoge and Andrews [9]	Youth general offending
VRAG	Harris et al. [10]	General violence
COVR	Monahan et al. [11]	General violence
SORAG	Quinsey et al. [12]	Sexual violence
STATIC-99/ STATIC-2002	Hanson and Thornton [13, 14]	Sexual violence—historical
STABLE	Fernandez et al. [15]	Sexual violence—dynamic
ACUTE	Hanson and Harris [16]	Sexual violence—acute

Table 16.2 SPJ risk assessment tools used in Europe

Tool	Reference	Type of risk assessed
HCR-20/ HCR-20^{V3}	Webster et al. [23]; Douglas et al. [1]	General violence
VRS	Wong and Gordon [24]	General violence
FAM/FAM^{V3}	de Vogel et al. [25, 26]	Female violence
SAPROF	de Vogel et al. [25, 27]	Protective factors for violence
DASA	Ogloff and Daffern [28]	Situational violence
START	Webster et al. [29]	Short-term violence
SVR-20	Boer et al. [30]	Sexual violence
RSVP	Hart et al. [31]	Sexual violence
VRS-SO	Wong et al. [32]	Sexual violence
SARA	Kropp et al. [33]	Intimate partner violence
B-SAFER	Kropp et al. [34]	Intimate partner violence
PATRIARCH	Kropp et al. [35]	Honour-based violence
MLG	Cook et al. [36]	Group-based violence
VERA	Pressman [37]	Extremist violence
SAM	Kropp et al. [38]	Stalking
SRP	MacKenzie et al. [39]	Stalking
CARE	Agar [40]	Child abuse
SAMI	Zapf [41]	Suicide risk
S-RAMM	Bouch and Marshall [42]	Suicide risk
SAVRY	Borum et al. [43]	Youth violence
SAPROF-YV	de Vries Robbé et al. [44]	Protective factors for youth violence
START:AV	Viljoen et al. [45]	Short-term youth violence
J-SOAP-II	Prentky and Righthand [46]	Youth sexual violence
EARL-20B/21G	Augimeri et al. [47]; Levene et al. [48]	Childhood violence for boys/ girls

may not always lead to an accurate estimate of the likelihood of violent recidivism (for an overview of the evolution of risk assessment procedures, see, for example, [1]). Regardless of the level of professional expertise and years of experience working with patients and offenders, mental health workers and decision-makers are inevitably at risk of cognitive distortions and misinterpreting important indicators that influence their judgement. The violence potential of those who seem difficult and divergent could be overestimated, while for those who cooperate and appear to be willing and understanding, the level of violence risk may be underestimated. Although attitude and treatment alliance are valuable factors, other warning signs, strengths and weaknesses should not be overlooked. For this reason, it is vital that risk evaluations aid the assistance of empirically derived checklists. These checklists should include the most prominent risk and protective factors that have emerged from the literature as being related to violent behaviour and reoffending, such as those presented in the risk assessment tools described below. Utilizing these tools to guide the assessment process has become recognized as best practice in most European countries. In their review of current directions in violence risk assessment, Skeem and Monahan [2] describe a shift from the prediction of violence to the prevention of violence (re)occurrence and state that group-based instruments are useful for aiding the assessment of an individual's risk and understanding its causes in order to guide prevention. They conclude that risk assessment instruments should be chosen based on an evaluation's purpose (i.e. risk assessment vs. risk reduction).

This chapter aims to offer insight into the intended use of risk assessment tools in clinical practice, as well as their potential for guiding treatment efforts and risk management planning. It should be noted that the focus in this chapter lies on violence risk assessment. However, many of the described tools concern general life domains, which are also valuable for the assessment of non-violent outcomes such as general offending (e.g. LS/CMI). Different methods of violence risk assessment will be explained, focusing predominantly on the widely used structured professional judgement (SPJ) approach (e.g. [3]). The most commonly used risk assessment instruments in Europe will be discussed, including tools for specific groups of patients. Distinct attention will be paid to tools for the assessment of protective factors. Finally, a case study will be described to demonstrate the assessment process, and some general recommendations will be given regarding the use of risk assessment in clinical practice.

16.2 Approaches to Risk Assessment

Two decades ago, most risk assessment in forensic psychiatric institutions was carried out based on best clinical judgement of those in charge of the treatment, assessment or decision-making. Research has since then shown that this unstructured clinical judgement has several major limitations, such as the above-mentioned proneness for cognitive distortions, the risk of ignoring potentially relevant factors, the low interrater reliability, poor predictive validity and finally the lack of transparency of this method (e.g. [4]). Therefore, in the mid-1990s the use of standardized risk assessment tools was recommended to increase the reliability and validity of

the risk assessment. Knowledge on risk and protective factors that influence violent reoffending has grown rapidly over the past 20 years. Many studies have been conducted and reported on in the international literature, providing valuable insight into the importance of specific risk and protective factors at group level. From this, risk assessment tools have been developed for general violent behaviour; for more specific types of violence such as sexual violence, intimate partner violence and child abuse; and for specific groups such as female offenders and juveniles. These tools can be divided into tools following the actuarial approach and SPJ risk assessment tools. These two methods will shortly be described below. For a more in-depth description, see, for example, Douglas and Reeves [5]. Despite the general international developments regarding different methods of evidence-based assessment, risk assessment practice remains to vary greatly between countries and settings. For example, clinical practice in some Southern and Eastern European countries appears to still be based predominantly on the unstructured professional judgement approach, while in other countries the use of actuarial tools is preferred within certain settings and the SPJ tools are preferred in other settings. In most Northern European countries, the SPJ approach is seen as the most useful way to assess violence risk and inform treatment. Each of these methods of risk assessment has its benefits and disadvantages; however, it has widely been acknowledged that assisting the risk assessment process with an empirically based risk assessment tool increases the reliability, validity and transparency of risk assessment practice in clinical practice (see [2]). Thus, it is considered current best practice to employ a form of structured risk assessment, which comprises factors that have emerged from the empirical literature as being related to future offending behaviour.

16.2.1 Actuarial Risk Assessment

Seeking a more evidence-based risk assessment, researchers set out to collect all available evidence regarding the group-level validity of many different risk factors for specific types of violence. From this, actuarial tools have been constructed for varying types of violence, based on the assumption that future violence risk can best be predicted from an actuarial calculation of evidence-based risk factors. Risk assessment tools following this approach include only items which have emerged from empirical studies as having a significant relationship with offending behaviour. Conclusions from these tools simply represent the calculation of the total score on all items according to a predetermined algorithm. Generally, this total score is being viewed in the light of a pre-established reference group, for example, parolees within a North American probation context. If a particular individual receives a higher total score than a certain cut-off score for his reference group, the level of risk is rated as ‘high’. There are many risk assessment tools which follow this model, and their predictive validity is generally quite good at group level (see Table 16.1 for an overview of commonly used actuarial tools in Europe). Well-known actuarial tools include intervention guidance tools (e.g. (Y)LS/CMI, based on the risk-need-responsivity principles), tools for general violent behaviour (e.g.

VRAG) and tools for sexual violence (e.g. STATIC-99). For an overview and explanations of different sexual offending risk assessment tools, see Hanson et al. [6].

The major advantage of actuarial tools is that they apply quite straightforward coding guidelines and leave little room for clinical interpretation of the findings, which makes them objective and transparent. The often mentioned downside of actuarial tools is their assumption that all factors within these tools are universal for the assessed population and equally important for every individual (thus always carrying the same weight in the final score). This leaves little room for an individualized view of which factors are most important for the specific patient, nor does it provide the possibility to include additional factors which may be vital for the individual. Moreover, the use of reference groups complicates generalizability to other samples, as each sample is likely to have its own cut-off points in terms of recidivism likelihood, implying that reference groups ought to be available for a specific patient population before these tools can reliably be applied. Perhaps the most prominent disadvantage of many actuarial tools is that they include mostly static historical variables, which do provide a useful baseline measurement of the level of risk, but offer fewer guidelines for treatment interventions (see [17]). However, there are exceptions such as the (Y)LS/CMI, the STABLE and the ACUTE, which are (party) comprised of dynamic factors and do offer guidance to treatment and risk management. Thus, actuarial tools are generally objective and useful in the sense that they provide a valid baseline risk evaluation, which at group level shows to be related to violent outcome. However, they are limited in their ability to apply the assessment to the individual and interpret his or her unique combination of (dynamic) factors in relation to violent behaviour within a specific context.

16.2.2 Structured Professional Judgement

In response to the poor reliability of unstructured clinical judgement and the criticism regarding the limited clinical applicability of the actuarial risk assessment tools, a new generation of risk assessment instruments was developed: the structured professional judgement (SPJ) tools. SPJ can be regarded as the meeting point between empirical knowledge and clinical experience. Violence risk assessment tools following this approach generally comprise a checklist of factors which have shown from empirical studies to be related to violent behaviour. These factors may be historical or dynamic in nature. In fact, most SPJ tools include both static and dynamic factors. With the SPJ tools, the assessor first rates all factors in the checklist that are present and relevant for the assessed context, before making a well-informed final judgement regarding the likelihood of future violence risk. It is this process of combining, integrating and weighing the factors to finally arrive at an overall conclusion regarding the level of violence potential which is unique for the SPJ approach. It implies that the decision-making process regarding the level of risk could be different for each assessed individual and for each different context that an individual is assessed for, depending on the importance of each factor for a specific individual in the assessed context. The assessment procedure inspires the assessor to seek (clusters of) factors which interact with one another and play a vital role for

the assessed individual. For example, well-known clusters of factors that significantly increase the risk of (sexual) violence are high levels of psychopathy in combination with sexual deviance and the presence of a major mental illness combined with substance abuse.

Following the full procedure of SPJ risk assessment, the assessor is prompted to consider what factors have together led to previous violent behaviour in the individual case, an exercise named risk formulation. One theory of what moves people to specific behaviour is that every individual seeks to reach certain goals in life, but offenders have tried to accomplish these by means of antisocial behaviour. Gaining insight into which factors have played an important role in the pathways to violence in the past aids in the clear formulation of hypotheses about the future. Once all the important factors have been assessed and past violence has been analysed, the assessor can start thinking about possible risk scenarios for the assessed: future violence risk scenarios which could potentially take place. In other words, a narrative of what we are afraid might happen. Issues to consider in formulating risk scenarios are what type of violence could take place, how soon could this happen, who could be the victim, how severe would it be, what factors would enhance the likelihood of this violence scenario or what factors could decrease its likelihood. Creating these narratives gives us a much clearer picture of what it really is we might be worried about and, thus, what we need to prevent from happening. Often multiple risk scenarios can be formulated from an assessment. For example, it may be hypothesized that a scenario of intimate partner violence could unfold when a patient is being assessed for first-time unsupervised leaves; however, an altogether different scenario might be inpatient violence towards staff when the patient returns from his unescorted leaves and might be under the influence of alcohol.

16.3 Risk-Focused SPJ Assessment Tools

Over the past two decades, numerous SPJ tools have been developed and implemented in clinical practice around Europe and the world. The most well-known and widely used SPJ tool is the Historical Clinical Risk Management-20 (HCR-20) and its recent revision the HCR-20 Version 3 (HCR-20^{V3}). Western European countries have long been at the forefront of the risk assessment development as treatment in these countries aims to be innovative and evidence-based. Over the past decade, interest for implementing structured professional risk assessment tools has grown in other European countries as well (for a guideline regarding adapting risk assessment tools to new jurisdictions, see [18]). A large-scale international survey carried out in 2014 examined different methods of violence risk assessment and the utility of these methods as perceived by mental health care professionals from over 40 different countries [19]. This study concluded that violence risk assessment is a global phenomenon and the HCR-20 was found to be the most widely used tool in the world for violence risk assessment. The HCR-20 has been translated in many languages. The tool is commonly used in clinical practice in most Western European countries and has more recently also been adopted in countries such as Greece,

Table 16.3 HCR-20^{V3} item ratings for John for the context of inpatient treatment with unsupervised leaves

Historical scale—history of problems with:		**Presence**	**Relevance**
H1	Violence	Yes	High
H2	Other antisocial behaviours	Possible	Low
H3	Relationships	Yes	High
H4	Employment	Yes	Moderate
H5	Substance use	Yes	High
H6	Major mental disorder	Yes	High
H7	Personality disorder	No	Low
H8	Traumatic experiences	Possible	Low
H9	Violent attitudes	Possible	Low
H10	Treatment or supervision response	Yes	High
Clinical scale—recent problems with:		**Presence**	**Relevance**
C1	Insight	Possible	High
C2	Violent ideation or intent	No	Low
C3	Symptoms of major mental disorder	Possible	High
C4	Instability	Possible	High
C5	Treatment or supervision response	No	Low
Risk management scale—future problems with:		**Presence**	**Relevance**
R1	Professional services and plans	Possible	High
R2	Living situation	No	Low
R3	Personal support	Possible	Moderate
R4	Treatment or supervision response	Possible	High
R5	Stress/coping	Yes	High

Note: The sub-items of the HCR-20^{V3} were also coded but are not all shown in this table
Coding of the HCR-20^{V3} items. Presence: *No* not present, *Partly* present to some extent, *Yes* present
Coding of the Relevance for the assessed context: *Low* not relevant, *Moderate* relevant to some extent, *High* highly relevant

Turkey and Romania. Although cultures and behaviours may differ from country to country, it is generally being assumed that the HCR-20 risk factors are formulated broad enough to be valid in most societies. The tool contains 20 empirically based risk factors, half of which are historical and the other half dynamic factors (for an overview of the HCR-20^{V3} factors, see Table 16.3). The dynamic factors consist of five clinical factors that concern the recent past and five risk management factors that are to be rated about the near future. Items are rated on a 3-point scale, indicating the extent to which each risk factor is present. In doing so, the tool gives an overview of the factors that are present and relevant from the past and the present and provides a guideline for treatment and risk management planning. The HCR-20 tools have together been evaluated in over 250 empirical studies and have been found to demonstrate good interrater reliability and good predictive validity for future violent behaviour in many different samples around the world (see [20]). Moreover, especially HCR-20^{V3} offers valuable guidance to treatment and risk management in forensic clinical practice.

Following the HCR-20 example, many other tools have now been developed which also apply the SPJ approach for a wide range of outcomes, including tools for general violence, sexual violence, domestic violence, honour-based violence, group-based violence, extremist violence, stalking, child abuse and suicide risk (see Table 16.2 for an overview of available SPJ tools in Europe). There are also SPJ tools that look at a more short-term timeframe, such as the DASA (imminent risk) and the START (weeks to months; which looks at multiple adverse outcomes like violence, substance misuse and self-harm). In addition to the abundance in tools for adults, there is also a range of tools specifically for juveniles, including the commonly used SAVRY, and even risk assessment tools for children. Finally, there has been considerable debate about the applicability of general risk assessment tools for female populations (see [21]). For this reason, an additional manual has been developed in order to also include female-specific risk factors: the Female Additional Manual (FAM), which is intended to be used in addition to the HCR-20 or HCR-20^{V3} when assessing violence risk for females. Although it has been argued that there is little difference between various risk assessment tools in regard to their ability to predict violent reoffending [2], it has generally been acknowledged that tools for specific populations provide better predictive validities [22].

16.4 Protective Factors

Virtually all actuarial and SPJ tools focus exclusively on risk factors for some form of violence while ignoring the incorporation of strengths or protective factors. Theoretically, all SPJ tools should pay attention to situational and personal protective factors when a final judgement is made. However, the positive factors that are implicitly being weighed and integrated in the formulation of risk scenarios and final judgements often are not empirically based and rather concern factors which are deemed useful for an individual case from the assessor's clinical judgement. Although it is now increasingly being recognized that explicitly considering protective factors is as much part of risk assessment as considering risk factors, this part of the assessment process has long been underappreciated and understudied [49]. Very few risk assessment tools do also include a focus on strengths or protective factors. Some of the exceptions are the START, START:AV and the SAVRY. In the START tools for short-term evaluations, the assessor is requested to rate every domain simultaneously on a risk scale as well as on a strength scale, implying that every risk domain has a negative and a positive potential. This way of thinking inspires clinicians to also focus on observing positive development. The SAVRY risk assessment tool for juveniles contains six distinct protective factors which are to be rated regarding the recent past. Although the number of protective factors is relatively limited and the factors are rated as either present or absent, they too provide the notion of the relevance of strength-based factors.

In working with the HCR-20 in clinical practice, this phenomenon of the unstructured inclusion of protective factors while formulating final conclusions from the assessment was recognized as a major shortcoming of the otherwise structured and

Table 16.4 SAPROF item ratings for John for the context of inpatient treatment with unsupervised leaves

Internal items		**Score**	**Key**	**Goal**
1	Intelligence	1	☐	
2	Secure attachment in childhood	2	☐	
3	Empathy	1	☐	☐
4	Coping	1	☐	✓
5	Self-control	1–	☐	✓
Motivational items				
6	Work	2	✓	☐
7	Leisure activities	2	☐	☐
8	Financial management	2	☐	☐
9	Motivation for treatment	1+	☐	✓
10	Attitudes towards authority	1	☐	☐
11	Life goals	0	☐	☐
12	Medication	1	✓	☐
External items				
13	Network	1	☐	✓
14	Intimate relationship	0	☐	☐
15	Professional care	2	✓	☐
16	Living circumstances	2	☐	☐
17	External control	2	✓	☐

Note: Coding of the SAPROF items. Presence: 0 = not present; 1 = present to some extent; 2 = present
Key factor: item is considered essential for the prevention of violent behaviour in the assessed context
Goal factor: item is considered important as a treatment goal as improvement on this item may have a protective effect

empirically based SPJ assessment process. For this reason efforts were made to develop an evidence-based structured professional judgement tool specifically for the assessment of protective factors for violence risk, which could serve as an additional manual to existing risk-focused assessment tools. Based on literature reviews and experience from clinical practice, a tool was developed specifically for assessing protective factors: the Structured Assessment of Protective Factors for violence risk (SAPROF; [25, 27]). The SAPROF was intended to be used in addition to risk-focused SPJ assessment tools, such as the HCR-20^{V3} or VRS, in order to include an empirically based measure of protective factors for violence risk in the assessment process, aiming to better inform the final conclusions drawn from the assessment. The tool is also being used in combination with actuarial tools such as the STABLE or the LS/CMI. The SAPROF is now available in 15 different languages and has been implemented in clinical practice in many European countries and abroad, including The Netherlands, United Kingdom, Spain, Cyprus and Poland.

The SAPROF consists of 17 protective factors which are predominantly dynamic in nature and are to be rated for the near future, similar to the HCR-20 risk management items (for an overview of the SAPROF factors, see Table 16.4). As factors are

rated for the future (on a 7-point scale), they are inherently context dependent, meaning that ratings may vary when the context changes. For example, a patient with a history of substance-related violence (risk factor) who is allowed to leave a psychiatric hospital under supervision may have good self-control (protective factor) in this context and not relapse into substance use while being escorted. However, if the context changes to unsupervised leaves to the community, the individual's self-control may be assessed less optimistic. By applying the tool in this manner, protective factor assessment can be used to guide treatment adjustment and risk management decision-making. Moreover, the process of risk assessment becomes more individualized through the marking of the most salient factors for each individual, either as key factor that offers significant protection for the individual or as goal factor that holds promise for improvement during treatment. Through this process of highlighting the vital factors for the individual, the risk assessment offers more personal guidance for treatment. The assessment of risk factors (with a risk-focused tool, such as the HCR-20) and of protective factors (with a strength-focused tool, such as the SAPROF) is integrated within the risk assessment, and conclusions drawn from the assessment (risk scenarios, final judgements) should be based on the whole picture of positive and negative factors together. Research results with the SAPROF demonstrate good inter-rater reliability and good predictive validity for desistance from violence. Moreover, several studies have found evidence for incremental predictive validity of the SAPROF protective factors over the HCR-20 risk factors, indicating that both tools complement each other and together offer a more valid and well-balanced risk assessment (see [50]). Currently, additional manuals to the SAPROF are being developed that contain additional protective factors that are of particular relevance to desistance for specific populations, such as sexual offenders, individuals with intellectual disabilities, inpatients in intensive care settings and possibly females. Lastly, given the fact that juvenile behaviour is highly changeable and influenceable, in part through interventions, it seems especially promising to encourage positive development of strengths for young people. Therefore, a SAPROF—Youth Version (SAPROF-YV; [44]) was developed, based on literature regarding juvenile desistance. The SAPROF-YV is intended to be used alongside risk-focused assessment tools for juveniles, such as the SAVRY or the YLS/CMI. It includes items such as school, future orientation, peer and family support as well as different items which together comprise the resilience scale (social competence, coping, self-control and perseverance).

