Forensic Psychiatry

Forensic Psychiatry:

Clinical and Ethical Approaches

Edited by

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PREFACE

Forensic Psychiatry is a specialty (or considered by others as a subspecialty) of Psychiatry that has been gaining increasing attention and dedication from mental health professionals. It can be defined in a very basic way as the science of psychiatry in the service of Justice. In this way, this is an interface between psychiatry and law.

So, unlike other psychiatric subspecialties, which have a certain homogeneity among different countries, the practice of forensic psychiatry is affected by different legislation around the world. This was one of the reasons why the editor of this book invited psychiatrists from different countries and continents to write the chapters.

Currently serving on the board of directors of the Forensic Psychiatry Section of the World Psychiatric Association, the editor was able to perceive relevant and current topics that require a more in-depth approach. Thus, the book began with the concepts of forensic psychiatry in different countries. Next, the different possibilities of learning forensic psychiatry around the world were offered. Um capítulo inteiro foi dedicado à atualização da psiquiatria forense na nova Classificação Internacional de Doenças (CID), recentemente divulgada. Furthermore, it is important to highlight that the following chapters always cover the latest in forensic matters. A particularly thorny and delicate topic, but extremely important and current in discussions, was covered in the chapter on chemical castration. Finally, in addition to technical issues, ethical particularities in forensic psychiatry were not forgotten and, therefore, were discussed in the last chapter.

There with, it is believed that the book will bring great collaboration to the study of forensic psychiatry in its various aspects, with renowned professionals in the field. It will be of particular importance to clinical and forensic psychiatrists, residents of psychiatry, psychologists and legal professionals.

—Elias Abdalla-Filho
Editor

CHAPTER 1

CONCEPTS OF FORENSIC PSYCHIATRY IN DIFFERENT COUNTRIES

BIRGIT VÖLLM

Highlights
Introduction
Legal Traditions
Criminal Responsibility
Entry Criteria for Admission to Forensic Mental Health Services
Treatment Pathways
Review of Detention and Discharge
Length of Stay
Aftercare Arrangements
Recent Developments
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Highlights

Forensic psychiatry is a specialty of medicine applied to law, and might be concerned to criminal or civil matters.

In many civil law jurisdictions, tests for criminal responsibility are enshrined in statute, typically having cognitive and volitional elements, while in common law traditions decisions arise from case law.

A country which only accepts cognitive elements in their insanity defence will mainly admit patients with severe psychotic disorders to forensic mental health care settings, while countries using a sliding scale of responsibility

and/or also allowing for volitional elements to be considered will have a higher proportion of personality disordered individuals.

Typically, the age of criminal responsibility in Europe is set at about 14 or 15 years of age, but some, often African, countries use a very low cut-off of 7 years.

Regarding substance use disorders, according to the UK Mental Health Law, individuals with such conditions cannot be compulsorily committed to any psychiatric care, including forensic: *[dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of [the Act]*.

A number of countries have undergone significant changes in their legal provisions for mentally disordered offenders, partly in response to international human rights developments such as the Convention on the Rights of People with Disabilities.

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Abstract

This paper describes concepts of forensic psychiatry in different countries with a focus on Europe. Differences exist across the treatment pathway, e.g. regarding criteria for admission (e.g. the role of criminal responsibility), treatments offered, procedures for review of detention and discharge, length of stay, and supervision after discharge. Some of the advantages and disadvantages of different approaches are discussed. Forensic psychiatry, as any area of law and medicine, is subject to constant change in line with, e.g., societal changes. Practitioners and policy makers can learn from observing practices elsewhere in order to adapt their own approaches.

Introduction

Forensic psychiatry is a specialty of medicine applied to law. It might be concerned with criminal or civil matters. From a criminal point of view, it is concerned with individuals who have offended or are at risk of doing so and, at the same time, suffer from a psychiatric disorder. Mentally disordered offenders (MDOs) are treated in prisons or secure psychiatric facilities which aim to reduce an individual's risk of reoffending through addressing relevant risk factors, including, but not limited to, the psychiatric disorder.

In addition to the treatment of MDOs, forensic mental health professionals also have a role as expert witnesses in court and in advising on and conducting risk assessments in different contexts. Forensic mental health professionals have obligations on the one hand for the individual patient (for their health, well-being, etc.) as well as for society (i.e., protecting others from their patients). This dual-role dilemma can cause tensions and poses challenges, particularly ethical ones, for practitioners. These challenges but also the highly restrictive and costly nature of forensic-psychiatric (or forensic mental health to use a broader term better acknowledging the role of non-medical professions) institutions call for exceptional care in designing these settings and services, ensuring safeguards are in place for those detained within them.

