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

N. Nedopil (✉)
Department of Forensic Psychiatry, Psychiatric Hospital of the University (LMU) of München, Munich, Bavaria, Germany
e-mail: norbert.nedopil@med.uni-muenchen.de

P. Taylor, C.B.E., M.B.B.S., M.R.C.P.
Division of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, Cardiff, UK
e-mail: taylorpj2@cardiff.ac.uk

K. Goethals (ed.), *Forensic Psychiatry and Psychology in Europe*,
https://doi.org/10.1007/978-3-319-74664-7_13

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.

References

1. Fazel S, Seewald K. Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. Br J Psychiatry. 2012;200:364–73.
2. SWANZDSAJCS. Offenders with mental disorder on five continents: a comparison of approaches to treatment and demographic factors relevant to measurement of outcome. Int J Forensic Ment Health. 2009;8:81–96.
3. Salize HJ, Dreßing H. Coercion, involuntary treatment and quality of mental health care: is there any link? Curr Opin Psychiatry. 2005;18:576–84.
4. Salize HJ, Dreßing H, editors. Placement and treatment of mentally disordered offenders: Legislation and practice in the [old] European Union. Lengerich: Pabst Science Publishers; 2005.
5. Cassells-Barker A, van Lier E, Taylor PJ. Services for offender patients: European perspectives (available from second author). in preparation.
6. Casselman J, Bobon D, Cosyns P, Wilmotte J, Arteel P, Depreeuw W, DeRuyver B, Janssen V, Mormont C, Snacken S, editors. Forensic psychiatry in Europe. Leuven: Law and Mental Health; 1992.
7. Grounds A, Gunn J, Myers WC, Rosner R, Busch KG. Contemplating common ground in the professional ethics of forensic psychiatry. Crim Behav Ment Health. 2010;20:307–22.
8. Gunn J, Nedopil N. European training in forensic psychiatry. Crim Behav Ment Health. 2005;15:207–13.
9. Nedopil N, Gunn J, Thomson L. Teaching forensic psychiatry in Europe. Crim Behav Ment Health. 2012;22(4):238–46. https://doi.org/10.1002/cbm.1845.
10. Nedopil N, Taylor P, Gunn J. Forensic psychiatry in Europe: the perspective of the Ghent Group. Int J Psychiatry Clin Pract. 2015;19(2):80–3.
11. Taylor PJ, Woolfenden N, Nedopil N. Forensic psychiatry training in Europe. Die Psychiatrie. 2013;3:181–7.
12. Thomas A. What about forensic psychiatry as a career? Undergraduate and early post-graduate medical perspectives. Crim Behav Ment Health. 2012;22(4):247–51. https://doi.org/10.1002/cbm.1838.
13. O'Grady J. Time to talk. Commentary on forensic psychiatry and general psychiatry. Psychiatr Bull. 2008;32:6–7.
14. Turner T, Salter M. Forensic psychiatry: re-examining the relationship. Psychiatr Bull. 2008;32:2–6.
15. McInerny T. Dutch TBS forensic services: a personal view. Crim Behav Ment Health. 2000;10:231–28.
16. Gómez-Durán E, Muñoz García-Largo L. Training in forensic psychiatry when no nationally recognised scheme exists. Crim Behav Ment Health. 2012;22:257–60.
17. Thomson LD, Goethals K, Nedopil N. Multi agency working in forensic psychiatry: theory and practice in Europe. Crim Behav Ment Health. 2016;26(3):153–60. https://doi.org/10.1002/cbm.1998.
18. Gunn J. Forensic psychiatry as a subspecialty. IntJLaw Psychiatry. 1982;5:65–79.