16.5 Case Example

John is a 32-year-old man, convicted for attempted manslaughter and sentenced to 18 months in prison and mandatory inpatient treatment at a forensic psychiatric hospital. John has had a reasonably good childhood with loving parents and one older brother. However, he is teased at school for his clumsiness, which causes him to be a loner in early childhood. At age 16, he becomes more social and starts hanging out with a group of drug-using peers. On one occasion he is arrested for shoplifting. After finishing high school, John finds a job at a bakery. From age 22 onwards,

he starts to become more and more withdrawn and gradually becomes increasingly convinced that evil forces are out to get him. In order to calm himself down and forget about his problems, he starts drinking and using drugs excessively. When he drinks, he tends to become less timid; however, his suspicious thoughts remain, causing him to easily feel threatened by relatively harmless social interactions. His behaviour becomes increasingly aggressive when under the influence of alcohol and drugs. He seeks help but voluntary outpatient substance abuse treatment attempts fail. Multiple times he gets involved in bar fights, for which he is arrested and convicted twice. After threatening one of his co-workers, he loses his job at the bakery. People become increasingly afraid of him and he becomes estranged from his friends and family. At age 27 he eventually commits the index offence. Under the influence of excessive amounts of alcohol and drugs, he severely assaults another man in a bar fight, after the man makes a seemingly harmless joke about his drug use, and John becomes convinced the man is part of an evil plot against him. The victim survives the incident, but John is convicted for attempted manslaughter. In prison he appears to have bizarre and paranoid thoughts about people who are after him. After an in-depth evaluation by a psychologist and a psychiatrist, he is diagnosed with paranoid schizophrenia and substance dependency.

After his prison sentence, John is admitted to a forensic psychiatric hospital. His mandatory treatment sentence is imposed for indefinite time and will continue for as long as deemed necessary by the courts, to ensure a safe return to the community. Every year John's treatment is evaluated in order to assess his treatment progress and the necessity for further intervention. The aim is to gradually and safely reintegrate John back into society. After initially resisting interference by the treatment team, he starts to become more aware of the necessity for him to change his attitude and is willing to accept antipsychotic medication. Although his paranoid thoughts remain present to some degree, his behaviour appears much less influenced by suspicions. He starts working in the hospital kitchen and takes classes in order to gain certificates to become a confectionery baker, which would significantly increase his likelihood of finding a job in the community. He often plays his guitar and is persuaded by the music teacher to join the hospital music band. Although his mood fluctuates, overall he has a gloomy attitude. He remains somewhat ambivalent towards his treatment team. However, usually he attends his meetings with the psychiatrist and follows all agreements. He takes part in a psychoeducation group and a substance abuse prevention group. Given his apparent progress, he is granted supervised leaves to the community, during which he always behaves appropriately. During the second year of his treatment, John keeps developing well. He remains adherent to his antipsychotic medication and seems motivated to stay on the right track. He feels supported by the relationship with his parents and brother, which is gradually being restored. He continues to work in the hospital kitchen and finishes his confectionery certificate. Although he has limited financial means, he manages his finances appropriately. His behaviour is calm; since the start of his treatment, there have not been any aggressive incidents. John finds it difficult to face his violent past and the pain he has caused others. He does not foresee any possibility of becoming violent again. Occasionally, he does however discuss his urge to drink

alcohol when on leave. One time he attempts to walk into a bar but is called back by the supervising staff member. He plays down the incident and claims he was just trying to find a bathroom. In order to be able to find a job in the community and make the next step in his reintegration process, the treatment team proposes to grant John unsupervised leaves outside the hospital. For this reason, a risk assessment is carried out for the context of unsupervised leaves.

16.5.1 John's Assessment

Risk factors: Tables 16.3 and 16.4 show the risk factors (HCR-20^{V3}) and protective factors (SAPROF) that have been assessed by the treatment team. John's historical risk factors show quite a problematic background, with major issues on different domains, such as past violence, relationship problems, employment difficulties, substance misuse, his paranoid schizophrenia and failed treatment attempts. The recent past shows a more positive picture, with still some problems with insight into his disorder and violence potential, symptoms of paranoia which remain present to some extent despite the medication and affective instability as well as some impulsive behaviour. Regarding the anticipated problems for the unsupervised leave context, some problems are foreseen regarding the reduced intensity of supervision given that the treatment team will not be by his side at all times and he may get tempted to use alcohol or drugs again. His response to treatment and supervision in the new context with increased freedom may also be more problematic. The limited personal support is still an issue as well. In addition, the challenges of this new treatment phase are anticipated to be quite stressful for John, since he now has to start solving problems in the community on his own and faces challenges, such as finding a paid job and leisure-time activities in the community.

Protective factors: Looking at the protective factors, the assessment shows his average intelligence and secure attachment in childhood. All dynamic items are rated for the future context of unsupervised leaves. Empathy for potential victims, coping with difficulties he may encounter and self-control are present to some extent. However, his self-control regarding substance use may be tested when passing restaurants and bars in the community unaccompanied by a staff member. Work is anticipated to remain a strong point for John, although transferring to a workplace outside the hospital may prove challenging. He still plays in the hospital band and it is anticipated he will keep managing his finances well. He will likely remain fairly motivated for treatment and adhere to the general agreements, although his ambivalence might become more prominent again with the increased freedom and temptations. It is anticipated he will remain medication adherent. The medication may not be fully effective to reduce all psychotic symptoms; nevertheless, it is considered a vital protective factor for John. Although his social network is small and the reconnection with his family is quite recent, he does feel supported by them. He does not have any clear life goals nor is he involved in an intimate relationship. The professional care from the treatment team will remain intensive, he still lives in the hospital, and the court order of mandated treatment will remain in place. This means the treatment team can intervene at any moment when warning signs show. These external factors

are seen as key protective factors for John during the unsupervised leaves. For the coming 6–12 months, further improvement of his coping skills, strengthening his self-control, motivating him for continuation of treatment and expanding his social support network are seen as the most prominent goals for treatment.

Final risk judgement and conclusions: Viewing the protection from John's internal, motivational and external factors together with the historical and dynamic risk factors, for the unsupervised leave context, the level of protection available to John is judged as *moderate–high*. Next, the risk of violent behaviour during unsupervised leaves is judged as *moderate*, although the risk of serious physical harm or imminent violence is judged as *low–moderate*. In terms of violence scenarios, the main worry the treatment team has is that John might be tempted to use alcohol again, which could lead to loss of self-control and potentially behaving violently towards others in a bar, or towards staff upon return to the hospital when under the influence of alcohol. However, it is anticipated that severe substance abuse will likely not happen quickly and a build-up of John's temptation to use alcohol is likely to be noticed by the treatment team. Moreover, his current functioning is quite stable, the medication has reduced his paranoid thinking significantly, he is motivated to do well, and his leaves outside the hospital are only during the day and will be discussed and prepared quite thoroughly. Therefore, it is anticipated that even when he does drink he will likely not become violent right away and his behaviour will be less extreme than before. The results from the risk assessment are written down in a report, which becomes part of the larger treatment and risk management plan that will support the court proposal for officially granting John unsupervised leaves to the community.

16.6 Recommendations for Clinical Practice

Based on current best practice, several recommendations can be made regarding the practical use of risk assessment. First of all, it should carefully be considered which risk assessment tools should be used in order to guide the assessment. The tool should be a good fit in terms of demographics (age, gender, psychopathology, etc.), type of offending behaviour, timeframe for the evaluation, type of factors (static/dynamic, risk/protection) and aims of the assessment (establishing risk level, informing treatment goals, etc.). It is essential to use risk assessment tools that match with the individual case and provide the intended outcomes. Before using risk assessment tools, one should attend training in how to use the tools properly. This also includes booster training or regular consultation with colleagues, discussing general scoring guidelines or specific ratings of a particularly difficult case. In addition, assessors should always use the tool's manual when rating a case. Without reading the scoring guidelines in the manual, it is possible that assessors start drifting away from the actual coding rules as described and slowly create their own interpretation of a factor or concept. In order to retain reliable risk assessment ratings, proper training and use of the scoring manual are essential. Keeping up with the literature regarding specific types of violence is also recommended, to ensure that the assessor is informed by the latest scientific knowledge. This also includes findings on base rates for specific types of recidivism among specific types of offenders.

An assessment can only be as reliable as the information that is used to inform the evaluation. Thus, extensive and preferably verifiable information is key for a good risk assessment. Ideally, information from multiple sources is used, such as self-report, information from family, friends, employers, sports coaches, and other network members. Treatment reports generally provide a rich source of information, as well as previous court reports and case notes regarding past and current functioning. In order to be able to make an accurate description regarding the recent past, formulate reliable expectancies regarding the near future, generate recommendations for interventions and measure change over time reliably; sufficient dynamic information is essential. This means in-depth information needs to be available regarding the recent past.

A further recommendation concerns the use of multiple raters. Research has shown that assessments carried out by different assessors together provide better predictive validities (see [51]). Preferably these different assessors are from different disciplines, such as treatment supervisors, ward staff and diagnosticians or researchers. Each assessor generally has their own insights and information regarding the individual, which influence their ratings of the risk and protective factors. By including multiple assessors, information from different sources is brought together, providing a well-informed and balanced assessment process. Team assessments could either be done individually first by each assessor and then be discussed in a consensus meeting, to arrive at an agreed rating for each factor, or if this is too much preparation, the assessment could also be done directly in consensus in a team evaluation meeting. Besides providing more reliable and valid ratings, team assessments also have the advantage of providing a constant feedback and training loop as different assessors will correct each other when drift from the coding instructions occurs. Perhaps most importantly, having different disciplines take part in the assessment process ensures that all treatment providers are on the same page regarding their views on violence risk and the important risk and protective factors that should be targeted in treatment. This makes it much easier to agree on treatment goals and evaluate treatment progress as a team.

Regarding the actual assessment, as stated before, it is highly recommended to explicitly include both risks and strengths in the assessment. Focusing on protective factors as well provides a more balanced and well-rounded view of the individual's current functioning, their weaknesses and their strengths, as well as potential protective factors that could be developed over the course of treatment. Having this two-sided view on risk assessment inspires clinicians in their treatment efforts and offers hope to patients in terms of potential positive changes. Generally, it is advisable to write a report after each risk assessment, describing the main findings from the assessment in a coherent narrative. It is recommended to not use numbers or actual ratings in this report, but to be descriptive instead. The most relevant risk and protective factors for the individual in the assessed context should be described, as well as the most likely risk scenarios and possible treatment goals. When discussing the results from the assessment with the patient, it may be helpful to share the written report with the patient. In communicating with the patient regarding potential risk of harmful behaviour, it proves valuable to also discuss the positive factors. Even when not many protective factors are in place yet, discussing the possibility of developing these factors may inspire treatment motivation and enhance treatment alliance.

Finally, risk assessment should inform risk management and guide treatment interventions [52]. Thus, risk assessment should not be viewed as a snapshot

evaluation of the likelihood of violence risk but instead should be used as a treatment tool that offers insight and guidance regarding the most promising treatment approach for the individual and the feasibility of specific treatment and risk management plans. In this regard, it may be useful in some cases to rate the future items of the assessment for different situations or contexts simultaneously. This way it will likely become quite clear whether a newly proposed step in treatment (e.g. leaves outside the hospital) is feasible or whether perhaps it is still too risky to enter this new treatment phase. Also, it could be contemplated to make an additional rating for the hypothetical situation "what if the patient were to be discharged today". The ratings for this hypothetical discharge context could be compared to the ratings for the present context, which could be helpful in convincing the courts of the necessity of further treatment, or perhaps if the results turn out more positive, it may be an eye-opener regarding the feasibility of discharge. In addition, repeated assessments should be seen as treatment evaluations that can monitor an individual's progress, which offers additional potential for communication with third parties such as the court. Moreover, it offers the potential to adjust interventions along the way and evaluate the effectiveness of specific interventions. Thus, it is highly recommended to carry out repeated assessments regularly, at least every 6–12 months or when the context changes. If more dynamic tools are used or the assessment concerns younger individuals, these reassessment timeframes may even be much shorter.

One last remark regarding the applicability of risk assessment is that risk assessment tools should be considered helpful aids to map out an individual's unique combination of risk and protective factors that may influence their future (violent) behaviour. Although they have proven to be reliable and valid, these tools do not provide the holy grail of certainty regarding an individual's future behaviour. Results from the assessment should always be viewed in light of the particular individual, context and circumstances. Predicting human behaviour is extremely difficult. Risk assessment may be able to guide us through this process and provide well-informed advice regarding our judgement of the likelihood of future violent behaviour, no more, no less.

Take-Home Messages

- Risk assessment improves our knowledge about an individual; it does not provide certainty.
- The most applicable assessment tool to use depends on the individual being assessed, the type of anticipated violence and the scope of the assessment.
- Carefully considering the context is of vital importance for risk assessment.
- Risk assessment should inform risk management and guide treatment interventions.
- Comprehensive risk assessment explicitly includes both risk factors and protective factors.

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Prioritizing Research in Forensic Psychiatry: A European Perspective

17

Florence Thibaut and Thierry Pham

17.1 Introduction

Forensic psychiatry differs between European countries due to different historical backgrounds and to different legal and mental health-care systems. In fact, in Europe, the legal tradition comes from two different main roots: the Roman-French law (used in most European countries) as opposed to the Common law, which is used in the United Kingdom and Ireland. The Anglo-Saxon law, as opposed to the Roman-French law, (1) is less prescriptive and uses a more pragmatic approach (laws are less detailed) which means that the judge has wider options (interpretation is less limited as compared to the Roman-French law, where the codes state offenses and lay down procedures and punishments); (2) emphasizes behaviors more than psychological elements; and finally (3) does not consider the concept of responsibility as basic.

Yet, forensic psychiatry shares some common goals across European countries such as:

- Being at the interface of law and psychiatry
- Giving evidence to courts
- Providing treatment for mentally disordered offenders

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– Working toward improving living conditions of mentally disordered offenders
– Taking care of ethics and human rights

17.2 Several Epidemiological Studies Were Conducted in Europe

Salize and Dressing published on the website several reports (cited below) with the support of European grants. These reports may be considered as state-of-the-art surveys on the questions that need to be addressed by research programs in European forensic patients.

In 2002, a first report was entitled "*Placement and treatment of mentally disordered offenders – Legislation and practice in the European Union (EU).*" Report is available at http://ec.europa.eu/health/ph projects/2002/promotion/fp promotion 2002 frep 15 en.pdf. [1]

Their main conclusions were the following: forensic psychiatric care varied substantially across Europe in terms of legal systems, frameworks, key concepts, services, capacities, routine procedures, pathways to care, etc.

In this context of great heterogeneity among European countries, evaluation or comparison between countries was seriously hampered. In addition, the outcomes were not defined; indicators were not implemented; criteria for models of best practice did not exist; and under-provision with specialized services was common. According to their report, harmonizing legal frameworks or basic standards for forensic care across the EU seems hard to achieve. More than 10 years later, their conclusions remain true.

They have also concluded from their survey that, in all European countries, forensic psychiatry remained an under-researched field with scarce administrative and research data.

Salize and colleagues conducted another interesting survey in 15 European countries in 2002 entitled: "*Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States*" Grant Agreement No. SI2.254882 (2000CVF3-407).[2]

They have concluded that legal regulations on the practice of involuntary placement or treatment of mentally ill patients were very heterogeneous across European Union member states. A comparison of the legal frameworks of the member states or an evaluation of the effectiveness of their approaches entailed serious methodological problems: (1) international epidemiological research in this field had not yet developed a convincing statistical model for correlating changes in mental health-care legislation to any outcome of compulsory admission procedures; and (2) moreover, even the most basic outcome data, in terms of valid or reliable annual frequencies or rates of compulsory admission of mentally ill persons, were missing in many countries.

They also draw the following conclusions from their survey: in the future, applying coercive measures or compulsory interventions to mentally ill people will still be inevitable under specific circumstances, in order to avoid harm to the patients

themselves as well as to the general population. Compulsory admission and compulsory treatment, however, infringe fundamentally upon human rights; therefore appropriate legal regulations will be even more crucial in the future. It will be an ongoing task to adapt continuously legal frameworks in all countries to keep pace with developments and new achievements in mental health care and to balance public safety and patients' rights and interests against their needs and rights for treatment. All in all, every mental health-care expert agrees that the involuntary placement or treatment of a given patient should be a modality of utmost crisis intervention, strictly restricted to situations where less restrictive alternatives have failed. Ten years after this conclusion, we have conducted another literature search, using the English-language literature indexed on MEDLINE/PubMed with the following keywords: "involuntary treatment or compulsory admission, Europe, and psychiatry" (without time limits). We have found 304 (211 with compulsory admission) items including mainly national epidemiological data (country per country). Unfortunately, clinical research concerning, for example, relationships between compulsory admission and treatment or type of patients remains too scarce.

Finally, Salize and Dressing conducted a third survey entitled:*"Mentally Disordered Persons in European Prison Systems—Needs, Programmes and Outcome (EUPRIS)"* in 24 European countries published in 2007. Grant Agreement no. 2004106 EUPRIS.[3]

In their final report, they have pointed out some important items that should be taken into account for further research in the field of mentally disordered prisoners in Europe:

1. None of the prisons or health administrations throughout Europe knew neither how many nor what kind of mental disorders were prevalent in the national prison systems. The annual number of prison suicides was the only feasible indirect indicator for mental health problems in prisons available. Indeed, none of the countries provided regular national statistics on the frequency of mental disorders of prisoners or on the availability or frequency of psychiatric treatments. Missing structure and epidemiological or outcome data currently prevented the identification of a favorable concept of prison mental health care across Europe. Conventional indicators for mental health care failed to work in the prison context due to a largely varying involvement of national health services into prison mental health care.
2. In general, specific requirements regarding the care of mentally disordered prisoners were not sufficiently covered by the professional training of prison mental health-care staff. European standards did not exist in this field.
3. Regular mental state screenings of prisoners that fulfilled quality standards were rare across Europe. Inadequate diagnostic procedures prevented the implementation of adequate primary, secondary, or tertiary prevention programs for the mental disorders most prevalent in prisons. Moreover, due to inadequate release planning, psychiatric aftercare for mentally disordered persons released from prison was deficient. This situation may increase the risk of relapsing and/or re-offending.

4. Treatment programs for specific mental disorders in prison were not sufficiently provided. The available information supported the hypothesis that psychopharmacologic drug use by prisoners may significantly exceed that of the general population. After adjusting for age, rates of psychotropic prescribing in prison were 5.5 and 5.9 times higher than in community-based men and women, respectively [4].

Almost, 10 years after these pessimistic conclusions, we have conducted a literature search, using the English-language literature indexed on MEDLINE/PubMed with the following keywords: "forensic psychiatry, Europe, clinical research or epidemiology, and prison" (without time limits). Few papers concerned descriptive epidemiological data (544) (51 with prison as an additional keyword) or clinical research (918) (32 with prison as an additional keyword). Most of these latter articles about epidemiology or clinical research were not related to forensic psychiatry except when the term prison was included as a keyword. When the terms "prison and forensic patients" were used without time limits, only 334 papers were found.