Legal Traditions

As Völlm et al., (2018) noted, "forensic psychiatry operates within the legal and societal context of a country and is therefore subject to the wider influences and trends of that society". Laws rule human behaviour and change over time. Generally, one can distinguish *civil law* (also called Roman law) and *common law* traditions. Additionally, law systems might be based on religious law such as Canon or Islamic law.

Many European legal systems share a common heritage that can be traced back to Greek and Roman influences, which already early on recognised the need to exempt people with mental illnesses from the same punishment than otherwise in place in society. As described in Tomlin & Völlm (2021), countries in Europe mostly belong to the civil law tradition as is also the case for, e.g., Japan and much of South America. In this tradition, the sources of law, including criminal law, are comprehensive legal codes (covering all potential matters and scenarios), which are applied by judges to individual cases. Criminal procedure is *inquisitorial* with the examining judge playing the role of the investigator, reviewing the evidence, questioning the defendant, witnesses, defence lawyers and prosecutors. The role of the lawyer is to support their client in the process and present the facts from their perspective while also trying to encourage the judge to use any discretion they have in favour of the defendant. The prosecutor on the other hand presents the case through the lens of society. The amount of discretion a judge has varies but is generally less compared to common law systems. Case law plays a marginal role and judges are not bound on decisions of higher courts.

Common law legal systems originated in England but have since been adopted in Commonwealth Nations (including, e.g., the United States, Canada, Australia, and New Zealand) and most former British colonies (Beis et al., 2022). Although much of criminal law has been codified in statute, in common law traditions decisions arise from case law. Previous decisions of higher courts are binding on lower courts as precedent. Instead of starting with legal principles and applicable legal provisions as would occur in a civil law jurisdiction, common law lawyers and judges begin with looking for past rulings in cases with the same or similar factual circumstances or legal issues. Criminal procedure in common law systems is *adversarial*. One of the main differences compared to civil law systems is the role of the judge. Judges are more passive than their civil law counterparts and hear cases presented by lawyers representing the defendant and lawyers representing the state. In the proceedings both the defence and prosecution pursue their own investigative work and evidence gathering and are competing to persuade a judge or jury of the merits of their arguments. In cases involving serious offences a jury is often employed in common law countries, although some do not follow this practice out of fear of bias. In case of a jury trial, it is the jury which decides on the issue of guilt with the judge merely advising the jury on their role and clarifying aspects of the proceedings as well as, if the defendant is found guilty, determining the sentence.

Proponents of civil law systems point to accessibility and certainty: Legal codes are available to all citizens to guide their behaviour. Importantly, in civil law traditions the principle of separation of power is upheld: The legislative power (usually) lies within parliament, while the judiciary simply applies (rather than also makes) the law (in systems where jury trials are employed, these might mitigate against the blurring of powers). On the other hand, one advantage of common law is its more organic nature, therefore the law can be more responsive to societal change.

Individuals who are detained in whatever setting are particularly vulnerable regarding potential human rights abuses. Therefore, it is essential that procedures are in place to prevent such abuse as well as unnecessary restrictions. Such procedures are, e.g., complaints mechanisms involving external bodies, regular reviews of placement, access to free legal aid, and inspections from outside bodies. In Europe, the 46 member states of the Council of Europe (see About the CPT - CPT (coe.int) accessed 7.7.2023) are obliged to adhere to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1953). The Committee for the Prevention of Torture (CPT) develops standards for

places of detention and inspects such institutions on a regular and ad-hoc basis. Following these detailed inspections, a report is written, which is submitted to the government of the country highlighting any concerns and making suggestions on how to remedy these. The reports then become available on the CPT website.

Criminal Responsibility

Criminal responsibility is an important concept and a prerequisite for punishment. The age of criminal responsibility is the minimum age under which children cannot be punished through the criminal justice system. The idea behind such a cut-off is that a certain degree of maturity is required in order to fully apprehend the right and wrong of certain actions. Typically, the age of criminal responsibility in Europe is set at about 14 or 15 years of age (Salize & Dressing, 2005), but some, often African, countries use a very low cut-off of 7 years (Beis et al., 2022). Some jurisdictions use a different age depending on the severity of the offence committed with a lower age for more serious crimes (e. g. 10 or 14 years in Australia, 12 or 18 years in Canada) or a different age for girls and boys (Iran: 9 years for girls, 15 years for boys, Beis et al., 2022).

An issue forensic psychiatrists are more commonly concerned with is the criminal responsibility of adult mentally disordered individuals. Again, individuals who lack responsibility for the act they have committed are exempt from punishment and therefore cannot be sentenced to a prison sentence. This necessitates some alternative system of detention for those for whom there is a risk of future harm to others, which is one of the crucial factors in the development of forensic-psychiatric systems.

While these principles are accepted in most countries, there are significant differences in the way criminal responsibility is defined and in the role it plays in admission to a forensic mental health facility. One important difference in definition relates to the question as to whether or not volitional elements are considered in addition to cognitive ones.

According to Tomlin & Völlm (2021) criminal responsibility is assessed differently in civil and common law jurisdictions. In England & Wales, e.g., the M'Naghten test, originating in case law, is used: An offender will not be 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". Additional components, such as the 'irresistible impulse test', have been

added to this in subsequent cases in some countries. The requirement that the defendant knows the nature, quality or wrongfulness of an act means that the approach to criminal responsibility adopted in the M'Naghten test is primarily *cognitive*. If successfully pleaded, the defendant might either be acquitted or be committed to a forensic mental health institution usually based upon an assessment of ongoing dangerousness.

In many civil law jurisdictions, tests of criminal responsibility are enshrined in statute. These typically have *cognitive* and *volitional* elements. An example of this can be seen in § 20 of the German Criminal Code (StGB), which states (Müller et al., 2017):

> Whoever, at the time of the commission of the offence, is incapable of **appreciating** the unlawfulness of their actions or of **acting in accordance** with any such appreciation due to a pathological mental disorder, a profound disturbance of consciousness, mental deficiency or any other serious mental abnormality is deemed to act without guilt.
> (Bold and underline added for emphasis by the author).

Some countries operate a dichotomous concept whereby criminal responsibility can either be present or absent, e.g. Austria, but most acknowledge a graded concept with full, diminished, or absent responsibility, or sometimes with even more categories, like in the Netherlands, where there are five grades of criminal responsibility (Edworthy et al., 2016). Diminished responsibility, where it is recognised, can then result in a less severe punishment, i.e., a shorter sentence of imprisonment. England and Wales are not easily fitted into these categories as the concept of diminished responsibility only applies to murder; if successful, the charge is reduced from murder to manslaughter and disposed of accordingly. Sweden is also an exception as the only country in Europe to have abolished the concept of criminal responsibility in their penal law; MDOs will be found guilty but given a hospital disposal.

Entry Criteria for Admission to Forensic Mental Health Services

The way criminal responsibility is defined and the role it plays in admission decisions is one of the most important differences in forensic mental health provision across jurisdictions and determines to a significant degree the composition of the patient population. E.g., a country which only accepts cognitive elements in their insanity defence will mainly admit patients with severe psychotic disorders to forensic mental health care settings, while countries using a sliding scale of responsibility and/or also allowing for

volitional elements to be considered will have a higher proportion of personality disordered individuals as is, e.g., the case in the Netherlands.

Most countries require some degree of reduced criminal responsibility (at the time of the offence) for entry into the forensic mental health system, while individuals with full responsibility for the crime committed will be subject to punishment, even if they did suffer from a mental disorder at the time of the act. MDOs not fully responsible at the time of the crime are diverted away from the prison into the forensic mental health system. However, in some countries, e.g. the UK, access to forensic psychiatric care is independent of criminal responsibility and determined only on the basis of the mental condition at the time of the trial. The emphasis here clearly lies on the need for treatment. This might also explain why there are so few cases (under 50/year) of insanity. It simply does not matter, with regards to admission to a treatment setting, whether the individual was ill at the time of the offence.

There are advantages and disadvantages to both models. One of the disadvantages of having a system where diversion to a forensic-psychiatric hospital is clearly linked to criminal responsibility is that it may be much more difficult to admit someone who needs to be in hospital at a later stage, i.e., after they have been sentenced. Systems which do not focus on criminal responsibility are able to respond more to the needs of patients and also admit patients at a later stage of their prison sentence or admit even patients who have not committed an offence at all but who need to be treated in a secure setting as is the case, e. g., in England & Wales. However, there is an important ethical issue in keeping these patients in restrictive settings, potentially for a very long time and longer than their prison sentence would have been.

Countries also differ with regards to exclusion criteria for forensic mental health care. A number of national laws within Europe provide exclusion criteria for detention in a psychiatric, including forensic-psychiatric, hospital, e.g. personality disorders, substance use disorders or paraphilias. This may be welcome from a civil liberty perspective as it means subjecting fewer people to the restrictions of compulsory psychiatric care and detention; on the other hand, such exclusion might also result in a lack of service provision for those in need.

An interesting case is that of substance use disorders. According to the UK Mental Health Act 1983 (as amended, Mental Health Act 1983 (legislation. gov.uk), accessed 8.7.2023), individuals with such conditions cannot be

compulsorily committed to any psychiatric care, including forensic: *[d]ependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of [the Act]'* (§ 1(3)). In other countries, e.g. France, Ireland, Italy, and Finland, it is routine practice and clinical guidance that excludes these patient groups instead of legal provisions. On the other hand, Germany, Switzerland, and Austria all offer specialised forensic treatment for patients with substance use disorders. § 64 of the German Criminal Code (Müller et al. 2017), e.g., stipulates that such individuals can be committed to forensic mental health care for a limited period of time – usually 2 years – if the substance use disorder is related to the crime committed, there is a risk of further offences and a reasonable prospect of the treatment being successful. Unlike for other disorders, under this provision reduced or absent criminal responsibility is not a requirement for admission but those with full or partial responsibility are given a parallel prison sentence which can mostly be served concurrently or is suspended. If the treatment proves not to be successful, individuals can be transferred to prison at any time.