17.3 Research on Management of Violence Using Technological Innovations

In the field of forensic hospitals and security wards, Tully et al. [5] have focused their research interest on technological innovations used for management of risk and violence in forensic psychiatric settings (electronic monitoring by GPS-based tracking devices of patients on leave from medium secure services and closed circuit television (CCTV) monitoring and motion sensor technology at high secure hospitals). They have concluded that these types of technological innovations should be subject to thorough evaluation that addresses cost-effectiveness, qualitative analysis of patients' attitudes, and safety as well as ethical considerations.

17.4 The COST Project

Recently the EU has provided a 4-year grant entitled COST Action (IS 1302 available at www.cost.eu) to conduct a European study on forensic care (especially on long-term forensic care) across 19 European countries. This European project is intended to increase research in the field of forensic psychiatry, to harmonize professional training and education, to standardize indicators for forensic service provision and outcomes, and to stimulate aftercare and inter-sectoral perspectives.

The aims of the COST Action are the following:

- To provide a standardized description of epidemiology (patients' characteristics, practices), forensic psychiatric assessment, service provision, long-term forensic patients, patients' needs, and quality of life
- To describe similarities and differences
- To find evidence for best practices

- To optimize patients' quality of life
- To increase training and networking in order to increase research in this field

17.5 Sex Offenders

In the particular field of sexual offenders, research interest has increased during the last 20 years in Europe. A literature search was conducted, using the English-language literature indexed on MEDLINE/PubMed with the following keywords: "sexual offenders, research, and Europe" (without time limits). We have found 144 papers. Yet, sex offenders constitute an important group among forensic patients, nearly 50% [6]. Moreover, their mean duration of stay was of, respectively, 8 years [6] and 4 years (according to [7]). In France, a national cohort of 345 male sexual offenders with paraphilias (80% were child or adolescent sex offenders) was recently established. All sex offenders were outpatients, and 90% were under compulsory mental health care. The epidemiological and clinical data of this cohort are currently under analysis. Some international guidelines concerning (1) biological treatment of adult sexual offenders with paraphilias and (2) guidelines for the treatment of adolescent sexual offenders with paraphilias were published ([8, 9]; available via www.wfsbp.org or via PubMed). Pedophilia, which is associated to sexual offending in a substantial number of cases, has gradually become an increasingly accepted research field ([10] for review).

17.6 Assessment of Forensic Patients

In this section, we will develop three aspects of research on assessment of forensic patients: (a) the structured evaluation of diagnosis, (b) the issue concerning the systematization of violence risk assessment, and finally (c) the quality of life measures to monitor improvement under treatment in forensic populations.

17.6.1 Prevalence of Mental Disorders in Forensic Patients

The use of internationally standardized assessment scales, especially concerning diagnosis, are important elements in the evaluation of national and European policies. Salize and Dreßing [11] outlined that the use of common international standards in mental health reporting is essential, at least within the EU, to guarantee valid overviews and provide a basis for more detailed research in the field. According to the survey of Dressing et al. [12], only a minority of the EU member states were able to provide diagnostic characteristics for involuntary placements. Non-standardized use of diagnostic categories was common. Their survey revealed that "almost none of the included countries provided regularly national statistics on the frequency of mental disorders in prisoners or on the psychiatric treatments used. A major reason for the lack of data on the prevalence of mental disorders in prisons is

the deficient implementation of standardized psychiatric screening and assessment procedures following admission to prison and during their time in prison. These observations suggest the strong necessity for further research in this field based on structured instruments in order to describe the prevalence of mental diseases and to monitor psychiatric needs of forensic populations.

17.6.2 Violence Risk Assessment

The World Health Organization has named violence prevention as one of its priorities over a decade ago. Unstructured professional judgment is not as accurate as structured methods especially in sex offenders [13]. For the last decades, around 90 violence risk assessment tools have been developed [14, 15]. These instruments combine known risk and protective factors for violence. Actuarial approaches, or structured professional judgment (SPJ) and dynamic factors instruments, which are more clinically based, were developed.

These structured measures are composed primarily of static risk factors which are unchangeable aspects of an individual's history. More recently, researchers have developed instruments that combine static and dynamic risk factors. Dynamic risk factors are potentially changeable and offer direction to providers about what offender problems to target in order to reduce risk to re-offend. Presently, mental health professionals are frequently asked to assess the risk of violence among inmates or forensic patients. This is also recommended by the current clinical guidelines for psychologists [16], psychiatrists [17, 18], and nurses [19–21]. These guidelines were implemented in mental health and criminal justice settings, where they are used by psychologists, psychiatrists, or criminologists to help professionals toward making a decision about release into the community, treatment options, or other management decisions. Indeed, recent meta-analyses have suggested that different risk assessment instruments discriminate between violent and non-violent individuals with comparable accuracy, implying that it is difficult to base tool choice solely on predictive validity. In light of such findings, experts have recommended to focus on the assessment needs of the practitioner in terms of the purpose of the evaluation and the population assessed [20, 22]. According to a search of PsycINFO, EMBASE, and MEDLINE, ten surveys have been published between 2000 and 2014 investigating violence risk assessment practices [20]. The studies have provided evidence that risk assessment tools are commonly used by psychologists in the United Kingdom and Denmark. However, use of risk assessment scales is nearly nonexistent in some countries like France due to the lack of training of professionals. Prior surveys of risk assessment methods have been largely circumscribed to individual countries and have not compared the practices of various professional categories. Recently, a web-based survey was developed to examine the international use of structured instruments in the violence risk assessment across five continents and to compare the perceived utility of standardized instruments by psychologists, psychiatrists, and nurses. The survey was completed by 2135 respondents from 44 countries [20]. Generally, respondents had used instruments to assess, manage, and monitor violence risk in more than half of the cases in the past 12 months; psychologists reported using more often instruments than psychiatrists or nurses who were less trained to

use them. In Belgium, the subsample was composed of 86 mental health professionals (essentially 69 psychologists, 12 psychiatrists, 1 nurse). In the past 12 months, respondents have conducted an average of 41 assessments using a structured instrument in over half of the cases. The most commonly used scales were the PCL-R (Psychopathy Checklist-Revised; [23]) and the HCR-20 (Historical Clinical Risk-20; [24]), which were considered as useful. To develop a violence risk management plan, the instruments were used less frequently; however, the HCR-20 was found the most useful. In fact, the Singh et al. [20] survey reported that risk management plans were not implemented in over a third of cases. Another major result of the Singh et al. survey consisted of the communication domain. Indeed, feedback process regarding outcomes was not common: respondents who conducted structured risk assessments reported receiving feedback on accuracy in less than 40% of cases, and those who have used instruments to develop management plans reported feedback on whether plans were implemented in less than 50% of cases. Yet, social psychology research demonstrated that judgment accuracy increases when decision-makers receive feedback on their performances [25]. Moreover, risk assessment tools may not help to reduce violence unless their findings are communicated transparently and suggestions for risk management are organized [26]. Hence, receiving feedback following risk assessment and developing risk management plans could improve the efficacy of mental health services [21].

Although the dynamic factors used in some scales are better conceived as repeated measures, most of the time, risk assessment evaluations are only performed on a single occasion. Future research should systematize but also repeat the evaluation in order to assess the potential dynamic changes of patients.

Finally, answers to these questions may help individual clinicians working with mentally ill and criminal justice populations to identify and implement the risk assessment tools with the greatest acceptability, efficacy, and fidelity [27].

17.6.3 The Use of Validated Questionnaires About Needs and Quality of Life in European Forensic Psychiatric Institutions

The European COST Action "long-term forensic psychiatric care" (www.lfpc-cost.eu/) has launched an online survey. This survey investigates to what extent forensic psychiatric services make use of questionnaires in order to investigate the quality of life experienced by patients and also their needs. In many fields, quality of life (QOL) measures are increasingly used to evaluate the way individuals perceive their physical and psychological health, their social relationships, and the quality of their environment [28]. To understand the concept of QOL as a whole, many generic and specific measures have been developed. Generic measurements are used to compare groups of individuals with different mental disorders [29]. More specifically, in forensic patients, QOL sensitive areas are particularly affected by the conditions of confinement (control, security, dignity, etc.) and the environment where criminological variables take a large place [30–33]. However, until now, this measure has not been systematically implemented in forensic populations. Yet, it seems unavoidable with respect to the evolution of individuals and provision of health services and forensic institutions

[30, 31, 34, 35]. QOL instruments were recently introduced among forensic inpatients [30, 31, 36] but also among prison inmates [37] and constitute an appropriate approach to tap positive and humanistic psychology [38] as defined by the "Good Life Model" [39], for which validation studies are still missing.

Conclusion

National and international research on psychiatric prevalence in prisons and on prison mental health care must be stimulated and increased wherever possible.

The few rudimentary prison mental health data that are available at a national level are not standardized. As a basic prerequisite for any action taken, more awareness of the deficiencies and problems must be raised by responsible authorities and decision-makers, both at a national and European level. The definition of common (European) indicators would be most crucial.

Currently, another important field for common European actions would be the harmonization of training of prison mental health caregivers, which should become a prerequisite for medical staff and other caregivers working in prisons.

Some important clinical aspects are still pending in all European countries, such as the relationships between the psychiatric diagnoses and the penal codes, the systematic use of standardized tools for diagnosis or evaluation of risk of offending, the implementation of prevention programs in at-risk populations (such as adolescents with antisocial personality disorders or sexual fantasies or activities involving children, etc.), and finally, the monitoring of patient and institution changes using quality of life measures in order to improve care strategies and trajectories in forensic populations.

Finally, some basic research on the determinants of violence (sexual and non-sexual) is also urgently needed.

It is urgent that our governments in coordination with our European leaders take action because the price society has to pay for saving on prison mental health care is an increased number of relapses and an increased rate of re-offending by released prisoners – and thus a loss of public safety, an increased strain on national health budgets, and increased expenditures by the criminal justice system.

Take-Home Messages

- Systematic use of standardized assessment tools for diagnosis, violence risk measurement, or quality of life should be strongly promoted in European forensic populations.
- Training of prison mental health caregivers should become a prerequisite for medical staff and other caregivers working in European prisons.
- National and international research on psychiatric prevalence in prisons and on prison mental health care as well as on violence must be increased, and the European Research Council should urgently add this topic to their list of research themes.

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Part V

Capita Selecta

18 A (Possible) Role for International Associations in the Development of Forensic Psychiatry Education and Training

Marc Hermans and Florence Thibaut

18.1 The Context

Migration from one country to another is a very common phenomenon nowadays. Though one expects this to happen more easily with colleagues of more technically oriented specialties, e.g. surgery, psychiatrists move around the globe with no less enthusiasm [1]. They see themselves confronted with the more cultural aspects of human encounters and among them the linguistic aspects. These difficulties are evidently less important for countries where English is a mother tongue, but they evidently occur between countries with different languages.

The signing of the Treaty of Rome on 25 March 1957, thereby establishing the European Economic Community (EEC), has certainly contributed a lot to the increased mobility. It was preceded by the foundation of the Benelux by the governments of the three participating countries in exile in London in September 1944. Both treaties expressed the will to build a better future for next generations inspired by the solidarity grown during the terrible world war experience. The Benelux member states strived for common goals at an economic level together with durable development, a shared policy in justice and internal affairs. The EEC highlighted these aims even more by stressing the value of freedom worded in its goals of free movement of goods, capitals, services and persons.

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18.2 Union Européenne des Médecins Spécialistes (UEMS)[1]: European Union of Medical Specialists (EUMS)

It was not only by pure collegiate feelings that in July 1958, the UEMS [2] (www.uems.eu) was established. The foreseen free movement of medical doctors created the need for harmonisation all over Europe in order to keep the same level of quality of undergraduate and postgraduate training, continuous medical education and service delivery. The French name justly refers to the francophone initiators though English became the most currently used language. The concern for quality was immediately present and conveyed through intense communication with the European Commission. In this way the UEMS contributed significantly from the very beginning to the content of European legislation concerning medical specialties.

In 1962, the UEMS members, all national *general* medical associations, established the Specialist Sections and Boards for the main medical specialties recognised in the different member states. Each member can appoint two delegates to a Section. They are expected to work on their own specialty specific aspects. Each Section has a Board, a permanent working group of particular interest because its delegates mostly have an academic background. A Board should aim at the highest standards of care within the field of its specialty by ensuring to raise the training to the highest possible level. The second delegate within a Section is frequently a member of the board of a union-like association. In this way academic science and daily professional practice are both represented.

The delegates of a particular Section are proposed by national association(s) relating to that particular specialty. However it's the national general medical association's prerogative to also formally appoint them. Ever since 1962, these operational bodies without separate legal personality status became "the flesh and blood" of UEMS striving for quality and harmonisation of training in each specialty. The Section and Board of a particular specialty write down the necessary competencies to be acquired by trainees in their document "European Training Requirements for the Specialty of …." (ETR).

The enormous growth of UEMS has brought with it a more complex but still performing structure [3].

Three standing committees take up the different tasks related to different issues: the Standing Committee on Continuous Medical Education and Continuous Professional Development, the Standing Committee on Postgraduate Training and the Standing Committee on Quality Assurance. All three have their issue related councils: the European Accreditation Council for CME (EACCME), the European

[1] The union was established in Belgium as an international not-for-profit association. Consequently the statutes had to be written in one of the country's official languages at that moment, Dutch or French. The founding members did choose French since it evidently was the most commonly shared language. Ever since then English became the main language for common use within UEMS. French remains one of the two official languages in the association and the French acronym the most frequently used one.

Council for Accreditation of Medical Specialist Qualification (ECAMSQ) and the European Accreditation Council for Quality Management in Specialist Practice (EACQMSP).

The European Accreditation Council for Continuous Medical Education® (EACCME) is the UEMS body accrediting educational events. UEMS has at this moment agreements with 21 countries in Europe allowing doctors to get accreditation in their country with a certificate from providers who organised an EACCME accredited event.

The European Council for Accreditation of Medical Specialist Qualification® (ECAMSQ) is another council striving to achieve a common background for the assessment and certification of medical specialists' competence based on curricula developed by the Sections. The development of formative assessments of knowledge, skills and attitudes in formats such as Multiple Choice Question (MCQ) Examinations and Direct Observation of Practical Skills (DOPS) is an important objective.

The European Accreditation Council for Quality Management in Specialist Practice (EACQMSP) is the third council but had up until now a rather low impact. Most reasons are related to the many differences between the organisation of care delivery in different countries and within countries themselves.

The Council for European Specialists Medical Assessment (CESMA) is another council giving advice and recommendations on the organisation of examinations, by providing guidelines on how to conduct assessments, to encourage colleagues to take board examinations as a personal quality mark, sometimes as an alternative for national examinations (e.g. ophthalmology).

The processes of subspecialisation and the increasingly overlapping areas of competencies between specialties have further contributed to the development of different fora where specialists and other professionals can collaborate.

Multiple joint committees work on a field of interest shared between different Sections. A Division is the body devoted to a particular field of interest within one speciality. Thematic federations allow to formally collaborate with nonmedical professionals under a UEMS umbrella.

The contribution of the UEMS Sections highly influenced the content of the first EEC directives relating to doctors (Directive 75/362/EEC and 75/363/EEC) based on the UEMS Sections' surveys presented to the EEC authorities. Given the specific situation for medicine, the EEC established the Advisory Committee on Medical Training (ACMT) composed by three delegates per country representing the government, the training institutes (universities) and practitioners (professionals). The European Commission offers an overview of the actual situation [4].

The UEMS has never had formal political power. It publishes consensus papers or guidelines reflecting the values shared by delegates representing more than 1.6 million specialists in Europe, approved on semi-annual council meetings. These documents are freely available for consultation via its website (www.uems.eu). Most important are the many *Charters.* The ones on Specialist Training [5], on Continuing Medical Education [6] and on Quality Assurance in Specialist Practice [7] reflect the three pillars which UEMS' activities are focused on.

Ever since the EEC became larger and eventually became the European Union (EU) many countries joined the original six. At the time we're writing, the UEMS enjoys membership of 37 countries, among them are also candidate countries, not (yet?) belonging to the EU. At an operational level, it counts 43 specialist Sections for the main specialties.

In 2005, the UEMS revised its statutes and obtained legal personality status according to the Belgian law on international non-profit associations.

18.3 The Section of Psychiatry

The Section of Psychiatry, established on November 16th 1991, soon began to work on the same fields and produced several documents. They are still available via the Section's website (www.uemspsychiatry.org). Three documents occupy a very important position in the Section's work.

The UEMS Charter on Specialist Training contains six chapters, five of which are common to all specialties. The Charter addresses the role of national regulating authorities (Ch. I), general aspects of training (Ch. II), requirements for training institutions (Ch. III), requirements for chiefs of training (Ch. IV) and requirements for trainees (Ch. V). The last chapter, chapter VI, *European Training Requirements for the Specialty of Psychiatry* [8] is recently updated and currently submitted for approval by the UEMS Council.

This document was followed by *The Profile of a Psychiatrist* [9], a position paper describing necessary competences and tasks of a psychiatrist. It was mainly aimed for other medical professionals, educators, politicians, decision makers and other stakeholders such as service users and their families. The seven CanMEDS 2005 roles, expert/clinical decision maker, communicator, collaborator, manager, health advocate, scholar and professional, were the main guiding principles explaining the view of the Section.

Perhaps the most important paper the Section ever published was the *European Framework for Competencies in Psychiatry* (EFCP) [10]. This addressed all colleagues involved in training of psychiatrists. It was written by a working group composed of members of the Section, delegates from the European Federation of Psychiatric Trainees (EFPT) and medical educationists. They set up an iterative process with national psychiatric associations, trainee associations, patient and carer associations, as well as with the European Psychiatric Association (EPA) and the World Psychiatric Association (WPA).

The EFCP document lists learning outcomes which national associations and regulating bodies can refer to, when they conceive curricula for postgraduate training or systems for continuing professional development. It defines a curriculum as a whole set, i.e. a statement of learning outcomes, a description of a training structure and, last but not least, also suggests useful assessment tools. However, the document abstains from proposing a professional development structure out of respect for national conditions, customs and traditions.

The EFPC document again refers to the CanMED 2005 roles and defines these roles as metacompetencies, each described by key competencies and further

supporting competencies. The authors formulate it all in an operational way in order to facilitate learning as well as their assessment by a number of evidence based methods.

In 2011 the Section also developed a strategy based on a SWOT analysis to make itself more visible within a broader network. An officer was appointed vice-president for training, another vice-president for CME. To collaborate with other stakeholders became a major topic of interest. Therefore the Section appointed an officer to develop working contacts with a patient organisation, *Global Alliance of Mental Illness Advocacy Networks* (Gamian) and an association of carers, the European Federation of Associations of Families of People with Mental Illness, EUFAMI.

The European Federation of Psychiatric Trainees (EFPT) became a very active partner during and, even more, after the meetings. The contacts with the European Psychiatric Association (EPA) were revitalised. A delegate of the EPA Board attends the meetings of the Section's general assembly. The Section's vice-president for training attends the meetings of the EPA's Committee on Education. The president represents the Section within the WPA in its Section on Education. This represents a very active network with one common goal: increasing the quality of psychiatric training and care delivery.

18.3.1 A Possible Future for UEMS and the Section of Psychiatry

The world has changed dramatically after the fall of the Berlin wall and the opening of the Central European borders. UEMS has to face different issues now. This poses a stress at the organisational level. UEMS might have to rethink its structure. The Sections became very active and developed into almost independent operational units. This no longer corresponds with their statutory position of dependent UEMS bodies. On the other side it is almost undoable for officers of the Executive Committee to further bear the responsibilities for all actions undertaken by the different Sections. They started in many perspectives very fruitful collaborative projects with, for example, European scientific associations. This clearly contributed a lot to increased quality of postgraduate training, continuing medical education (CME) and professional development. This collaboration between Sections and European scientific associations has led within different specialties to Europe wide examinations (e.g. in ophthalmology, in certain branches of surgery and internal medicine). Very recently a Task Force on Education in European Psychiatry was established as a collaborative initiative shared by the EFPT, the EPA, the Section for Psychiatry and the World Health Organization.

The Section of Psychiatry, in contrast with other sections, remained rather discrete at this level. This has to do with the huge diversity in training in psychiatry all over Europe, in organisation of care and organisation of psychiatric practices. Most striking perhaps is the position of private practice. In some countries it's a position taken by more than 90% of the psychiatrists (e.g. Belgium), in other countries it's less frequent (e.g. United Kingdom) and sometimes seen as care for an elite of patients, especially when it is not reimbursed by the insurance system. Nevertheless, the documents produced by the Section might serve as a solid basis for adjustment.

The Section increasingly collaborates with other stakeholders. For example, colleagues offer support to exchange programmes as setup by the European Federation of Psychiatric Trainees [11]. For many young colleagues, such programmes are opportunities for networking. Many of them feel inspired by new elements in psychiatry they discover abroad and suggest to implement them in their own national system. The reform in psychiatric training and modalities of care in Central European countries nowadays offers a very good opportunity for this kind of adjustments. In the already more elaborated training programmes in Western European countries, this is different. In this way, one may consider that establishing a European training programme in forensic psychiatry is a good opportunity to almost start from scratch in psychiatry. Colleagues working in other fields of interest might learn from this experience.

18.4 The European Psychiatric Association (EPA)

Another important stakeholder from a European perspective is the European Psychiatric Association (EPA) (www.europsy.net). It was established in 1983 [12] according to the French law on non-profit associations as the Association of European Psychiatrists (AEP). At its beginning, the AEP gathered mainly French and German psychiatrists. The founding members wanted to create a counterweight to the increasing influence of the American Psychiatric Association when DSM II was published in order to safeguard the values and traditions of European psychiatry and increase the impact of European research.

The young association carried forward from the very beginning the intention to develop a scientifically inspired series of activities. The choice for Strasbourg as headquarter, on the border between France and Germany, symbolised the presence of a strong European cultural background. Being located in the neighbourhood of the European parliament was evidently also a clear political statement. As an association for individual members, AEP attracted psychiatrists from outside the European Economic Community, later the European Union. After the disappearance of the iron curtain, the attraction spread even further towards colleagues from the Central European Countries who joined the association, engaging enthusiastically in scientific events.

The association made steps forward by becoming a consultative body for the Council of Europe in 1989. Different parts of the European Union rely on advice and opinions of EPA members. The EPA has always worked in collaboration with other organisations such as the World Health Organization (WHO), the World Psychiatric Association (WPA), the Section of Psychiatry of the UEMS, the EFPT and the European College of Neuropsychopharmacology (ECNP).

The association changed its name in 2008 to European Psychiatric Association and created a council of national psychiatric associations in addition to individual members.

18.4.1 Scientific Events

The EPA is well known for its *EPA congresses*. The first annual congress was held in Strasbourg in 1984. At the beginning they took place at the president's hometown but this quickly changed. Different major cities in Europe hosted this important EPA event. Since a few years, some of the presentations given at the congresses are available on line.

Of particular interest are the *CME Courses* [13] organised during the congresses. Everyone can submit a proposal. The high number of proposals made an evaluation process necessary. The topic, the clinical relevance and the scientific value of the content are considered as important criteria to fulfil.

Very similar to the CME courses are the *Itinerant CME Courses.* These are courses to be given in collaboration with national psychiatric associations (NPAs). An NPA can apply for a course of its choice by contacting the EPA's headquarters in Strasbourg. Applications however can only be accepted according to the yearly assigned budget.

The *EPA Academia Summer School* [14] addresses each year aspects of comorbidity between mental and physical disorders. European trainees and young colleagues within their first 2 years after the end of their training can apply to attend this summer course. A thorough selection procedure chooses those who, during a whole week, will be trained. According to many participants, the contributions out of different medical specialties lead to very enriching experiences.

Since 1986, *European Psychiatry*, the journal published under the auspices of the EPA, has become an element in disseminating scientific knowledge with an impact factor of 3.54 [15].

Next to peer-reviewed research articles, this journal also publishes the *EPA Guidance Papers*. The *Guidance Committee* prefers the term "guidance" because of the huge differences within Europe concerning training duration and content, availability of drugs and delivery of care in the field of psychiatry, among others. Developing generally accepted guidelines for the whole of Europe would become hardly possible.

Recently the Committee on Education explored *e-learning* options. The first author explored a few years ago some e-learning options as a member of the Committee on Education (CoE), but the CoE concluded that these would lead to financial commitments too important to bear for EPA. Very recently the EPA has taken a first step by launching a MOOC on cognitive behavior therapy.

18.4.2 EPA Committees and Sections

If one hopes to engage EPA in the development of education and training in forensic psychiatry, a basic view on its operational bodies is helpful. In order to facilitate collaboration on different operational levels, EPA established a number of EPA Committees. Next to these committees, Sections fulfil an important position [16].

The *Scientific Programme Committee* organises the congresses, helped by the *Advisory Scientific Committee* for more general scientific aspects, while *Local Organising Committees* are involved in more practical aspects.

The EPA has started different programmes to improve professional knowledge and skills under the umbrella of the Academia for Excellence in European Psychiatry. The *Committee on Education* invites every year a selection of young colleagues to attend the EPA Summer School. The committee members evaluate CME courses given during the annual congresses and also compose the list of itinerant courses mentioned above.

The *Committee on Ethical Issues* has mainly an advisory function in this very broad field. The committee's interests vary from teaching ethics in medicine and psychiatry to offering advice to individual psychiatrists. It collaborates with national psychiatric associations and produces EPA position statements on ethical issues which might be of interest in the forensic field.

The *Early Career Psychiatrists Committee* focuses on issues arising at the very beginning of a psychiatrist's career. This Committee developed a special track for young colleagues on the annual EPA congresses, focusing on education as well as on more pragmatic aspects relevant for a young professional.

18.4.3 The EPA Section for Forensic Psychiatry

One of the 21 EPA sections is dedicated to forensic psychiatry. The members see it as their mission to "promote high quality care for mentally disordered offenders through improved standards of assessments, the development of effective interventions and an increase in research activity in the field of forensic psychiatry" [17]. The Section has formulated more concrete objectives listed on its website. The Section is involved in organising symposia and educational events on the EPA congresses. Relevant issues addressed in the past were the treatment of sex offenders, the role of neurobiological factors in antisocial behaviour and overviews on treatment outcome results. Next to these activities, the Section is actively seeking collaboration with other stakeholders, e.g. the Ghent group.

18.5 The European Federation of Psychiatric Trainees (EFPT)

One of the most vivid associations in the field of European psychiatry is the European Federation of Psychiatric Trainees. After an informal meeting in June 1992, the European Forum for Psychiatric Trainees was continued all the years later. The forum has since then increased its number of participating trainee associations out of the different European countries.

In 1998, the participants from 22 countries present at the annual forum, created the European Federation of Psychiatric Trainees. Participants appointed a Board composed of three officers: a president, a treasurer and a secretary. Enthusiastic trainees started to spread *EFPT statements* on training, its organisation and quality,

as well as quality assurance. But they also addressed the issue of mental and physical health of trainees and accredited psychiatrists [18].

At this moment EFPT obtained a permanent representation within the two psychiatry-related UEMS Sections where these young colleagues have shown themselves as very active participants in the debates. Both the Section for Psychiatry and the Section for Child and Adolescent Psychiatry are actively involved in the development and achievement of projects. Next to that, EFPT has also developed contacts with the World Health Organization.

The *EFPT Annual Fora* allow trainees not only to network but also to present their own scientific work in poster sessions and oral presentations. In this way EFPT continues to create an opportunity for young colleagues to gain experience in presenting in front of an international audience, certainly not uncritical though supportive.

By adopting statutes according to Belgian law in 2010, EFPT made the step from an informal association to an international non-profit association with the status of a legal person.

18.5.1 EFPT Working Groups

The outcome delivered by the EFPT is mainly brought forward by its main operational bodies, the Working Groups. Actual focuses of interest are child and adolescent psychiatry, Maintaining and Establishing a National Trainees Association (MENTA), exchange programmes, involuntary interventions,[2] recruitment and positive image promotion, psychoactive substance use disorders, psychotherapy and research.

The enthusiasm, the positive energy emerging out of these young colleagues is very inspiring for all involved in psychiatry. It fulfils one with hope and courage for the future of psychiatry in Europe.

18.6 The European Federation of Associations of Families of People with Mental Illness (EUFAMI)

Patients and their families play an increasing role in different medical specialties, and their important role is now well recognised in psychiatry. EUFAMI was formally founded [19] in 1992 after a congress, taking place in 1990 in Belgium. Carers from all over Europe shared their difficult experiences of helplessness and frustration while living with family members suffering from severe mental illness.

EUFAMI is an international non-profit organisation, registered in Belgium. It's a federation of 29 family associations (including one non-European) and five other mental health associations that support family carers and people with mental illness

[2] All interventions without the consent of a patient.

throughout Europe. EUFAMI has members in 22 European countries and one non-European country.

They resolved to work together to help both themselves and the people they cared for. EUFAMI aims to represent at a European level family carers in order to obtain recognition and protection of their own rights as carers. They conceive this as having the right to decide to what level to be involved in decision-making, planning and follow-up of care without being held legally responsible. The organisation also actively supports those who want to establish associations for family carers in their country.

During its international congresses, EUFAMI brings together their member associations, but the association also participates in other psychiatry-related events. A synopsis of its main goals and aims, the *Sofia Declaration* [20], was published after its 2015 congress in Bulgaria. As soon as 2009, EUFAMI stressed the importance of taking care of the physical health of psychiatric patients by publishing its *Mental and Physical Health Charter* [21]. A recent initiative is the organisation of a training programme, *Prospect,* addressing those who had experiences with any kind of mental illness, a programme available in 11 European languages [22].

18.7 The Ghent Group

The Ghent Group [22] is an informal group of European forensic psychiatrists and trainees in forensic psychiatry interested and experienced in training in the field. It was named after their first meeting in 2004 in Ghent, Belgium, and focuses on the commonalities and differences in training between different European countries (http://www.ghentgroup.eu).

Its interests are focused on best practices and training of young psychiatrists. With regard to the increasing harmonisation of medical practices and qualifications in all specialties across the European Union, the Ghent group has formulated some primary objectives to assist this harmonisation process within the domain of forensic psychiatry.

The Ghent group particularly stresses the importance of the following points:

1. A *European Certificate of Completed Specialist Training* (CCST)
   A European CCST would enable psychiatrists in one country of the EU to work in any other EU country if language conditions are fulfilled.
2. *Recommendations about and promotion of all aspects of training and continuous education*
   The Ghent group wants to facilitate high levels of training and practice of forensic psychiatry across European countries, further development of highly qualitative concepts in theory and practice. The Ghent group therefore organises annual summer seminars for European consultants and trainees experienced in forensic psychiatry.
3. *The development of professional forensic groupings*
   The Ghent group wants to support processes of grouping formation in countries developing new forensic services. In this perspective an annual autumn meeting

is organised every year in a different European city open to forensic psychiatrists interested in these goals.

18.8 An Example of a European Network: A COST Action on Forensic Psychiatry

Recently the EU has provided a 4-year grant entitled COST action [23] (www.cost.eu) to conduct a European study on forensic care (especially on long-term forensic care) across 19 European countries. This European project is intended to increase research in the field of forensic psychiatry, to harmonise professional training and education, to standardise indicators for forensic service provision and outcomes and to stimulate aftercare and inter-sectoral perspectives.

The aims of the COST action are the following:

- To provide a standardised description of epidemiology (patients characteristics, practices), forensic psychiatric assessment, service provision, long-term forensic patients, patients' needs and quality of life
- To describe similarities and differences
- To find evidence for best practices
- To optimise patients' quality of life
- To increase training and networking in order to increase research in this field

18.9 A Possible Future Role for the Three Main Stakeholders in Forensic Psychiatry?

Many specialties in Europe have now their own central examination organised by the Sections' Boards. In some countries a specialist who succeeds in a particular European Board examination is directly recognised and obtains an official certification as specialist. The most successful scenarios are based on a fruitful collaboration between UEMS Sections and their specific partner associations.

It's quite evident that this poses major difficulties to resolve in psychiatry, many related to language problems. Therefore it seems more doable to organise Europe wide common training curricula in specific domains where language is less defining the context of the examination. It's obvious that more technical interventions are less susceptible to language biases. One might imagine that neurophysiological tests, e.g. quantitative EEG analysis, after obtaining a solid scientific basis and hence possibly more commonly usable in psychiatry, would become object of such examinations. Psychopharmacology might be another valuable candidate. However, it remains more difficult to foresee how this can be organised on the practice of psychotherapy mainly because of the language differences and long-standing local traditions in training and cultural differences in doctor-patient relationships.

A European examination might also be a valuable procedure for those fields of interest in which a rather limited number of colleagues are involved, e.g. in treatment of sex offenders. Succeeding in an examination on such a particular field of interest would at least offer to the bearer the benefit to have obtained a label of internationally guaranteed quality. It can be left afterwards to national certifying authorities to decide to what degree this kind of certification can be implemented in their national procedures.

Forensic psychiatry is a recognised subspecialty of psychiatry with a separate CCST in the United Kingdom and Ireland only. However, this is not the case in most other European countries, though most of them do have specific training programmes in forensic psychiatry or develop further specific regulations such as Belgium.

With increasing mobility between countries and a continuously expanding EU, it is likely that more specialists will seek or be invited to work outside their native country. Judicial authorities will experience an increasing need for transfer of cases to psychiatrists competent in forensic psychiatric care. In the forensic field, there will be an increasing need for international consultation and clinical follow-up.

With regard to scientific support, it's obvious that the main publishers in the world all have textbooks and peer-reviewed journals about forensic psychiatry. However, they mainly address clinical psychiatry subjects (disorders, age- or gender-related issues, substance abuse, etc.), how clinical examinations and testing should take place, risk assessment, content and format of reports or formal legal and ethical aspects. A single chapter on transcultural issues is mostly the sole aspect possibly related to international interest. If collaboration between law enforcement institutions faces the challenge of increasing globalisation, this is even more so for forensic psychiatry.

18.10 Forensic Psychiatry: A Field of Interest Though It Is Not a Speciality of Its Own

At least one can say that forensic psychiatry certainly has gathered a solid basis of scientific knowledge and evidence. Unfortunately, this evidence is showing that uncertainty can prevail over certainty. If psychiatry remains the field in medical practice where humility is justly at its place, this is certainly true for forensic psychiatry.

A significant number of colleagues in all European countries are practicing within this field of interest in all kinds of clinical environments. This might be seen as a proof for the need of a more qualified approach to psychiatric assessment and care for people within a criminal justice system though the supporting scientific basis still might be too weak at this moment.

Last but not least, there is a growing interest in mental disorders and their treatment within our society, not only concerning the general population but more specifically about mental ill health of criminal offenders.

These three elements strongly support a strategy to obtain the recognition by the European authorities of a distinct competency in forensic psychiatry.

Take-Home Messages

- We need a forensic psychiatry syllabus, a list of items about knowledge, skills and attitudes based upon existing scientific evidence.
- Conceive a task force with delegates from the UEMS Section of Psychiatry, the EPA Section of Forensic Psychiatry together with interested trainees from EFPT.
- Its tasks could be:
  - To define priorities, shared needs and common goals on a European level
  - To initiate, develop and support further Europe-wide research in forensic psychiatry to consolidate the scientific basis for the discipline
  - Becoming a compass for all stakeholders involved, an exquisite body to develop standards for training, accreditation and continuous professional development

Great ideas many a time are realised by enthusiasts who act with conviction, inspiration and patience. Why not hope that we can find colleagues to start such a project?

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Deinstitutionalization Versus Transinstitutionalization

19

Thomas Marquant and Francisco Torres-Gonzalez

19.1 Introduction

Deinstitutionalization is happening at different speeds and rates throughout the world as well as in Europe [1–6]. Although beds are closing all over, differences in the organization of mental health care or justice systems do not always allow easy answers or generalizations when it comes to investigating the consequences or links with forensic psychiatric beds. Nevertheless, the trend of deinstitutionalization is a general trend and does seem to have an important effect on forensic beds as well. Italy, a trendsetter in deinstitutionalization, closed all of its psychiatric beds in 1978, while Belgium only started deinstitutionalization from 2011. In Spain, the closing of beds started in the 1980s [7]. In the Netherlands, beds were closed down from the mid-1990s [8]. Hodgins et al. [4] mentioned an increase of forensic beds throughout European countries that did close beds ranging between 10 and 143%, depending on the rigourness of the deinstitutionalization. Also, other authors found a trend in increased forensic bed use and describe a re-institutionalization into forensic mental health-care facilities [1, 9]. Mentally ill patients shifting from regular care to forensic care, or worse, to prison, would be an unwanted and harmful side effect of deinstitutionalization, more appropriately named *transinstitutionalization* [1, 2]. The term indicates a shift towards institutional settings run by the justice department instead of mental health care. Already in the USA, up to 10% of prison population suffer major mental illness, and patients suffering from mental illness have an 800%

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greater probability to have a first encounter with law enforcement instead of health care (Fazel 2002) [10, 11].

In Europe, one of the countries where the rise in forensic beds was well demonstrated was in Denmark. Kramp and Gabrielsen [12] described how, over a period of 30–40 years, Denmark organized its deinstitutionalization. As such, from 1980 till 1990, he reported a decrease from 10,000 to 4000 beds in regular psychiatry. His results revealed an increase in forensic beds, as well as an increase in patients that were deemed not guilty for reason of insanity (NGRI) and homicide rates by mentally ill offenders. The effect was not immediate yet only manifested itself in the long term. But he also stated community care or social support—non-forensic—has little effect on the findings.

Priebe supported these findings, giving information from six European countries from 1990 till 2002. All countries reported a decrease in beds yet rises in prison populations and forensic beds [1].

It is clear deinstitutionalization does not come without (side) effects on forensic mental health care and raises issues for concern. We will look into such effects on forensic beds of deinstitutionalization in Europe and throughout countries that have implemented closing of beds.

In the current chapter, we need to get an idea of the influence of deinstitutionalization on forensic mental health care throughout Europe as well as the position of the phenomenon amidst other elements that might be driving the number of forensic beds up. One way would be to go through the different European countries, yet we choose to construct the chapter going through the different elements that the literature provides when it comes to the rise in forensic beds and the role of deinstitutionalization. Several authors have described how the rise in forensic beds is mediated through a range of causes [7, 12, 13]. To detect these elements, we choose to start from the Austrian case. Also, we will add some new elements of our own.

19.2 The Austrian Case

Austria is a country with a very well-documented experience concerning deinstitutionalization. Especially [13, 14] has devoted several articles to the phenomenon. In his opinion deinstitutionalization is part of a more ambitious project of the 'normalization' of psychiatry. On the one hand, there is a shift towards community-based care, next to another trend to empower patients and reduce coercion. In this context, it makes sense to reduce beds.

Austria as a country is interesting to follow up shifts in beds in favour of community care, as it is a small country, with stable and low crime rates and a stable population. The number of psychiatric beds went down from 11,851 in 1970 to 6282 in 1990 and just 4496 in 2002. In the same period, hospital admissions went down by 72%. The last change in penal legislation dates from 1975 [14]. Legislation that might influence mental health care has remained stable and could not have biased the findings.

He sets the stage in the 1970s, where 94% of all inpatients were involuntary, and community care was limited to outpatient clinics in university settings. Yet, in the late 1970s, beds were cut by 47%, which reduced the mean length of stay from 167 days in 1970 to just 54 in 1990. From 1990 till 2002, beds were further reduced by 28%. Beds went down over this time from 11,851 to 6282, then 4496 in the end.