Treatment Pathways

Treatment is offered across a range of settings including secure hospital settings, specialised wards in general psychiatric hospitals, the community, and prisons. Some countries have developed liaison and diversion schemes which allow for the detection of mental disorders early on in the judicial process, e.g. at the time of arrest or at the first court appearance through placement of mental health professionals in police stations or in courts. This may allow, particularly in the case of minor offences such as theft or non-payment of fines, for the diversion of individuals into an appropriate health care setting without further involvement of the criminal justice system (Völlm et al., 2018).

With regards to secure hospital settings, some countries operate a system of different levels of security, e.g. high, medium, and low. This allows for a good fit of need to the environment, thereby ensuring, e.g., that patients are not detained in settings more restrictive than necessary. On the other hand, if levels of security are provided in completely different institutions, there are issues around transfer which can cause delays in the treatment pathway. Providing different security levels within the same institution allows for more flexibility and the application of the same treatment model across the whole pathway. In addition to security levels, hospitals often provide different wards according to, e.g., gender, diagnosis, offence type, therapeutic

approach, etc. This allows teams to develop specific expertise with regards to offer tailored interventions to particular patient groups.

There is little research with regards to which models of care work best and very limited information regarding which countries focus on which approach. In fact, most countries do not have national guidelines prescribing specific approaches so that it is often up to local leaders to develop treatment programmes for their institutions.

The effectiveness of interventions for MDOs is a topic of much research, and evidence indicates that group based cognitive-behavioural approaches work best (e.g. McGuire, 2008). In addition to such specific types of interventions, some general elements of care have been shown to be helpful. The risk-need-responsivity (RNR) model (Andrews & Bonta, 2010) is the most influential model of offender rehabilitation. It suggests that programmes following the risk (meaning that treatment should be tailored to the risk level of the offender with more intense interventions being offered to higher risk individuals), need (interventions should focus on criminogenic needs) and responsivity (treatment needs to take into account responsivity factors such as motivation and personality traits) principles work best.

The healthcare system of the UK is known for its focus on evidence-based medicine. As described in Völlm et al. (2018), Tapp and colleagues (2016) undertook a Delphi survey to identify key aspects of high secure care. In the first round of the survey, experts agreed on important elements of medical (clozapine), psychological (CBT-based interventions) and social interventions (e.g. off-ward activities) as well as general elements (multidisciplinary working, patient involvement) of care delivery, though in subsequent rounds experts could not agree on how essential each element of care was. For medium and low secure care detailed standards are available in the UK (Royal College of Psychiatrists, 2019; Townsend et al., 2021), which could aid the development of similar documents in other countries. The standards have been developed by professionals, patients, relatives, and other stakeholders and act as a framework for the assessment of the quality-of-care delivery. This assessment is conducted on a voluntary basis (though almost all services participate) through mutual visits by a team of professionals and experts by experience.

One important element of care is gradual leave, starting usually with escorted leave, then unescorted leave and finally overnight and longer leave periods. Countries differ in terms of the decision-making processes around leave decisions. In countries where the courts continue to be involved

throughout the placement, they also have a role in leave decisions as is the case e.g. in Germany. Practise differs though and often there is a combination of clinical decision making, e.g. for escorted leave, and (in addition) permission from a court for more high-risk leaves. In other countries, e.g. the UK, courts do not have any further involvement following sentencing. There, all leave, transfer, and discharge decisions are made by the clinical team, though exceptions apply for patients on so-called "restriction orders". Such restrictions orders are applied at the time of sentencing and necessitate the Ministry of Justice giving permission for, e.g., leave, which can add significant delays to the patient's journey.

Review of Detention and Discharge

Given detention of MDOs is linked to their risk, it follows that there need to be regular reviews regarding the ongoing need for detention. Once the risk is sufficiently reduced, the individual should be released. Review periods differ between countries, usually from six months (e.g. Finland, France, Ireland) to two years (e.g. Luxembourg, Portugal) – sometimes different timeframes are prescribed, depending on, e.g., diagnosis or length of stay. In Germany, e.g., individuals detained under § 64 StGB (substance use disorders) are reviewed every six months, those under § 63 (severe mental disorder) once/year (Müller et al., 2017). In the UK, patients can request a review of their detention every six or twelve months, but a mandatory review is conducted after three years if they don't. Procedures also vary with regards to the requirement of an external expert opinion and the body that makes the final decision. With regards to the latter, civil law countries often have ongoing involvement of a court, while in England & Wales, e.g., a Mental Health Review Tribunal, consisting of a judge, an independent psychiatrist, and a lay member make the decision with some patients, however, needing additional approval by the Ministry of Justice. Such involvement of the executive carries the risk of political influence on decisions, e.g. at a time of elections or for high profile patients. External expert opinions might be prescribed by law at regular time points or requested by the patient. To take the example of Germany again, an external expert opinion is required every two years. The threshold required to continue detention rises after six and 10 years according to the principle of proportionality. After 6 years, detention has to be terminated unless there is a risk that further offences will be committed that will cause "serious" physical or psychological harm, after ten years there has to be "grave" such risk.

Length of Stay

Given the highly restrictive and resource intensive nature of in-patient forensic mental healthcare, lengthy stays in these settings are of concern. As Völlm (2022) noted, there is no generally accepted standard for LoS. Cut-offs of between 2 and 10 years are used to define long-stay. Using a cut-off of 10 years for high secure care, 5 years for medium secure care and 15 years if patients stayed in both such settings, Völlm et al. (2017) found a prevalence of long-stay of found that 23.5% for high secure and 18.1% for medium secure patients in England. The actual time patients stay in forensic settings varies considerably between countries (Tomlin et al., 2021): The Netherlands appears to have the longest mean period of treatment at 10 years, Slovenia the shortest with just over one year. Between are Germany (8 years), Ireland (7 years), Italy (3 years) and Poland (2 years).

Few countries provide specialized services for long-stay patients, in Europe this is the case for the Netherlands. As this model of care might be of interest to practitioners in other countries, it will be described here in more detail: Entry criteria for the service are a total length of stay in a forensic setting of six years; in addition, patients have to have undergone treatment in two different institutions without a significant reduction in risk. If these conditions are fulfilled, the clinical team can apply for the patient to gain long-stay status which means they are then transferred to a special long-stay forensic mental health facility. About 10–15% of the forensic population in the Netherlands are detained in such facilities, which focus on quality of life rather than risk reduction. Practitioners and patients alike confirm that the reduction in treatment pressure has a positive impact, possibly even to an extent that patients then want to re-engage in psychological therapy. Importantly patients can move back to mainstream forensic care at a later point if they choose to and this seems a good way forward. As such, the long-stay facility is not a “dead end” and does not mean patients are “given up”.

A number of countries have started to actively, through legal provisions, restrict the amount of time patients can stay in forensic mental health facilities (see e.g. Edworthy et al., 2016). Croatia, Italy, and Portugal do no longer allow detention in hospital to exceed the length of a prison sentence the individual would have been given had they been convicted as a non-mentally disordered offender. While not going this far, in Germany the constitutional court ruled in 2011 that the length of detention has to be proportionate to the index offence – the longer detention lasts, the more the

individual's right to freedom weighs in relation to the protection of the public.

Aftercare Arrangements

Little comparative work has looked at the issue of aftercare following discharge from a forensic psychiatric institution. Most countries have a system of trial leave before full discharge and/or ongoing supervision possibly with certain requirements, such as where to live, not to take drugs, etc., allowing for readmission if these are breached. This could add considerable restrictions on an MDOs life even years after discharge (which in itself could have been longer compared to their non-mentally disordered counterparts). Looking at these issues in detail, there is an important gap in the research and human rights literature, which often focuses on the situation of in-patient care.

Recent Developments

A number of countries have undergone significant changes in their legal provisions for MDOs, partly in response to international human rights developments such as the Convention on the Rights of People with Disabilities. One of the most significant re-shaping of services has happened in Italy, where the passage of Law 833/1978 led to the closure of psychiatric hospitals at the end of the 1970s. However, forensic mental health care remained untouched by this development and six high secure hospitals with around 1600 beds remained. Following the integration of forensic mental health services into the National Health Service and some very critical reports regarding the state of the high secure hospitals by the CPT, further laws were passed mandating the closure of these facilities and the development of 30 Residences for the Execution of Security Measures (REMs), small (20 patients), highly staffed community-based residential units focusing on rehabilitation. This transition was largely completed in 2017. The effects of this change are yet to be evaluated.

References

Andrews, D. A., Bonta, J. (2010). Rehabilitating criminal justice policy and practice. Psychology Public Policy Law 16, 39–55.

Beis, P., Graf, M. & Hachtel, H. (2022). Impact of Legal Traditions on Forensic Mental Health Treatment Worldwide. Frontiers in Psychiatry 13, 876619.

Edworthy, R., Sampson, S. & Völlm, B. (2016). Inpatient forensic-psychiatric care: Legal frameworks and service provision in three European countries. International Journal of Law and Psychiatry 29, 18-27.

McGuire, J. A. (2008). Review of effective interventions for reducing aggression and violence. Philosophical Transactions of the Royal Society of London 363, 2577–97.