From 1991, the number of NGRI patients started rising significantly in Austria [14], although legislation remained unchanged since 1975, as well as the total crime rate. While 110 NGRI patients were sentenced in 1990, in 2008 the number rose to nearly 350, yet the length of stay in forensic beds remained stable. This led to a rise in forensic beds, of course, which is a clear example of transinstitutionalization. As a consequence, mentally ill patients could be at risk of ending up committing crimes, which led to admissions in forensic units.

According to Schanda, deinstitutionalization is accompanied by several other elements before it leads to transinstitutionalization, which we will describe [1, 13]. He mentioned the expansion of community care, shifts in characteristics of residential and community patients, a critical percentage of bed closing, a potential of wrongful transfers to forensic care and changes in civil commitment law. Of course, there is an overlap between some, if not all, of them. Next to the main ones, we add three of our own, namely, training and education, funding and forensic deinstitutionalization.

19.3 Elements of Transinstitutionalization

19.3.1 Community Care

Community care is important in several ways. It needs to replace the care given in the beds that were downsized, as this will inevitably mean patients will need alternatives for the continuation of their treatment. As such, it is important to see what community treatment looks like and what its relation to the remaining beds will be.

The continuity of community care-based programmes covers a wide range of ways to bring care to patients. Also, insight in the exact nature of community care is important if we want to compare it to hospital care. Community care can be placed on a continuum, measuring its intensity in delivering treatment [15]. Very intense ways, specifically designed to replace hospitals, are assertive community treatment (ACT) or flexible ACT [16, 17], the so-called outreach programmes. Less intense forms of community care could be community mental health teams and outpatient clinics in the UK, amongst others [18]. ACT consists of a strict model of care that focuses on seriously mentally ill people and offers 24/7 follow-up, multidisciplinary care with substance use disorder treatment at home of the patient including emergencies at home. When executed effectively, it has proven to be very effective in the USA. Results in Europe, such as in the UK, have been less convincing, though [19]. Rather than avoiding admissions, there is more proof that ACT reduces the length of stay but is significantly better if it comes to quality of life and experienced self-control [20]. This does suggest that even in the most intensive forms of community care, there will always be a need for beds for short-term crisis admissions. This was

also the case in Austria, where the number of hospital admissions went up from 25,000 to 65,000 between 1970 and 2007 [13].

In Austria, Schanda mentioned that community care only started to develop from 1990 onwards, when deinstitutionalization had already been happening for 10 years. He mentioned outpatient clinics and sheltered housing. Some beds were actually reopened from 2002 yet on psychiatric wards in general hospital wards. This does seem to adapt well to the need for residential back-up community care still needs. Sheltered housing moreover is a well-known element of successful community care [21].

Strangely, the rise in forensic beds started only from 1990, after the start-up of replacing community care. Obviously, this seems to suggest community care makes little difference after deinstitutionalization. Yet, it might be argued that solely outpatient clinics on their own are not the answer to the high needs of the patients leaving the hospitals. Low compliance and a lack of insight are important characteristics of these patients and would need outreach strategies and motivational techniques as opposed to clinics. These findings stress how community care must rely on a complex net of settings, and it should be able to face unmet needs of the several mental disorders: from lodging and sheltered work to all sorts of clinical care services, including physical health supervision. As such, it is not an expensive model, but more efficient than the institutional one.

Vázquez-Barquero [7] told us how community care, although intended, was insufficiently developed in Spain, following deinstitutionalization, as well, mostly due to a lack of financing and a lack of understanding by politicians of the high complexity of the community mental health-care model.

In Belgium, deinstitutionalization was only started very lately, in 2011, and only on a small scale. Even today, the available psychiatric beds per capita in Belgium are second in the world next to Japan [22]. The reduction in beds was compensated by well-elaborated community mental health teams, based on the flexible ACT teams in the Netherlands [17]. It will be interesting to follow up the effects on forensic beds and NGRI patients in a context where community care was reasonably well organized.

19.3.2 Population Shifts

Closing down beds and shifting patients towards community care are likely to influence the population of the residual beds as well in such a way these changes could be partly responsible for transinstitutionalization [23].

In Austria, Schanda et al. [13] mentioned how a specific type of patient is leaving the hospital as a consequence of the bed closing, which he called ‘not nice to treat’. Reducing bed numbers was specifically done for chronic beds, which resulted in them ending up in community care. As we mentioned before, funding issues and model fidelity of the community care were unable to cope with these patients. ‘Not nice to treat’ stands for a subgroup of chronic patients, with a lack of motivation and insight, comorbid substance use disorders and non-compliance, who were at risk of committing more, smaller, crimes and coming into contact with police services [12, 13]. As this means several clinical and demographical

characteristics of these patients will clearly set them apart from the other patients, forensic care will need to provide specialized ways of treatment, often chronic in nature. In many cases, general psychiatry will have had their chance to treat them yet failed, mostly due to a lack of efficient treatment for people with complex pathology with poor compliance to treatment [4, 24].

It is important to mention differences in legislation regarding criminal responsibility throughout Europe, as these could influence which type of patients end up in forensic settings. A crucial element is which diagnostic categories are grounds to deem a person to be not guilty for reason of insanity (NGRI). This might influence what we understand throughout Europe to be a 'forensic patient'. Especially, the criterion of a primary (antisocial) personality disorder or a primary diagnosis related to substance use is relevant. The issue is well documented in a report by Salize [9] that overviews such legislation throughout Europe. Only a minority of countries in Europe consider patients with a primary personality disorder or a substance use disorder as sufficient grounds for diminished responsibility, not guilty for reason of insanity (NGRI). In Belgium and the Netherlands, for example, a primary personality disorder is a sufficient ground for diminished responsibility, and an important proportion of NGRI patients have a primary antisocial personality disorder. Of course, other elements such as severe substance use, learning disabilities or a revolving door pattern are usually extra elements that are considered in this decision. Yet, as this creates just the option of treatment for patients with APD, it facilitates their inclusion in forensic mental health care and becomes a reason for the increase in forensic beds, next to transinstitutionalization.

This is of course just one example of differences in the legislation between countries, and it might be good to remember deinstitutionalization happens in a complex, legal and social environment that limits generalization of any findings. Tailoring approaches to transinstitutionalization to these circumstances is advisable.

19.3.3 Critical Number of Psychiatric Beds

One of the elements that has been raised is that deinstitutionalization has a critical balance between institutional care and community care from where transinstitutionalization starts [25]. He stated that deinstitutionalization can only happen successfully when it happens in a well-organized and comprehensive mental health system.

Thornicroft proposed a stepwise approach, corresponding to the level of resources a country has. As such, he divided countries in countries with low, medium and high level of resources. There are three steps.

The first step integrates mental health care into primary care as a way of screening. If primary care fails, inpatient care is organized in general hospitals. The second step is called 'mainstream' mental health care and combines acute inpatient care, community mental health teams and outpatient clinics. Also, this step offers specialized, targeted or adapted employment and occupation. The final step expands the elements of step 2. Only the third step specifically mentions deinstitutionalization and the use of community-based care as an alternative to inpatient care. Highly resourced countries should implement all three steps proposed by Thornicroft, whereas medium countries

should include only two steps, and the low category is recommended to implement only the first step. Again, this stresses deinstitutionalization should never be a way to cut costs yet should offer a fully staffed and funded alternative to inpatient care. Inpatient and outpatient care are no islands, and according to Thornicroft, neither should exist on its own. A well-balanced equilibrium is strongly recommended.

19.3.4 'Zeitgeist'

A fear following deinstitutionalization is that an increase in forensic beds would suggest that mentally ill patients end up in these settings wrongfully, as a result of a 'Zeitgeist', suggesting an unsupportive and punitive societal environment in Europe towards mentally ill patients. The reality of patients returning into the community would clash with increased concern of society to deal with them and suspecting a link between crime and mental illness. This issue was researched by [4]. She compared clinical and historical data from general psychiatric patients with forensic patients at discharge from institutional care. The data was limited to psychotic patients with violent behaviour. Especially, histories of failed treatment, comorbidity, histories of crime and aggressive behaviour were looked into. The idea was that if no differences were found, this would mean that patients ended up in forensic care wrongfully, which could be a sign that a Zeitgeist was criminalizing psychiatric patients. The study was conducted in Canada, Sweden, Germany and Finland.

Interestingly, she did found differences. Eighty percent of forensic patients had a history of previous admissions in general psychiatric institutions. But all of the forensic patients had histories of violent crimes, compared to, still remarkably, 40% of the general psychiatric population. Also, the forensic patients had higher scores on scales measuring callousness. These findings demonstrated that forensic patients did differ significantly from their general counterparts, when it comes to aggressive behaviour, and that it is exactly this kind of behaviour that makes them shift to forensic care. Next to the clinical and demographic differences, this conclusion is supported by the finding that patients that were involuntary admitted for reasons of dangerousness to others are released much faster than in case of danger to self [26]. The issue of Zeitgeist as such means a failure of regular psychiatric services to deal with a specific type of mentally ill patient, who ends up in forensic care.

Salize [9] mentioned how Zeitgeist could also mean different attitudes towards care. He mentions how Latin countries, such as Spain and Italy, rely more on informal support and non-professional care, mostly consisting of family support.

19.3.5 Civil Commitment Legislation

Schanda mentioned legislation regarding involuntary admissions as an element to consider when discussing transinstitutionalization. In Austria, he described how civil legislation has shifted towards a more liberal view, which could have as a consequence that real coercive measures would be left to penal law and as such would lead to an increase in forensic admissions. But that did not happen in Austria. True,

forensic beds went up but so did the number of civil commitments. He explained that it is not the law change as such that creates an increase in forensic beds but, again, an inadequate dealing with aggressive patients during the civil commitment [13]. As we explained above, patients admitted involuntary for aggression towards others are discharged much faster than in case of self-harm. Together with the Zeitgeist and population shifts described above, changes of civil commitment legislation emphasize the specificity of the forensic patient.

Outside Austria, Kallert and Torres-Gonzalez researched civil commitment legislation in 12 European countries (EUNOMIA study, [27, 28]). The study clearly shows how much legislation on civil commitment differs throughout Europe, which makes generalization impossible. The difference between clients at risk of harm to others and the ones at risk of harm to themselves, for example, was not found in the EUNOMIA study. Countries differed in the way they consider the basic clinical conditions, such as the nature of the required mental health state, as well as additional requirements, such as risk requirements. Moreover, the countries differed on the degree of coercion used and patient and family participation. Different approaches towards civil commitment were likely to interact differently with penal legislation and transinstitutionalization as such [28]. Again this stresses the need for tailoring of an approach to the local complex reality of the health care.

19.3.6 Funding Requirements

Hospitals are expensive ways of care delivery, and shifting towards community-based care can also be driven by economic reasons. Adequate funding of community care is essential and at risk when financial reasons are the main drive for deinstitutionalization. Several authors explicitly mention the shift towards community is insufficiently followed by the necessary funding, resulting in loss of model fidelity and efficiency [7, 13, 29, 30].

Also, as the transinstitutionalization is forcing to raise funding and creating of the forensic number of beds, there is a risk regular services will specifically avoid patients at risk of police contact, claiming they are not funded to treat these patients. This might strengthen the pathway towards forensic care for patients at risk of committing even minor crimes.

19.3.7 Education and Training

A shift towards community treatment requires different skills and techniques to engage patients, skills that will need to be regarded in the training of staff [31]. Respect, accessibility, stigma alertness and cultural sensitivity are amongst a range of important skills [31]. As traditional schools are used to training mental health workers for institutions, this might mean there is a need for a paradigm shift within training settings towards community-based settings. Implementing and teaching specialized forensic rehabilitation models are strongly recommended [32]. The dominance and resistance of institutions to change can be a well-known barrier for staff to adapt, as it

was the case in Spain and Belgium. Secondly, training in risk assessment, even for non-forensic patients, should be implemented as well to adapt regular psychiatric services to better detect and possibly prevent patients being at risk of offending. In his report from 2005, Salize found only 5 out of 24 European countries have specific 'forensic' requirements for mental health workers to work in prison, which gives us an indication of how even in a forensic environment, proper education does not happen.

Similarly, regarding civil commitment legislation, in his overview of 12 European countries, Kallert and Torres-Gonzalez [27] showed how the authority to decide on the need for emergency commitment was only in four countries taken by a psychiatrist. Decisions on mental health status in other cases are made by regular physicians or even more strangely, administrative hospital personnel, family or attorneys.

Models to base training of forensic mental health workers should include the Risk-Need-Responsivity Model (RNR, [33]) and the Good Lives Model (GLM, [34]). Both models offer evidence-based rehabilitation theories for mentally ill offenders that target criminogenic as well as non-criminogenic needs yet introduce a hybrid functioning of the case manager that combines risk assessment with treatment and stresses the importance of.

19.3.8 Forensic Deinstitutionalization

When we discuss deinstitutionalization of regular beds and a possible shift towards forensic care, it is remarkable how this seems to imply that forensic care still means beds. Deinstitutionalization was developed as a way to normalize psychiatric care, and community-based care has since proven to be efficient, and to greatly improve quality of life and patient satisfaction [35]. Community care has become best practice for psychiatric patients. It does seem odd that these principles would not apply for forensic patients, and community-based care as an alternative to institutionalized care should be considered [36].

This will not be an easy task. In 2008, when confronted with the need to build a new prison, Aos [37] was asked by the state of Washington to research the evidence base of alternatives to building it. He limited the research to results that reported on effect sizes or offered enough material to calculate effect sizes and found over 500 reports. Her results seem to demonstrate that community care would need to be intensive and treatment oriented as opposed to control-oriented. Research in the USA, Germany and Belgium give hopeful results with forensic adaptations of assertive community treatment [38, 39].

19.4 Discussion

In conclusion, it is safe to say that the worldwide closing of beds had a great influence on the treatment of mentally ill patients in Europe and has played a part in the rise of transinstitutionalization.

Following the USA, all European countries that have decreased their psychiatric beds have seen a rise in the number of forensic beds and detentions of mentally ill patients. Although deinstitutionalization is partly to blame, it is certainly not the only cause. The whole shift towards community-based care is a complex phenomenon, where different elements play a part in creating a rise in mentally ill patients ending up in forensic care or worse, prisons.

Importantly, bed closing is insufficiently replaced by well-organized community care and suffers from a lack of funding and changes in education of professionals. Although the closing of beds started off as a way to empower patients and improve quality of life or in other words to normalize psychiatric care, insufficient funding and support created inefficient community care that couldn't uphold its model fidelity. As such, general psychiatric services failed to reach and efficiently treat an important part of the chronic patients released from the hospitals, namely, the 'difficult to treat'. Patients combining a severe mental illness or personality disorder with comorbid substance use, low insight and low compliance were unable to benefit from the new programmes and ended up in prisons and other forensic settings after dropping out, depending on the quality of the community network.

The consequences for forensic psychiatric care are important. Not only is there a greater need for more availability of forensic care, beds if you want, but the profile of forensic patients will differ greatly from patients in regular psychiatry.

Forensic psychiatry will be faced with difficult to treat patients, in need of lifelong care, suffering comorbid substance use and with failed previous treatment attempts in regular psychiatry. Many of these elements on top are well-known risk factors for new juridical contacts [33, 40].

As such, treatment strategies will need to be tailored for these specific patients and cannot rely blindly on the experiences and evidence base of the what works literature in regular psychiatry. Already, evidence for community-based care such as ACT strongly indicates these are ineffective when it comes to forensic outcome measures, and forensic adaptations are needed [41, 42]. Well-known bases to develop new, forensic, treatment models are the Risk-Need-Responsivity Model [33] or the Good Lives Model [34]. Motivational work and substance use will be major targets. Deinstitutionalization has a limit. Community-based approaches will still need small units of residential care for short-term crisis interventions, especially given the 'difficult to treat' character of patients.

Differences in legislation and social realities stress the need for local approaches, when it comes to reducing transinstitutionalization.

Lastly, forensic care is still very much a business of bricks, walls and above all, risk. It seems remarkable how deinstitutionalization is happening for 40 years now, yet how little research is available on community-based treatment for mentally ill offenders. Many authors have also stressed the importance of new, more positive outcome measures in the setting of forensic psychiatry, besides risk. This will be one of the great challenges for forensic psychiatry in the future.

Conclusion

The deinstitutionalization that sweeps through Europe has shown to have important consequences and risks for what kind of patients are at risk to enter forensic care, the number of forensic beds in countries and imprisonments. This phenomenon is also known as transinstitutionalization. At a closer look, though, deinstitutionalization is only one element that leads to transinstitutionalization. Funding, education and, most importantly, how community-based care is organized are important factors related to the phenomenon of transinstitutionalization.

Take-Home Messages

- Transinstitutionalization is a real risk for chronic, complex and care-avoidant patients.
- Deinstitutionalization is only one of several factors that can lead to transinstitutionalization.
- How we organize community-based care is one of the main factors related to transinstitutionalization.

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Ethical Issues in Forensic Psychiatry

20

Paul Cosyns

Mental health-care professionals have a duty to treat all persons with mental disorders with respect of their dignity, human rights, and fundamental freedom. Forensic psychiatry is a subspecialty of general psychiatry, and its purpose is the care and treatment of mentally disordered offenders and others requiring similar services, including risk assessment and management [1]. There is no such thing as "forensic psychiatric ethics" and the general principles of medical ethics apply. But the practice of forensic psychiatry is situated at the interface of psychiatry and the law. These two disciplines have quite distinct roles and rules in society with few interactions. The practice of forensic psychiatry involves mostly three parties, the psychiatrist, the patient, and the society represented by the justice or penal system. The person concerned is at the same time a client of the justice system and a patient of the health-care organizations.

The best interest of the patient is the core business of health-care providers, while the best interest of society is that of the judicial system. This balance of conflicting interests exists also in general medicine when, for example, in case of specific infections, the physician must notify the relevant authorities of the patient's disorder, whether the patient wishes so or not. In case of an involuntary admission to a psychiatric hospital, psychiatrists play an analogous role. A psychiatric expert in court works and testifies in the best interest of justice and, doing so, not necessarily in the best interest of the patient. A psychiatrist working in prison must accept a set of obligations that do not exist in current psychiatric practice. He may have dual roles and face conflicting situations where the prison's interests must be placed above the patient's and psychiatrist's interest.

Justice and psychiatry have a distinct frame of reference, but in the field of forensic psychiatry, they must find ways to work or interact together with respect for their

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respective values, finalities, and singularities. All European countries, according to their own history and cultural background, have different legal implementations of the same basic ideas to promote the well-being and treatment of prisoners, mentally ill offenders, or forensic patients in general. Forensic psychiatrists must know and consider in their practice their national or regional laws and regulations in this domain. It is also essential that in all cases, the forensic patient should be clearly informed about any limitations of the confidentiality rule, if any. He should always know what is likely to happen to information given to the psychiatrist, and it is the duty of this latter to inform correctly his patient and to obtain his consent.

This chapter will briefly highlight the following ethical key questions in contemporary forensic psychiatric practice: confidentiality and its limits, the right to treatment for forensic patients, autonomy of the patient, consent, and coercion. Complementary information can be found in *Ethics in Psychiatry* [2], *Ethical Issues in Prison Psychiatry* [3], *An Anthology of Psychiatric Ethics* [4], and *Forensic Psychiatry*: *Clinical, Legal, and Ethical issues* [5].

20.1 Confidentiality

The protection of patient's privacy and appropriate confidentiality are core values in psychiatric treatment. It means that personal patient's information will be carefully maintained by each health-care professional, regardless the form—verbal, written, electronic, videotape, and biological—in which this information is held. Confidentiality is both an ethical professional multimillennial obligation—since the Hippocratic Oath, 400 years BC—and a legal obligation in most European countries. Psychiatrists must know the laws of their country and comply with them, but in health-care decision-making, they will also consider and balance the different values present in each case. Obeying the law does not always guarantee an appropriate ethical treatment decision.