Müller, J. L., Saimeh, N., Briken, P., Eucker, S., Hoffmann, K., Koller, M., Wolf, T., Dudeck, M., Hartl, C., Jakovljevic, A. K., Klein, V., Knecht, G., Müller-Isberner, R., Muysers, J., Schiltz, K., Seifert, D., Simon, A., Steinböck, H., Stuckmann, W., Weissbeck, W., Wiesemann, C. & Zeidler, R. (2017): Standards für die Behandlung im Maßregelvollzug nach §§ 63 und 64 StGB. Der Nervenarzt, 88: 1–29.

Salize, H. J. & Dressing, H. (2005). Placement and Treatment of Mentally Ill Offenders – Legislation and Practice in EU Member States. European Commission - Health & Consumer Protection Directorate – General, 1-249.

Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., Moore, E. (2016). Essential elements of treatment and care in high secure forensic inpatient services: an expert consensus study. Journal of Forensic Practice 18, 189–203.

Tomlin, J., Lega, I., Braun, P., Kennedy H.G., Herrando, V. T. & Barroso, R. et al. (2020). Forensic mental health in Europe: some key figures. Social psychiatry and psychiatric epidemiology 56 (1), 109–117.

Tomlin, J. & Völlm, B. (2021). Forensic Mental Health in Europe: Shared legal heritage and contemporary landscape. Health Science in Eastern Europe 31 (7), 146–152.

Townsend, K., Rodriguez, K. & Deacon, J. (2021). Standards for Forensic Mental Health Services: Low and Medium Secure Care. Quality Network for Forensic Mental Health Services, 1–39.

Völlm, B. (2022). Long-Stay Patients in Forensic Care. In: Tomlin, J., Völlm, B. (Hg.). Diversity and Marginalization in Forensic Mental Health Care. London: Routledge, 105–114.

Völlm, B., Clarke, M., Bulten, E., Herrando, V.T., Seppanen, A. & Gosek, P. et al. (2018). European Psychiatric Association (EPA) guidance on forensic psychiatry: Evidence based assessment and treatment of mentally disordered offenders. European Psychiatry 51, 58–73.

Völlm, B., Edworthy, R., Holley, J., Talbot, E., Majid, S., Duggan, C., Weaver, T., McDonald, R. (2017): A mixed-methods study exploring the characteristics and needs of long-stay patients in high and medium secure settings in England: implications for service organisation. Health Services and Delivery Research 5: 11

CHAPTER 2

TEACHING FORENSIC PSYCHIATRY AROUND THE WORLD

GARY CHAIMOWITZ AND JOHN BRADFORD

Highlights
Introduction
Background
A brief history of forensic medicine and forensic psychiatry and how it impacts the development of forensic psychiatry training and education
The development of the subspecialty of Forensic Psychiatry in the United States
Challenges in teaching forensic psychiatry around the world
The International Forensic Psychiatry Lecture Series
Conclusion
References

Highlights

Teaching forensic psychiatry worldwide is challenging as it requires a deep understanding of the cultural, legal, and societal differences between countries.

A physician practicing psychiatry cannot avoid any interaction with the legal system, either the criminal justice or the civil system.

The first effort towards international forensic psychiatric education involved a group of well-known forensic psychiatrists from Europe who

tried to establish uniformity and even the possibility of recognition of subspecialties, called the Ghent Group.

E-learning and distance education are valuable tools for providing training and education to psychiatrists in remote or under-resourced areas, as this allows psychiatrists to access the latest research and developments in the field, even if they do not have access to a physical training facility.

What is missing is a platform to discuss and improve upon forensic psychiatry teaching internationally

Introduction

Teaching forensic psychiatry has largely developed based on whether there is a subspecialty recognition in any given country. For example, in North America, the United States pursued a subspecialty in forensic psychiatry, followed some time later by Canada. In both countries, there were education and clinical services provided in forensic psychiatry without sub-specialization before sub-specialization became a reality. If you examine the history of psychiatry from Isaac Ray to the McNaughton trial, the development of psychiatry follows the historical events of forensic psychiatry.

The first effort for international forensic psychiatry education involved the Ghent Group. This is a group of well-known forensic psychiatrists from Europe [the UK was part of the European Union at the time] who attempted to establish uniformity and even the possibility of subspecialty recognition across 28 countries in the European Union and about four other countries outside of the European Union but strongly associated with Europe. Under the leadership of one of the authors, Dr. Gary Chaimowitz, St. Joseph's Healthcare Hamilton and McMaster University brought in an international lecture series to teach forensic psychiatry internationally. This innovative project, now supported by the Forensic Psychiatry Section of the World Psychiatric Association, has been a spectacular success and is currently the leading platform for teaching forensic psychiatry worldwide. This chapter discusses teaching forensic psychiatry, going into some detail about practices in the United States and Canada, as well as some European countries. Many countries around the world teach forensic psychiatry although their style or type of teaching is less evident from the literature. Hopefully the discussion below will aid thinking about and innovating in the teaching of forensic psychiatry.