The "European Standards on Confidentiality and Privacy in Healthcare" justifies as follows the principles of health-care confidentiality [6]:

- Individuals have a fundamental right to the privacy and confidentiality of their health information.
- Individuals have a right to control access and disclosure of their own health information by giving, withholding, or withdrawing consent.
- For any non-consensual disclosure of confidential information, health-care professionals must have regard to its necessity, proportionality, and attendant risks.

These principles of medicine also apply to forensic psychiatry. A competent patient can give consent to disclosure of confidential information and exercise control over the dissemination of the information. Valid consent requires that the patient has been duly informed about the content, the purpose, and the consequences of the proposed disclosure. It requires also an adequate comprehension of the procedure and patient's freedom to accept or refuse disclosure. Opinions vary if the psychiatrist is then bound to the disclosure request of his patient. It may occur that the requested disclosure is not in the best interest of the patient.

Family members, acquaintances, or informal carers who are involved in the care of a patient may understandably request some information about diagnosis, treatment, or management of the health-care problems of the patient. These information may be in the best interest of the patient by improving their understanding of his problems and best ways to respond to and deal with his needs. The confidentiality rule remains, but the therapist can negotiate with the patient which kind of information can be disclosed to these persons to obtain that beneficial goal.

When the patient is incapacitated or unable to consent a family member or legal representative who has the right to give proxy consent must be contacted by the psychiatrist. Each European country has specific procedures that must be followed in such circumstances. It is generally accepted that the legal representative has to act in the best interest of the patient. In case of dispute between the psychiatrist and the legal representative, the court may be involved and settle the case.

In emergency situations, the psychiatrist may act in the best interest of the patient and disclose the minimal necessary information to deal with the acute and urgent situation.

The psychiatrist can never disclose information in the best interest of a competent patient without his consent, but in exceptional situations, disclosure may be necessary to protect overwhelming interests of third parties. Exceptional situation in which the disclosure serves an interest that outweighs the patient's right to privacy. Take, for example, situations where the life or integrity (physical, sexual, or psychological) of a third party is at risk. Without disclosure, there is no possibility of averting the harm, and disclosure will likely avert the harm. It remains a controversial issue if the "duty to protect" is also a legal issue, and therapists should inform and comply with the national laws of their country. It is recommended to therapists confronted with such a problem to discuss the case anonymously with a colleague in support of his own judgment. It may also be argued that the disclosure of information in such a case may be helpful to both parties: it protects the potential victim but also the patient in treatment from committing new crimes. It is not the primary duty of a therapist to prevent relapse, but relapse is obviously not the best interest of the patient. Treatment and relapse prevention are not per se antinomies.

Concerning incompetent patients, disclosure may be justified to protect them as victim of severe abuse, for example, sexual abuse.

In any case the health professional should always record all the details of the decision in the patient's record and its justification to disclose confidential information. If possible look for support for patients whose confidentiality is to be breached, and if possible ensure that the potential victim has access to appropriate support and advice.

Forensic psychiatrists have a double knowledge in psychiatry and law, and besides their duty to treat mentally disordered offenders, they may be asked to appear in court as expert witness to give their opinion on specific issues requested by a judge. All European countries have a specific legal system concerning the concept of criminal responsibility or competence as a prerequisite for punishment. In case of lack of criminal responsibility, the person will be admitted to a treatment facility rather than a prison. The psychiatrist in court acts within the law of his country and accepts the authority of the legal profession. He provides in court his opinion, but the judge or jury takes the decisions. As expert witness he no longer serves

the best interest of ill individuals but the best interest of the legal system and society. In this context the forensic psychiatrist faces several ethical issues and must:

- Duly inform the examinee about his role as expert witness, and explain that in this situation, he is not a health-care provider.
- Inform the examinee that the confidentiality rule is not applicable in this context and explain the consequences of it.
- Refuse to assess his own patient as expert witness to avoid a conflict of role.
- Get the approval of the examinee (or the court) before interviewing the family, friends, or third parties to gain more information.
- Present his specialist knowledge as forensic psychiatrist in an understandable written or spoken language for the judge, lawyer, and examinee.
- Provide objective information focused on the questions asked by the judge and avoid going outside of this scope.
- Although the expert witness is not a treating psychiatrist, he may inform the court of treatment needs which are in the best interest of the examinee.

20.2 The Right to Treatment for Prisoners and the Principle of Equivalence

Physicians and health-care providers have the professional duty to treat patients and relieve their suffering. Even in the absence of a "legal" right for treatment as such, the basis of the right of mentally disordered prisoners for appropriate care, as compared with care delivered in the community, can be found in the United Nations Universal Declaration of Human Rights and the European Convention on Human Rights and Biomedicine (2006). Since persons who are detained in criminal justice institutions are no longer free to access treatment for themselves, it is accepted that providing optimal treatment to them constitutes an ethical and professional obligation in European countries. Treatment must be defined not only in terms of medications but also nursing, psychological treatments, and community support.

The Draft Recommendation Rec(2004) of the Council of Europe states that in penal institutions "…the principle of equivalence of care with that outside penal institutions should be respected with regard to their health care" (art. 35, Council of Europe [7]). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) also considers the principle of equivalence as fundamental. Forensic health-care services inside as well as outside prisons should be able to provide medical treatment and nursing care in conditions comparable to those provided outside prison in regular psychiatric facilities.

The CPT is part of the Council of Europe and visits on a periodic basis any places in Europe where persons may be deprived of their liberty. It provides to the states a controlling but nonjudicial preventive mechanism to protect persons deprived of their liberty against any form of ill-treatment. The professional competence and independence of the caregivers is stressed in the CPT Standards: whatever the formal position under which a prison doctor carries on his activity, his clinical decisions should be governed only by medical criteria (71/72, CPT Standards [8]). Independence of the health-care staff is indeed an ethical issue because it may conflict with

considerations of prison management and security (the dual role conflict). The assessment of quality and effectiveness of medical work should be done by a qualified medical authority and not by bodies responsible for security or administration.

According to the European Convention on Human Rights and Biomedicine (2006), the principle of equivalence of care promotes the ideal of "equitable access to health care of appropriate quality," but it does not mean "same" care as outside prison or forensic settings. Specific characteristics of the detention situation are to be considered. Not all the state of the art treatment modalities or treatment goals are necessarily possible in prison or forensic settings. Principally the detention in closed correctional settings is a complicating factor to provide medical and psychological care and treatment. Treatment programs, protocols, or guidelines from the regular non-forensic mental health care can generally not be used as such in detention settings but must be adapted to this specific environment. It is easier for medical forensic hospitals to comply to the principle of equivalence than for prison settings due to the negative impact of the prison culture on treatment possibilities. This is more obvious for the low level of psychological treatment possibilities in prison and, as consequence, a higher level of prescription of psychopharmacological drugs.

In many European countries, there is a growing trend to create structural bridges between the criminal justice system and health-care authorities in order to improve the medical and psychological treatment of mentally disordered prisoners. Providing treatment is not part of the core business of the criminal justice system or prison authorities. Therefore, we can only hope that the structural integration of the health-care authorities in the organizational and financial framework will enhance the overall level of the principle of equivalence. In most European countries, the equivalence of care remains an object of concern taking into account cost cuts, the rising number of prisoners and a prison culture that is not focused on rehabilitation [9].

20.3 Autonomy of the Patient and Consent to Treatment

Mental health-care professionals have a duty to treat all persons with medical or psychological disorders with respect to their dignity, human rights, and fundamental freedom. There is a universal agreement about the importance of the ethical principle of respect for the autonomous choices of persons and the individual decision-making in health care, especially informed consent and refusal. The European Convention on Human Rights and Biomedicine (2006) states this basic right as follows (art 5): "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it…The person concerned may freely withdraw consent at any time."

Respect for patient's autonomy means that the therapist complies with the "informed consent" doctrine which is threefold in an ethical perspective:

1. The right of the patient to get information on the treatment, and the duty of the therapist to provide information.
2. The competency of the patient to understand its significance and consequences.
3. The competency of the patient to give his/her consent.

It is a legal as well as an ethical obligation to obtain patient's consent, and this depends strongly on the quality of the relationship between the psychiatrist and the patient which is of prominent importance in this perspective. The dialogical process between psychiatrist and patient must convey trust, empathic understanding, and emotional support. To obtain consent to treatment is often a first step in the development of a working alliance necessary for the treatment process.

In case of an incompetent patient, the psychiatrist must obtain the informed consent of the family, patient's legal representative, or caregiver according to the legal provisions of his country. They should act in the best interest of the patient which means that they should consent to what the patient would have chosen if he/she had retained decision capacity in the current situation [10]. Even if the patient is incompetent and legally unable to consent (say "yes") or refuse (say "no"), it remains advised to ask for his/her opinion and to let him/her participate as far as possible in the treatment decision process. This is an advised preventive measure to reduce the need for coercive interventions as much as possible.

The principle of patient's autonomy and consent to treatment is not absolute and has its limitations. The "Declaration of Madrid" of the World Psychiatric Association states this as follows: "No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient." A patient may refuse a proposed treatment, and the therapist must comply with it, but in some cases, he is empowered to reverse this refusal. In the next subheading, we will focus on the ethical justification of coercion or involuntary treatment and on the moral rightness of whatever we define as appropriate coercion in psychiatric treatment.

20.4 About "Coercive" Measures and "Compulsion" in Forensic Practice and Correctional Institutions

There is a continuum of possible treatment pressures to influence patient's decision-making about a proposed treatment by therapists. The most common is "persuasion" that appeals to reason in the patient-therapist dialogical process, followed by "coercion" with conditional propositions and "compulsion" and the use of force.

Coercion is generally linked to conditional propositions, i.e., if the patient accepts the proposed treatment, the therapist will do something in his interest. Take, for example, a sex offender who may be released from prison if he accepts community treatment as an outpatient. This is an "offer," and if he refuses he remains in prison which is his current baseline situation. Another example is the psychotic patient who will be involuntary admitted to hospital if he does not accept medication as an outpatient. This is a "threat"; his future condition will be worse if he doesn't comply with the proposed treatment. In both cases the patient feels subjectively that he is not totally free to take a personal decision and feels some coercion to accept an

alternative he would otherwise not have chosen. In any case the proposed conditional alternative of the therapist must always be in the best interest of the patient.

Compulsion means involuntary admissions to a psychiatric hospital as well as involuntary treatment and involves the use of force against patient's will. It is regulated by law, and therapists will comply with the laws on patient's or prisoner's rights of their country. The Draft Recommendation Rec (2004) of the Council of Europe "concerning the protection of the human rights and dignity of persons with mental disorder" states guiding cumulative conditions when considering involuntary treatment:

- The patient must present a psychiatric disorder stated by a health-care professional.
- He fulfills the criterion of dangerousness for himself or third parties. Dangerousness, the risk of violence or threat to physical integrity of third parties, and the presence of a psychiatric disorder are principal determinants and prerequisites for involuntary treatment. The threat to the physical integrity of third parties must be linked to the mental disorder of the patient and not to other environmental or social causes. Health-care professionals are not competent to treat social deviance as such in the absence of a mental disorder.
- The rule of the least restrictive alternative must be respected, which means that no less intrusive means of providing appropriate care are available. A patient who meets the (legal) criteria for involuntary treatment can avoid it if equal protection and treatment efficacy can be achieved at a lower level of constraint. Involuntary treatment must be proportional to the health status and symptomatology of the patient, and the therapist will use minimal coercion necessary to restore or maintain the competence of the patient.
- Even in case of involuntary treatment, the therapist shall take the opinion of the concerned person into consideration. He gives information about the current situation to the patient and about what will happen in the short term.
- Involuntary treatment should always be part of a written treatment plan, reviewed at appropriate intervals, and take place only in an appropriate environment, more specifically not in a prison but in a (forensic) health facility.

The major ethical justifications of the use of external coercion in treatment are:

1. The treatment redresses competence in incompetent patients.
2. The treatment reduces the risk of violence toward third parties.
3. The individual patient ultimately benefits from the planned treatment (lack of treatment will be detrimental for the mental health of the patient).

The proposed treatment must be suitable, beneficial, and effective for the psychopathological problem of the patient. Psychiatric conditions with poor prognoses will not improve with coerced therapy, whatever the treatment may be. Therapists must be aware of the limitations of their therapeutic decisions and/or programs.

Reducing the need for coercive interventions in psychiatry is obviously a legitimate aim because most patients judge negatively a previous involuntary treatment even though they nonwelded health benefits. This can be achieved by several ways:

- Therapists must aim for a more active role and involvement of the patient in making treatment choices and decisions at each stage of the therapy.
- Initiatives involving the use of "advance statements" by patients seem to be effective. Take, for example, a patient with a psychosis who anticipates a relapse. He may state in an "advance directive" his treatment preferences in anticipation of a future relapse of his psychosis. The patient has then a greater impact on his/her treatment at the time of psychotic relapse when he may be not capable of making treatment decisions.
- Coercive interventions on hospital wards such as the use of seclusion or restraint can be significantly reduced by appropriate staff education and management.

As forensic mental health care also shifts from forensic hospital to the community, the locus of the provision of mental health services has partly moved to the community. Take, for example, the coerced or even mandated compulsory community treatment of substance abusers proposed as an alternative to repeated inpatient hospitalizations in which involuntary treatment with medication is often required [10]. Another example is the coerced treatment of sex offenders released into the community. Even if the patient formally agrees with the treatment proposal of hormonal testosterone lowering treatment as a condition, there is often some form of informal coercion, e.g., if the prisoner wants a conditional release from prison, he must agree with the proposed hormonal treatment [11].

Take-Home Messages

- Forensic psychiatrists have the duty to provide appropriate care to mentally disordered offenders or prisoners, i.e., care comparable to those provided in regular psychiatric facilities.
- The psychiatrist can never disclose information of a competent patient without his consent, but exceptionally it may be necessary to protect third parties.
- The psychiatrist expert witness in court serves the best interest of the legal system and must inform the examinee that the confidentiality rule is not applicable in this context.
- Reduce as much as possible the need for coercive interventions or treatments in psychiatry.

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Pathways to Radicalisation and Violent Extremism

21

Thomas Marquant and Norbert Nedopil

21.1 Introduction

Europe has been faced with a recent wave of terrorism. Although the current wave, at first glance, seems to be novel in respect to extend and background, terrorism and violent extremism have been around for a long time. In modern times, four large waves of terrorism have been described by Rapoport: a first wave of anarchism in 1880, a second colonial wave in 1920, a new left-radical wave in 1960 and lastly a religious wave that started in 1979 [1]. The first wave knows famous protagonists, such as Bakunin and Kropotkin, and was started in Russia but spread to the USA and Western Europe as well. Terrorist attacks in those days were mostly aimed at the killing of high-profile leaders, and the victims included the Empress of Austria and a King of Italy.

The second wave was built on a basis of anticolonialism and aimed against colonial oppressors. Rapoport described how it started in the 1920s and mostly used a guerrilla tactic, targeting government officials and military personnel. The IRA was the most famous amongst them. From this wave on, terrorists did not see themselves as such anymore and have been claiming to be freedom fighters.

The third wave, built on a far-left extremism, with known participants such as the Baader-Meinhof group, used hijacking, like in Munich during the Olympic games of 1972 by a Palestinian group, as a more common tactic.

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The last wave then started with the revolution in Iran and is described by Rappaport as being driven by religion. Here, he mentions Islamic groups, Jewish extremists and also religious sects as protagonists of terrorism. One of these sects, the *Aum Shinrikyo* sect, released sarin, a deadly nerve gas, into the Tokyo subway system, killing 12 people and injuring over a thousand. Rappaport pointed out the emerging of suicide bombings in this wave. Besides a change of methods, terrorism became more international, and its leaders recruited foreign nationals in their groups. This phenomenon has been seen before in history, when foreign fighters were included in civil and international wars, e.g. in Spain in the late 1930s or in the war between Finland and Russia in 1939, but is a new phenomenon as a part of terrorism. The phenomenon has been important in Europe, and returned Syria fighters have been involved in attacks in Brussels and Paris. The international Soufan Group has presented an overview of the foreign fighters involved in the war in Syria [2, 3]. The report mentions 12,000 foreign fighters from 81 countries, from which 3000 originate from Europe. The majority worldwide comes from Arab countries, with Tunisia (2500), Saudi Arabia (2500) and Morocco (1500) on top. In Europe, France (700), Germany (270) and Belgium (250) represented the majority of fighters, and 400 fighters left from the UK.

Terrorism is not a new phenomenon, and it is not restricted to Europe. Of the 2201 terrorist attacks between 2005 and 2013, which killed more than 10 people, 25 were committed in Europe, most of them in Russia and Turkey [4]. Also, diverse ideologies have been used to justify terrorism as a strategy.

Interestingly, all terrorist groups eventually vanish [5, 6]. The authors reviewed 648 terrorist groups between 1968 and 2006. They found two main reasons for terrorist groups to end. Forty-three percent of them eventually joined the political process, 40% were arrested, or key members were killed by police or intelligence services. The authors stress that only 7% of terrorist groups were terminated by military force. Ten percent of the terrorist groups eventually succeeded in their goals, larger groups being more successful than smaller ones. Religious groups were the most tenacious, and only 32% of them end, whereas 68% of the total group eventually ended. On the other hand, no religiously motivated group achieved its goals.

21.2 Part 1: General Determinants of Radicalisation

From the point of view of psychiatry and psychology, the research questions centre less on the military and political dimensions but more on the roots of radicalisation and extremism in individuals and groups and on the assessment of individual terrorists.

In the first part of this paper, the determinants of radicalisation for members of a community are investigated and specifically the interaction of individual disposition and group dynamics in this process. An overview of the main determinants is given by Koomen and Van Der Pligt [7] in the following schema, which we will use to address each of the determinants (Fig. 21.1).

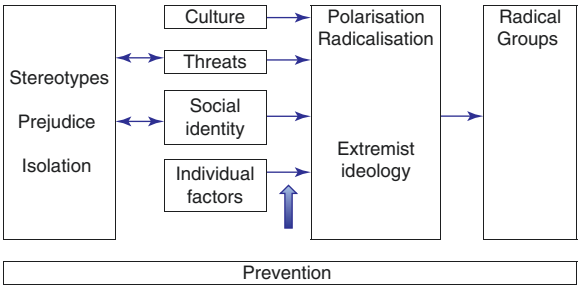

Fig. 21.1 Main determinants of radicalisation, with permission from [7]

21.2.1 The Foundations of Radicalisation

The roots of radicalisation has a strong base in a specific social environment: *isolation, stereotypes and prejudice* all interact to create negative meta-stereotypes, implicit or explicit, which lead to mistrust amongst minorities and majorities in a mutual way. The media often fuels these stereotypes [7, 8].

There is some indication, that interaction between groups can mitigate prejudice, on a quantitative level (intensity of contact) and qualitative level (quality of the contact). This is known as the social contact hypothesis. Basically, this means that when living in a mixed neighbourhood, social contacts are more frequent and more likely of a higher quality, both reducing prejudice and stereotypes [9, 10]. If this potential of contact is not available, the pathway to radicalisation by aversive stereotypes is more open and easier to enter. This effect is stronger in the majority than in the minority groups. Socio-economic status is related to terrorism in an unexpected way. Poverty as such is surprisingly negatively correlated to an inclination towards terrorism, as was shown in Muslim minorities in Britain and Israel [11, 12]. Possible explanations might be that a higher status provides the knowledge, interest and opportunity to engage in politics [7]. Or maybe, deprivation can be perceived in a relative way, and even wealthy members of minorities might still feel deprived when they compare themselves to the members of the majority.

21.2.2 Threats

A threat can be perceived when a minority feels subdued by a majority or a government [7]. The threat can be either at an interpersonal or at an intergroup level, the latter being more common in the field of radicalisation. The notion of threats is closely related to the injustice framework from Slootman and Tillie [13]. Just like the threats, they found that radicalisation in an Amsterdam population, for example, was strongly influenced by a (perceived) injustice towards themselves or their in-group. Slootman and Tillie [13] distinguishes four levels of analysis (Fig. 21.2).

Frame of reference for violent extremism
POLITICAL level Haves and have-nots
Example: Minority groups in society that experience a relative difference of wealth in society
Ideological level For-and-against
Example: Especially relgion delineates very strict between believers and non-believers
Cultural/ social level In/ out groups
Example: Bullying at school as a precursor of peer-rejection and subsequently the incident of a school shooting (loner)
Personal level / grievances Getting back (revenge)
Example: Relationships and break-ups can lead to perceived homogeneity of the group where the partner belongs to and subsequently revenge is projected onto the entire group.

Fig. 21.2 Injustice framework of reference [13]

21.2.3 Individual Factors

There is no evidence to support that personality disorders relate to radicalisation [7]. Mental illness as such has been reported to be rare in the process of radicalisation [14].

Yet other, more specific personality traits might however have relation to radicalisation, such as social dominance orientation or an authoritarian orientation. Both are rooted in a conservative and traditional orientation, which could be a reason why Islamic cultures or right-wing radicalisation might have it as a precursor. Sensation seeking might be an element to consider also, as well as a male gender [7]. Some of the more common dispositions are fearlessness, boldness and an affinity to weapons [15].

21.2.4 Social Identity

Belonging to a group creates a *social identity* [16, 17]. Two aspects are important here. First, how *important* it is for the individual to belong to a group and second *how much value* he gives to the group he belongs to [7]. In order to achieve this, the group has to have a positive image, and to stand out amongst other groups, and has to lend its positive image to its individual members. This feeling of belonging is a dynamic feeling that changes over time. When groups are under a threat, perceived or real, the sense of this standing out of a group becomes more important. This in turn strengthens the importance of the group. When such a group feels threatened, group coherence becomes more important and might become a source for more radical ideas [18]. The most common mechanism in these group dynamics seems to be greed, fear and the experience of injustice, deriving from being chronically underprivileged or acutely by incidences incurred by members of the in-group causing frustration and

anger [19, 20]. In Holland, for example, people with a Turkish background identified more strongly with their Turkish roots than with their Dutch background and even more than the Dutch people did with their Dutch identity [21, 22]. The identification with a minority group under threat further increases the in-group vs. out-group polarisation and the prejudices towards the out-group, which is then seen a homogenous crowd. This crowd differs considerably from the in-group, with which the individual feels a lot of communalities. Minority groups tend to resist assimilation and will perceive being a minority as a threat to their social identity [7, 22, 23]. The emphasis on differences can become particularly vulnerable to exaggeration if the values concerned are considered to be fundamental or if the perceived threats target stereotypes. From polarisation to radicalisation is then only a small step. Minorities might be perceived as unintelligent, while majorities could be perceived as racist. In severe cases, groups start to dehumanise others. Homogeneity and dehumanisation are important dynamics that can justify involving innocent victims into an attack.

21.2.5 Ideologies

Some ideologies offer a world view that can generate and justify certain goals [24]. These ideologies offer the notion that something is seriously wrong in this world, and the ideology explains how things should be [7]. Ideologies like religion, nationalism and some other political ideologies offer certainty and diminish uncertainty. Experienced injustice or 'threats' render people more inclined towards ideologies that reduce uncertainty [25].

Koomen and Van Der Pligt [7] lists hierarchy, fatalism, violence and honour as ideological elements that relate to terrorism. The way people look at hierarchy and tolerate a power distance towards people with power differs throughout cultures. Autocratic societies or groups with a rigid hierarchy are more susceptible to being radicalised through powerful leaders [26]. Fatalism, which externalises responsibility to a God or a powerful leader, is more prone to justifying violence through this entity and to ignoring individual responsibility. Cultures having higher rates of violence are more prone to encouraging violent and terrorist actions [27]. Honour, if hurt, calls for retaliation and personal or group vengeance [28]. Research has shown that, for example, people in the southern States of the USA, in Arab cultures and in American minorities are susceptible to radicalisation because of their honour culture and will more easily turn to violence when their honour is threatened [29].

21.3 Part 2: From General Determinants to an Individual Pathway

From these general determinants, we can conclude radicalisation as a process that is largely driven by group dynamics, which are linked to a social identity, perceived injustice, being threatened or offended or experiencing the suffering of members of

the in-group. Isolation, stereotype and prejudice free the way for perceived threats towards a minority group, which will mould the social identity of the people in this minority at a group level.

In the next part, we will describe a radicalisation process on a more individual level; on the individual level, several pathways have been described. Most of them imply a linearity of the pathway. We know, however, that this is not always the case, and many terrorists have never been radicalised or vice versa [5, 30]. There are many ways and many reasons to end up a violent extremist. Different pathways can lead to radicalisation (equifinality), and different individuals on a same pathway can have different outcomes (multifinality) [31, 32]. We will describe two linear pathways and contrast them to the 'cyclical complexity model' from Dean [33].

21.4 Linear Models

21.4.1 Staircase Model of Moghaddan

The staircase model of Moghaddan was developed for radicalisation in Muslims. The model is designed like a staircase that spirals through six floors, narrowing as it goes up [34]. The ground floor, according to Moghaddan, consists of the majority of people, asking questions about their position in society and about the fairness of their situation. People move up to the next levels through serious dissatisfaction, mostly related to the injustice framework described earlier [13]. In the second floor, they become open to externalising the reason for their perceived injustices, mainly towards the Western world or the USA. From there, a pathway is further described towards isolation, through a cognitive narrowing of the attention focus and a fixation on radical interpretations of an ideology. The last step consists of adding capability factors, such as combat training or weapon training.

21.4.2 NYPD (New York Police Department) Four-Stage Model

According to Dean, this is the most widely used model to visualise the pathway towards extremism in the context of Islamic extremism. The model consists of four phases, as presented in Fig. 21.3 [35, 36].

In the first stage, called pre-radicalisation, many of the individuals involved have normal lives. In the second stage, due to specific causal factors, a person starts to increasingly identify with Salafist ideas, which shows a disconnection with their previous lives and increasing association with new and like-minded individuals, adopting the extremist ideology. In the third phase, we see an intensification of the ideology, through the influence of peers or sometimes through social media. The last step

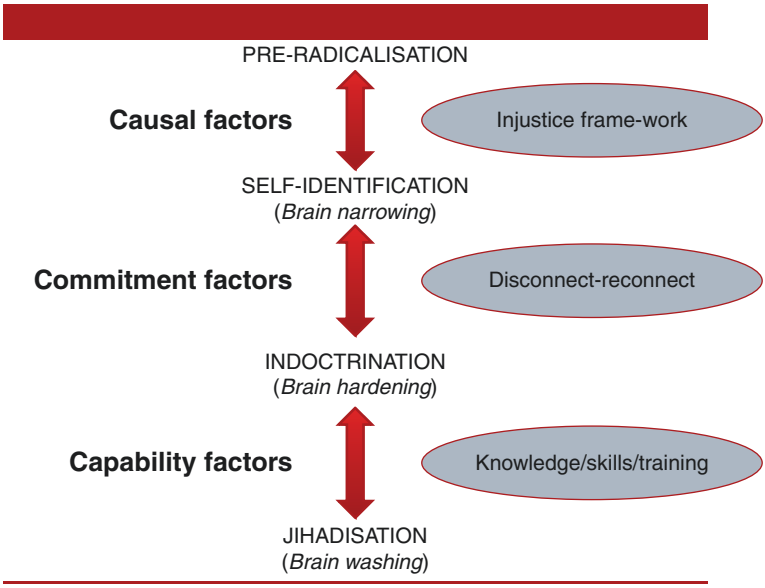

Fig. 21.3 NYPD-FBI/four-stage model of radicalisation [35]

involves a jihadisation, mostly when a person gains specific skills, such as combat skills, or learns how to operate weapons. These are called capability factors.

21.5 Nonlinear Models

21.5.1 Cyclical Complexity Model

The cyclical complexity model was designed by Geoff Dean and portrays extremism on a spectrum of intensity. According to this model, the individual moves through several 'pivotal points', each driven by distinct motivations and combinations of push/pull factors or inhibiting/constraining factors. The pathway looks like a spiral, where the individual goes through the different pivotal points, which either lead to extremist thinking or away from it. The pathway relies on a 'mental pathway', which consists of distinct phases in time, namely, an 'entry' phase, an 'engagement' phase and a 'disengagement' phase (see Fig. 21.4). The mental pathway is composed of four cognitive phases: cognitive opening (identification), rewiring (intensification), cognitive mindset (rigidification) and exiting (disillusionment).

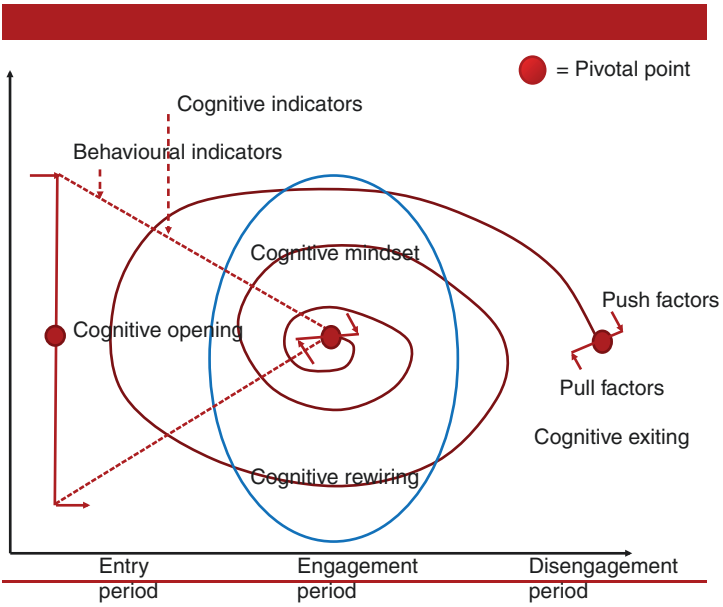

Fig. 21.4 The cyclical complexity model by Geoff Dean (adapted for this chapter) [33]

The strength of this spiral shape is that it allows for a large array of dynamics through the different stages and allows stages to be skipped or to go backwards. The model offers a good way to visualise in a very dynamic way the pathway through the stages leading up to radical thinking and the acceptance of the use of violence. We will go into the different phases using a case study.

Case Study (Abdel)

Entry Period

Abdel was born in 1980 in a family of Moroccan descent in Belgium and had a Belgian nationality. His family was religious, yet not fanatic or radical. His mother is a housewife, and his father had a steady job. Abdel was the eldest child and has three sisters. He did not finish school and started to work at young age and mostly in bars. He did not go to the Mosque and did not live by the five pillars of Islam. He drank alcohol and had poor knowledge of written Arabic. He had relationships with Western women. Abdel can best be described as an open character with a liberal attitude. He had no convictions.

For him, the first pivotal point came, when a relationship broke and his father died at about the same time. He later described how things changed, as he became aware of his Muslim background and how he started to identify with the worldwide fate of Muslims. When this happened, he stopped working and started to see a psychologist. The death of his father changed

his position in his family. He changed his behaviour and appearance. Abdel went to the Mosque, lived according to the Hadith and married a Muslim woman according to tradition. The Muslim society in his hometown was well connected and had a strong everybody-knows-everybody structure. Abdel is strongly influenced by the Muslim community of his hometown.

In this case, Abdel enters the pathway through a series of events that together create a pivotal point towards a more radical thinking. These events tip the balance towards a 'cognitive opening' and lead to his decision to enter the pathway. Push factors are the separation from his girlfriend and the death of his father. The most important pull factor is a general identification with his in-group, which then drives him into a more radical environment. Indeed, in many cases the main influence to radicalisation comes from the neighbourhood and the Salafistic scene in the vicinity [37]. Sageman [38] states that 68% of the 168 jihadi he interviewed said friendship was the main facilitator to joining a jihadi group. At this entry stage, important behavioural indicators of an ongoing radicalisation can be observed [31, 32, 39]. A large study done by the National Counterterrorism Center (NCC) detected 70 behaviours associated with violent extremism, with 16 of them appearing in over 50% of the cases [40]. An overview is given in Fig. 21.5.

Mobilisation behaviours	Percentage of cases(%)
Communication/ links to extremists	91
Consumption of jihadi videos/ propaganda	91
Pursuit of religous instruction	86
Suspicious travel (location)	86
Expressed acceptance of violence/ mrtyrdom	82
Weapons training	77
Expressed perception of exist. Threat to Islam	73
Effort to obtain weapons	64
Membership extremist radical groups	59
Use of cover terms to mask true meaning	59
Attempted /desired foreign travel	59
Internet research for target selection,…	55
Suspicious travel patterns	55
Isolation/ rupture with family	55
Participation in vlogs, chatrooms,…	50
Active role of leadership	50

Fig. 21.5 Top violent extremist behaviours

Engagement 1

Abdel found substantial support in his new environment and opened to the idea of action. Salafist ideology became increasingly important to him and started to dominate his thinking and living. Especially one Internet forum, with a strong Salafist base, exposed him in an intense, repeated and prolonged way to violent extreme thinking and prepared his mind for action. This forum is predominantly militant and less religious. The discussions they have are largely political, and the religious arguments reveal a poor interest or knowledge of the religion but using it as a basis for militancy. To this day, Abdel's knowledge of his religion has been limited and mostly concerned with a return to a romanticised past of the Muslim culture. His interpretation of religion is that one has to demonstrate faithfulness to his religion. Through this forum, he came into contact with people who were planning to join the fight in Tsjetsjenia, and he became one of the founding members of an extremist organisation that wanted to rally people for the support of Muslims in areas of conflict.

His engagement phase consisted of two factors: (1) the Internet putting him into contact with people who offered capability factors and (2) being the more important one; Abdel's life and attention were completely absorbed by the Salafist ideology. This and the creation of an organisation devoted to the rallying of young Muslims into the fight were the important pull factors of the second pivotal point towards further radicalisation: At this point, almost no inhibiting factors were left, he was disconnected from his family, and his world was dominated by other Salafist followers. The indoctrination through the Internet and through his Mosque remained the most important push factors at this stage.

Engagement 2

At this point, one of the main characters of the Internet forum started leaking their plans of going to Tsjetsjenia, and all members of the forum were arrested. After 6 months Abdel was acquitted and went home, where he faced a hostile world. His neighbourhood started to shun him, and people who had supported him previously avoided him now. He became isolated, and his return to his community turned out to be another pivotal point. He was driven into the arms of his Salafist friends and of the new group he was a co-founder of. The group became more militant, and after its leader was imprisoned, attendance to all meetings of the group was expected. Abdel had lost all connections to his old world and felt rejected. He left for Egypt to attend a training in combat and weapon-handling. From there, he set out for Syria to join the Islamic State, now strongly on the rise there.

In this second stage of the engagement, the dynamics of the first phase were reinforced, and the element of capability was added at this crucial pivotal point when Abdel went to Egypt for training. It was the last step in his

jihadisation. The push factors, which drove him towards action and made him travel to Syria, were a pending sentence in Belgium and the reaction of his home community after prison. Pull factors were the fate of Muslims in Syria and the romanticised idea of the Islamic State as portrayed through Internet propaganda.

Disengagement

After his arrival in Syria, Abdel was disappointed with the situation there. There was fighting, living conditions were poor, food was short, and housing was miserable. Many of the fighters had come for opportunistic reasons, and there was no commitment and no leadership in many instances. He was forced to trainings and to prepare for fighting. He became disillusioned and wanted to leave. But that was forbidden and proved to be difficult, but after 3 months, he was able to escape and to return to Belgium. There he needed to hide now and found refuge with a friend where he lived for almost 3 years before being arrested again. He was convicted for a total of 15 years for his plan fight in Tsjetsjenia and for his participation in IS actions in Syria.

Abdel entered the disengagement phase through a pivotal point in Syria, where he had to face the reality of the Islamic State, its poor organisation and its contrast with the propaganda. With this a very important pull factor vanished. The disinhibiting factors became more important. He realised that he was more a part of his home country and more attached to his family than he thought. But this might not be the final outcome, since he was now imprisoned, and we know that prison can be a strong push factor, as prison is a known risk factor for radicalisation.

21.6 Part 3: Terrorism and Forensic Psychiatry

Individuals who have committed terrorist acts often have been through similar pathways as described, but most of them differ considerably from the clientele seen by psychiatrists for assessment for criminal courts and for treatment or risk assessment after conviction. Most terrorists did not have a criminal history or an antisocial lifestyle, most of them did not suffer from mental illness or from drug abuse, and many do not even come from a disadvantaged background and very few signs of personality disorders. This raises the question whether forensic psychiatry is the adequate profession to occupy itself with individuals accused of terrorism or convicted for a terrorist attacks or for belonging to a terrorist group. One important warning is necessary before we continue to discuss the role of forensic psychiatry in dealing with radicalised individuals who commit terroristic crimes or others who have done so in the past: Terrorism is not a mental disorder, terrorists might be seen from different angles and might appear strange to our societies, and maybe some do have mental problems, but it is rare that these problems are the cause for terrorist violence.

The reasons for including the competence of forensic psychiatrists into the study of terrorism are twofold:

1. Forensic psychiatrists are experts in assessing, understanding and interpreting the biographies of offenders or other individuals who transgress the norms of established societies and by that come into contact with the criminal justice system.
2. An increasing number of people are convicted not only for committing terrorist acts but for belonging to terrorist groups or for supporting them. In many countries of Europe, their probational release depends on a risk assessment. Quite often this assessment has to be accomplished by forensic psychiatrists.

Another problem arises from this professional obligation: The individuals concerned differ according to age, the group they belong to, the form of terror they executed and many other aspects. Even though most of them are male, the number of female suspects has increased dramatically in the last 3 years in Europe [41]. Because of these many differences between the individuals concerned, there are only few common features and almost no empirical knowledge, which can be used to assess the risk and to answer the question whether a suspect will commit a terrorist act or whether someone convicted for a terrorist act will repeat his offence. Even if there are some characteristics which might be applicable to demonstrate the involvement with terrorism, none of these have been shown empirically or statically relevant, and everything we know and apply is derived from case studies and individual experience. But knowing these characteristics might help to consider the knowledge available, while the awareness of lack of empirical data should caution the assessor and should be made transparent to the deciding bodies.

The literature cites the following characteristics which should be examined when doing risk assessments.

The Violent Extremism Risk Assessment (VERA, [14]) advises to consider the following areas of interest:

1. Beliefs and attitudes, e.g. ‘Victim of injustice and grievances’.
2. Context and intent, e.g. ‘Anger and expressed intent to act violently’.
3. History and capability, e.g. ‘Network (family, friends) involved in violent action’.
4. Commitment and motivation, e.g. ‘Driven by moral imperative, moral superiority’.
5. Protective factors, e.g. ‘Family support for non-violence’.

McCauley and Moskalenko [42] consider these categories as relevant for risk assessment:

1. Personal grievance
2. Group grievance
3. Slippery slope

4. Love for someone already radicalised
5. Risk and status to be attained
6. Unfreezing by loss of (previous) social connections

If these categories are combined with the narratives, which form the basis of Salafist self-identification in Europe, or with a more general narrative for terrorists published by Leuprecht et al. [43], the important risk factors extracted by Monahan [15] seem to be quite plausible. The narrative of Salafists in Europe could be understood like that:

> We were suppressed and expelled, tortured and killed in our home countries (first, i.e. the Kosovo or Chechenia, and later it was Iraq and Afghanistan), and the local non-Muslims and its Western allies were cruel and unforgiving. Our Muslim brothers and sisters suffered and still suffer terribly because of their religion. The secular world and especially the capitalistic West support this torture and suffering. They invented the lie of weapons of mass destruction to occupy our home country and kill our men, rape our women and urinate on our holy scriptures. They use drones to kill peaceful farmers, women and children in Afghanistan, they kidnap our leaders and torture them in Guantanamo, and they don't even try to punish those who commit these crimes. They believe they are allowed to do everything without being held accountable for their crimes.