Background

It has been said many times that a physician practicing psychiatry cannot avoid any interaction with the legal system, either the criminal justice or the civil system. Medico-legal issues fundamental to forensic psychiatry, such as evaluating capacity for various tasks, are also part of general psychiatry. The capacity to consent to treatment is a large part of the civil legal interaction in general psychiatry. Risk evaluation for aggression and suicide is an essential part of the clinical practice of general psychiatry, but at the same time is fundamental to forensic psychiatry. Risk evaluation for future violence is part of forensic psychiatry's training and subspecialty requirement. In civil aspects of forensic psychiatry involving medical malpractice, the forensic psychiatric evaluation of suicide is also part of the training and practice of forensic psychiatry.

The specific medicolegal/psychiatric legal issues are defined in the standards set forth for fellowship programs in forensic psychiatry [1982] authored by Rosner. These standards for the fellowship programs define the scope of forensic psychiatry currently in the lead-up in the United States to sub-specialization. It was determined that it should include the following: –

- Civil forensic psychiatry.
- Criminal forensic psychiatry.
- Legal regulation of psychiatry.

Civil forensic psychiatry would include guardianship and confidence to manage affairs. Child custody determinations, parental competence, and termination of parental rights would form another part. Examination of child abuse and child neglect would be covered. Also covered in this area would be psychiatric malpractice, personal injury and Workmen's Compensation cases (Rosner, 1982).

Criminal forensic psychiatry would include the competence to stand trial, the competence to testify, the testamentary capacity and the insanity offence. Also, included would be confessions and whether they are voluntary or not. Further, the broad sentencing issues include risk evaluation, recommendations regarding release into the community, and supervision.

The legal regulation of psychiatry covers civil commitment, rehospitalization, confidentiality, the right to treatment, right to refuse treatment, professional liability and confidentiality of psychiatric records.

Specific medicolegal/forensic psychiatry subjects are broadly accepted in forensic psychiatry education worldwide.

These areas are for training that originated from the historical roots of forensic psychiatry. The partway to sub-specialization and psychiatry has relied heavily on the history of psychiatry and the origins of forensic psychiatry (Rosner, 1983b).

A brief history of forensic medicine and forensic psychiatry and how it impacts the development of forensic psychiatry training and education

To understand the education and teaching of forensic psychiatry internationally, one has to emphasize the history of psychiatry and the central role that forensic psychiatry plays in this history (Prosono, 2016). Prosono points out that most medical specialties developed alongside scientific development, including the natural sciences. This was not the case with psychiatry, which makes evolution more complicated. Rather than being a product of biological sciences and scientific advances, general psychiatry and forensic psychiatry developed as a combination of scientific and legal issues. Psychiatry as a medical specialty evolved in the late 18th century.

Forensic medicine evolved in ancient history. Imhotep, an advisor to the Egyptian Pharaoh Djoser, was described as "the first great man combining the sciences of law and medicine; he might wish to be described as the first medicolegal expert" (Prosono, 2016; Smith, 1951). Smith was referring to the development of forensic medicine in his paper of 1951. His point was that forensic medicine emerged as a separate scientific discipline early in human history. At the same time, he opined that forensic medicine as an entity could only be considered once a legal system was defined (Smith, 1951). Smith also refers to ancient Egypt and the history seen in numerous papyri, including in the British Museum in London. From 2500 BC onwards, there was a system of law related to crime and civil matters. Punishments for committing crimes were developed and ranged from being lashed, mutilation of hands or feet, and being thrown to the crocodiles in the Nile or being forced into labour building the pyramids. In this context, about 3000 BC Imhotep was a person who combined law and medicine and could be described, as said before, as the first medicolegal expert (Smith, 1951). Smith explains that the earliest record of a murder trial was found in Central Babylonia in Sumeria. This was found in a clay tablet dating back to 1850 BC with little reference to medicine. 1800 BC, the code of Hammurabi

refers to intent in criminal behaviour. The Greek civilization put medicine on an empirical and rational trajectory. At the same time, there was the development of the law. While there is no evidence of direct medical expertise in the courts, Hippocrates and others discussed medicolegal questions such as whether a wound was fatal. Of course, the Hippocratic oath which related to the ethical basis and the practice of the medical profession, was established at the same time. During the Roman Empire, medical progress continued, and physicians followed the developments and methods of the Greek physicians. However, it is unclear whether there was any systematic use of medical knowledge at the court level. One notable exception is the postmortem of Julius Caesar in 44 BC where a physician examined the body where there were 23 stab wounds and opined that there was one stab wound to the chest which was fatal (Smith, 1951).