Leuprecht et al. [43] condensed at following more general and more consequential narrative:

> We (i.e. our group, however, defined) have a glorious past, but modernity has been disastrous, bringing on a great catastrophe in which we are tragically obstructed from reaching our rightful place, obstructed by an illegitimate civil government and/or by an enemy so evil that it does not even deserve to be called human. This intolerable situation calls for vengeance. Extreme measures are required; indeed, any means will be justified for realising our sacred end. We must think in military terms to annihilate this evil and purify the world of it. It is a duty to kill the perpetrators of evil, and we cannot be blamed for carrying out this violence. Those who sacrifice themselves in our cause will attain glory, and supernatural powers should come to our aid in this struggle. In the end, we will bring our people to a new world that is a paradise (p. 265). These narratives combined with the known risk factors listed above show the following aspects as most common and most relevant ones, if we have to assess the risk of individuals or groups for committing terrorist acts (see also [15]).

21.6.1 Ideology

Saucier et al. [44, p. 256] define an ideology they term *militant extremism* as 'zealous adherence to a set of beliefs and values, with a combination of two key

features: advocacy of measures beyond the norm (i.e., extremism) and intention and willingness to resort to violence (i.e. militancy)'.

21.6.2 Affiliations

People who commit terrorist acts tend to associate with other people who commit terrorist acts [45, 46]. These groups are distinguished by a hostility towards individuals who are not members of one's own group, with altruism within the group, i.e. benefitting in-group members at a tremendous cost to oneself. But they also exert massive social pressure towards sacrificing oneself for the benefit of the group and for a common martyrdom.

21.6.3 Grievances

Grievances either through personal or group trauma and frustration, particularly in the form of the loss of loved ones due to military actions or to actions of a majority against a minority—in general by those perceived to be enemies—may be an undervalued individual risk factor for terrorism. Grievances may be particularly potent risk factors for terrorism in 'cultures of honour' [47] in which 'men are sensitive to a cultural script in which aggression is used to restore threatened manhood' [48].

Personal traumas and frustrations could encourage a 'collectivistic switch' to a terrorism-justifying ideology because the latter may afford a means for restoring the lost significance occasioned by various unsettling events. Besides, terrorism-justifying ideologies may afford a relatively simple means of substantial *significance gain* and attainment of a hero or a martyr status in the eyes of one's community.

21.6.4 Moral Emotions

Moral emotions is a term used when one group (most probably the majority group) violates one's own group's 'sacred values' [49]. Tetlock [50] defines a sacred value as 'any value toward which a moral community proclaims, at least in rhetoric, an unbounded or infinite commitment'. The expressions of these emotions are anger and disgust. Such a violation cannot be compensated with material values, and the emotions even might call for retaliation if monetary compensation is offered.

21.6.5 Caveat

It is, however, not adequate to base a risk assessment only on the evaluation of these four aspects; many other influences can play a role to substantiate risk. It is therefore not only worthwhile but indispensable to always consider the general theory and practice of risk assessment which obliges the assessor to take a number of variables and contextual factors into account [51, 52].

Conclusion

Terrorism and violent extremism have been around for a long time in different waves. The most recent of them has confronted new generations with its devastating effects worldwide. Next to the fear and anger created by the violent attacks, it has also widened the scoop for a lot of people, confronting them with a globalised world and the consequences of migration, culture and the mix with different religions and ideologies. Next to a military response, this has sparked the interest into the psychological mechanisms of radicalisation and the question how people turn towards extremist interpretations of specific ideologies and eventually become open to the idea of using violence. It can be hoped these insights could be helpful in the prevention of terrorist attacks or actions.

In this chapter, we've explored the main theories offered in the literature that try to describe a person's pathway towards extremism and eventually violence. At first, we looked in the main determinants of radicalisation, such as socio-economic situation, individual characteristics, group dynamics and ideology and culture.

It is important that amidst these different determinants, it is the sense of the in-group being under threat and the (perceived) injustices towards the in-group that fuel and start up the cognitive opening towards extremism and violent extremism.

Second, we described linear and spiralling pathways towards radicalisation and violent extremism. We were especially interested by the cyclical complexity model, designed by Geoff Dean, which sees a person go through three main stages, being an entry period, an engagement stage and possibly an exiting stage. People mainly move through the pathway at different speeds and mostly through 'pivotal points', which can be described as clusters of events that either push and pull a person towards further radicalisation or which can inhibit the further trajectory. Interestingly, mainly the first stag offers visible changes in the behaviour and interests of a person and might offer preventive actions, if required.

In a third part, we try to summarise the knowledge gathered by experience, case studies and literature review to make it applicable for specialists who have to deal and to take responsibility in managing the risk of the individuals, who come to the attention of the respective authorities. Besides applying the general knowledge and practice of risk assessment for violence, specific aspects should be examined and evaluated, namely, adherence to an ideology of militant extremism; affiliations with other terrorists; grievances about lost honour, meaning, identity, loved ones either individually or as a group, one belongs to; and moral emotions, like anger or disgust, because one's own sacred values have been violated.

Take-Home Messages

- Not all extremism leads to violent extremism and ideology rarely leads to extremism.
- Forensic setting, e.g. prisons, play an important role in the pathway towards radicalisation.
- Being able to understand the pathway towards radicalisation can improve detection and ways to tackle the issue more efficiently.

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Recommendations to the Practice of National Teaching, Training and Research

22

Kris Goethals

22.1 Teaching and Training

22.1.1 Legal Frameworks

For us as trainees in forensic psychiatry and psychology and forensic psychiatrists and psychologists, these frameworks are a bit 'exotic' but pivotal in understanding our profession. First of all, we have learned about the differences and similarities of adversarial and inquisitorial systems of trial and investigation in criminal procedure. The outcome of a trial is fair and just by the way in which lawyers, psychiatrists and psychologists and others work together within the giving system. Collaboration and communication with other disciplines is crucial. Next, training has to include legislation, both national and international, and ethical issues. We have to learn from mistakes that were made in the past. Networking among forensic mental health professionals has to be encouraged. Also we have to be aware of the legal approaches to criminal responsibility of mentally disordered offenders in Europe. These differences in responsibility may hinder the exchange of knowledge and best practices concerning forensic assessment among European forensic psychiatrists and psychologists. But as placement of patients is usually done on treatment needs and the level of dangerousness, and not on the basis of (the degree) of responsibility, mainly in theory, forensic psychiatrists and psychologists should also be aware of new developments in legal systems across Europe, since it affects their daily practice. Forensic psychiatry and psychology increasingly has to deal with questions which fall outside the area of professional expertise. And finally, we cannot practice forensic psychiatry and psychology without the influence of the

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European Court of Human Rights and the European Convention for the Prevention of Torture.

22.1.2 Service Provision and Frameworks

We have learned that process mapping provides a quick visual reference tool for understanding offender-patient pathways through the legal and clinical systems. And it may have applications for information leaflets for patients and their relatives and for fellow professionals. The pathway mapping also shows the extent to which we are similar or may differ in where services are provided. Research comparison of outcomes given these inherent differences would be a useful exercise. Whatever the funding system (public health and/or justice) and service provision are, equivalence and continuity of care should be guaranteed.

22.1.3 Specific Skills

Language can be a barrier to clinicians' international profession mobility, their ability to integrate with clinical teams and to communicate with patients. The dominance of English in the scientific community may be also a barrier to participate in scientific debate and dissemination of knowledge among non-native English speakers. An easier way to get experience in other countries is to work in countries with the same language, for example, exchange of the Dutch-speaking part of Belgium with the Netherlands or the German-speaking part of Switzerland with Germany or Austria.

Sound forensic psychiatry and psychology includes multidisciplinary teamwork. Multi-agency working in forensic psychiatry and psychology is defined as the coming together of people from different professional backgrounds, organizations and services, sometimes with varying primary purposes, such as safety, harm reduction and mental health care. Their common aim is then improving public safety and decreasing an individual's risk of harm to others. Several countries do not have this multi-agency working. Experiences from countries that have it can help these countries to set up this paramount collaboration.

We should always keep in mind that a strict distinction between the role of a treating clinician and expert or a dual role of a treating clinician and expert in one profession is an absolute must. Both approaches have its advantages and disadvantages. By visiting professionals in other countries, we can put into perspective each of these approaches.

Forensic psychiatrists and psychologists should have an in-depth training in psychotherapy. Some specific forensic psychotherapeutic themes should also be taught and trained by experienced professionals. The institution where forensic psychotherapy takes place presents an important environment that has a crucial impact on the therapeutic and work climate for all those involved.

22.1.4 Teaching and Training

Forensic psychiatrists and psychologists require expert knowledge and skills which must be gained through formal learning and apprenticeship. Major teaching themes in forensic psychiatry and psychology are:

1. Mental health legislation and the interface between mental health and law
2. Risk assessment and management but also the validity and usefulness of risk assessment instruments
3. Professionalism and ethics
4. The clinical expert/witness training

Traditional and modern methods of teaching can be utilized by teachers of forensic psychiatry and psychology. Pan-European bodies offer the opportunity to improve training and education by facilitating the exchange of ideas and experiences.

Forensic psychiatry is, across European countries, variously a specialty, subspecialty or development within medicine. For quality reasons, it is important that forensic psychology should also have specialist training in the field. People collaborating in residential Ghent group seminars have substantially improved their knowledge of their own country's practices as well as those in other European countries. It is important to incorporate southern and former eastern European countries into these seminars.

Professional with contributory expertise [1] should collaborate with those with interactive expertise. In general it is better for expert clinicians to take on the ultimate leadership role in accordance with ultimate responsibility, with the support of business managers rather than the reverse. All forensic mental health services need to maintain a continuous culture of learning so as to be open to new developments.

Empirical evidence may hardly give answers to the questions which treatment approaches should be considered state of the art in forensic psychiatric and correctional settings, certainly not in relation to a specific patient. Empirical evidence demonstrates that, when comparing two groups treated in different ways, significantly more patients have a positive outcome in one of the groups. Unfortunately we are still not close to answering questions like 'what works with whom, in what contexts, under what conditions, with regard to what outcomes and also why'. Therefore (translational) research in forensic psychiatry and psychology should be encouraged and funded in an appropriate way.

Risk assessment tools should be implemented in all European countries. Risk assessment should explicitly include both risk factors and protective factors. Training of prison mental health caregivers should become a prerequisite for medical staff and other caregivers working in European prisons. National and international research on psychiatric prevalence in prisons and on prison mental health care as well as on violence must be increased. The European Research Council should urgently add this topic to their list of research themes.

22.1.5 Capita Selecta

We should conceive a task force with delegates from the UEMS Section of Psychiatry and the EPA Section of Forensic Psychiatry together with interested trainees in forensic psychiatry from the EFPT. Its tasks could be to define priorities, shared needs and common goals on a European level. Next it should initiate, develop and support further Europe-wide research in forensic psychiatry and psychology to consolidate the scientific basis for the discipline. And finally, it can become a compass for all stakeholders involved, an exquisite body to develop standards for training, education and continuous professional development.

All forensic psychiatrists and psychologists should know the phenomena of deinstitutionalization and transinstitutionalization. Transinstitutionalization is a real risk for chronic, complex and care-avoidant patients. Deinstitutionalization is only one of the various factors that can lead to transinstitutionalization. How we organize community-based care is one of the main factors related to transinstitutionalization.

Forensic psychiatrists have the same ethical guidelines as general psychiatrists. He can never disclose information of a competent patient without his consent, but exceptionally it may be necessary to protect third parties. The psychiatrist expert witness in court serves the best interest of the legal system and must inform the patient/examinee that the confidentiality rule is not applicable in this context. It is our duty to reduce as much as possible the use of coercive measures in forensic psychiatry.

Forensic psychiatrists and psychologists should have knowledge about terrorists. The reasons are twofold. They are experts in assessing, understanding and interpreting the biographies of offenders and other individuals who transgress the norm of established societies and by that come into contact with the criminal justice system. And an increasing number of individuals are not only convicted for committing terrorist acts but for belonging to terrorist groups or for supporting them. In many European countries, their probational release depends on risk assessment and risk management. This risk assessment is often accomplished by forensic psychiatrists and psychologists.

22.2 Research

22.2.1 Why Is Research in Forensic Psychiatry and Psychology Important?

Research predicates change for the better, so it can be a leverage for diminishing stigma. And it contains costs and safeguards professional credibility and services. By giving (young) professionals an opportunity to do research, it can support recruitment and retention. A UK survey of the Royal College of Psychiatrists revealed that of 2000 respondents, 60% is doing some research, most often next to their primary role as a clinician. Indeed research is for most of them not their primary task. Above that, two-thirds of them would like to do more research and have more time for that.

22.2.2 What Would Help to Do Research?

An important aid would be protected time, so that clinicians do not have to care about patients during the dedicated time for research. Research needs funding. For forensic psychiatry and psychology, there should be a greater availability of funding, and professionals should know better how to apply for funding. There should be a reduced bureaucracy of research, by means of making the ethics approval processes simpler and by supporting research management. Professionals should enhance their skills, for example, for statistics and for research designs. Above all, there should be availability of academic support.

22.2.3 To What Extent Do Forensic Mental Health Services Require Specific Research?

Antisocial behaviour by patients with mental disorders can only be adequately researched within this group. Most research within patients with a cluster-B personality disorder are those with a borderline personality disorder. A huge problem is that standard randomized controlled trials (RCTs) of relevant treatments almost by definition exclude antisocial and/or complex cases. We all know that forensic psychiatric patients have a high degree of comorbidity with psychiatric disorders and/or somatic diseases. Specific research is also needed because of unique characteristics of some cases and ethical issues.

22.2.4 How Far Do We Have to Go?

With regard to treatments for patients with a personality disorder, McCarthy and Duggan [2] highlighted the difficulty to measure usable outcomes or personality changes in these patients. More recently, Duggan and Dennis [3] in a Cochrane review stated that only 17 randomized controlled trials of psychological treatments of sex offenders can be found. Contrary to that, 13,290 RCTs are registered on the Cochrane Database for schizophrenia and that 21% investigated psychological interventions. Even more, 16,483 trials are registered on the Cochrane Database for depression, anxiety and neurosis. Although schizophrenia and depression are much commoner conditions than sex offending, the contrast of the quality and quantity of studies is stark.

22.2.5 Are 'n-of-1' Trials a Solution?

A n-of-1 trial tries to find an answer to the question 'Is an intervention likely to benefit or cause unwanted effects in an individual?'. This design is most suited to interventions with the following features:

1. Interventions that act and/or cease to act quickly
2. Interventions with limited evidence
3. When complex patients differ from people included in conventional RCTs
4. When the prevalence of condition or condition combination is too low for conventional trials

There can occur a randomization of intervention/non-intervention. Also there can be blinding when appropriate. And finally, the Oxford Centre for Evidence-based Medicine (2011) classifies n-of-1 trials, when properly conducted as level 1 evidence.

22.2.6 Where Is the Funding? Where Is the Infrastructure?

Funding can be found by various sources, such as government research bodies, health service, national research councils, specific funding streams and dedicated charity, although we have to consider the fact that charity is hard to find for our forensic psychiatric patients. With regard to infrastructure, we need training posts, an obvious career pathway and a minimum sufficient network.

22.2.7 Looking for Other Partners

In the absence of immediate senior partners in forensic psychiatry and psychology, we have to look for other partners inside and outside the field of forensic mental health. Partners with relevant expertise outside the field are Clinical Trials Units teams, neuroimaging experts, technology application experts, public health experts and criminologists. Partners with relevant forensic mental health expertise in other centres can be found on a national and international level. Multicentre research in one's own country and abroad is often needed due to small patient numbers that can be found in one centre. Above that, international perspectives are vital in themselves due to several reasons: first of all, they can put systematic reviews in perspective; next, relevant conditions can contribute to a natural experiment; and finally, they may allow collating n-of-1 trials.

Examples of international collaborations are the SWANZJACS study, the Ghent group, the DUNDRUM and the STAIR. Forensic psychiatric services and interventions under criminal and civil law were investigated in the Nine Nations (SWANZJACS) study. Collaborating countries were Sweden, Wales, Australia, New Zealand, Denmark, South Africa, Japan, Canada and Scotland. This study highlighted similarities and differences in demographics of forensic psychiatric patients internationally. Also they stressed the importance of similarities and differences in clinical and legal pathways. The Ghent group, as previously discussed in several chapters of this study guide, tries to map similarities and differences in training, laws and legal processes, services, core concerns in treatment settings and potential for research. The DUNDRUM QUARTET is a handbook that describes a

suite of four structured professional judgement instruments. These structured professional judgement instruments are intended to provide a validated and transparent means of making decisions about admission, transfer and discharge in forensic mental health/psychiatry services. The DUNDRUM-1 triage security items are designed for the assessment of need for therapeutic security based on patient characteristics. Patients can be rated according to their need for high, medium, low or no therapeutic security. The DUNDRUM-2 triage urgency items are intended to aid the prioritizing of patients on a waiting list for admission to a therapeutically secure hospital. The DUNDRUM-3 programme completion items describe the extent to which patients in a forensic secure hospital have engaged successfully in treatments under five 'pillars' of care or domains relevant to reducing and managing risk of harm. These five domains are physical health, mental health, drugs and alcohol problems, problem behaviours and family, social and occupational function. The DUNDRUM-4 recovery items are intended to provide a structured professional judgement instrument for assessing the extent to which a person is ready to move to a less secure placement, based on stability, insight, rapport and working alliance, leave and dynamic risk. A programme evaluation examined a long-term cognitive skills inpatient programme (STAIR) in reducing rehospitalization and rearrest rates in mental illness [4].

22.2.8 Ten Steps Forward

In order to assure a future for research in forensic psychiatry and psychology, we can formulate ten steps:

1. To articulate our platform
2. To build from basics
3. To abandon stereotypes
4. Radical thinking
5. The use of technology
6. Creativity with blockages
7. Doing more with less
8. Managing regulation
9. Product targeting
10. The clarity of message

1. To articulate our platform
   Per life lost, we spend less on research into violence than on most other conditions impacting on health. This situation must change. Therefore forensic mental health research could make the difference.
2. To build from basics
   We need to know more about life course of relevant symptoms of disorder in the context of forensic psychiatry and psychology.

3. To abandon stereotypes
   We have to be aware of the fact that no condition is defined by untreatability. Future research and clinical insights can make conditions more treatable at a later stage.
4. Radical thinking
   There are much better alternatives to incarceration. We need to explore further biofeedback for behavioural disorders.
5. The use of technology
   Technology use can help to evaluate patient engagement and to monitor patients through apps.
6. Creativity with blockages
   First of all, clinicians should engage in n-of-1 trials. Next, we should bring in other research experts as mentioned above. And finally, we should facilitate appropriate diversion of quality assurance funds.
7. Doing more with less
   We should engage undergraduates and volunteers but never underplay skills. And we should always know when to end a research line.
8. Managing regulation
   We should promote the ethical problem of not advancing treatment and/or change through research. We should also set up the structures for accurate, easy responses and engage 'experts by experience' in the process.
9. Product targeting
   We have to know who is interested in the mission of forensic psychiatry and psychology. And we also explore the possibilities of crowd funding.
10. The clarity of message
    Our message should be very clear: sound forensic mental health research can save lives and reduce health and criminal justice costs.

Take-Home Messages

- The editing of this study guide was a very informative and rich journey. I myself have learned a lot by the contributions of several colleagues and friends. I hope that this study guide can find its way to many young enthusiastic colleagues from everywhere in Europe and in other continents.

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