As the power of the Roman Empire faded between A.D. 529 and 564, the Justinian code was in place, and this included regulations for medicine, surgery and midwifery, including proof of competence utilizing an examination of the classes of physicians to be recognized, the number of physicians in each town and penalties to be imposed for malpractice (Smith, 1951). Forensic medicine had no development for the thousand years after the fall of the Roman Empire, and the whole field of medicine stagnated for a thousand years (Smith, 1951). This was offset by developments in China in the 13th century when there was a document on procedures to be followed when investigating a death, particularly those that were suspicious or possibly the results of criminal activity. This was entitled "Hsi Yiian Lu," which, when translated, meant "washing away wrongs" and, according to Smith, can be paraphrased as "Instructions to Coroners"(Smith, 1951). In the 15th century in Germany, the Caroline Code was published and proclaimed by Emperor Charles V as the legal code. This Caroline Code influenced legislative changes elsewhere in France and subsequently throughout Europe. In 1600 France and Europe in the 1700s, further development in criminal codes occurred and physicians with scientific observations were consulted.

The world of scientific medicine began in 1800 and has developed substantially since then—with some famous medicolegal cases worth considering. For example, in 1678, the body of Sir Edmundbury Godfrey was discovered impaled on his sword. It was felt that this was to simulate suicide. It was also noted that his neck was broken. Two surgeons testified at the trial on the time of death that the sword thrust was postmortem and the neck injury caused his death and was related to a homicide. Three men were subsequently convicted and executed.

In 1699 the trial of Spencer Cowper was also an example of medicolegal medicine at this time. Cowper was a solicitor charged with the murder of a girl named Sarah Stout. The body was found floating in a dam near a mill. The evidence given by "experts," including sailors from His Majesty's Navy, was the observation that men who were killed and then thrown in the water floated as opposed to men who drowned (they sank). Dr. Cowper [who discovered Cowper's glands] argued this evidence was not accurate and that all bodies sank, regardless of whether they drowned or whether they were thrown into the water. The doctor also described drowning and the presence of water in the lungs and stomach as an indication of the cause of death. This led to the acquittal of Mr. Cowper [no relation] (Smith, 1951).

From 1800 scientific medicine developed in Britain. In 1788 the first step towards the development of forensic medicine occurred when a volume was published by Dr. Samuel Farr entitled "Elements of Medical Jurisprudence." In Edinburgh in 1789, Andrew Duncan was appointed Professor of the Institutes of Medicine [or physiology] at the University. He almost immediately started teaching medical jurisprudence. In 1798 he presented a "Memorial to the Patrons of the University of Edinburgh". This presentation used and developed the term medical jurisprudence. This led in 1807 to the Crown creating Edinburgh University's first chair of medical jurisprudence. This stimulated interest throughout the country, and from this time onwards, the influence of medical jurisprudence took off to impact and develop british forensic medicine (Smith, 1951). The science rapidly grew with Robert Christison developed toxicology and, in 1829, published the important "Treatise on Poisons, concerning Medical Jurisprudence, physiology and the practice of physicians."

In the United States, forensic medicine developed, but less systematically. In 1813 Dr. J. Stringham was appointed Prof. of Medical Jurisprudence in New York. He had studied medicine in Edinburgh and received his medical degree from that University. This led to the development of forensic medicine in the United States. In 1823 Dr. TR Beck published the "Elements of Medical Jurisprudence," which helped the growth.

The history of the development of forensic psychiatry was somewhat parallel to the development of forensic medicine. Prosono has an excellent list of important dates in forensic psychiatry in his chapter in the forensic textbook (Prosono, 2016):

- The code of Hammurabi in 1800 BC refers to intent in criminal behaviour, which would be the first explicit recognition of a mental component to crime and forensic psychiatry.

- In 1200 BC, Hebrew law also looks at intent concerning murder.

- In 528 A.D., the Justinian code referred to persons who were insane who received less punishment when committing a crime. Children were also acquitted from punishment.

- In 1256 A.D., the "wild beast test" becomes the first test of criminal responsibility.

- In 1681 A.D. Thomas Willis publishes "Opera Omnia, " describing psychosis and other psychiatric disorders.

- In 1724 A.D., the case of Arnold, was one of the first high-profile and violent attacks on a prominent citizen in the United Kingdom. Edward Arnold attempted to kill Lord Onslow. This was a case for applying the "wild beast test."In court, Arnold claimed that Lord Onslow bewitched him. The relatives of Arnold testified that he had psychiatric symptoms that today would be regarded as delusions. The trial judge instructed the jury to decide if Arnold was totally deprived of his understanding and memory and knew what he was doing "no more than a wild beast or brute or infant." Arnold was convicted and sentenced to death. Still, the death penalty was commuted at the request of Lord Onslow.

- In 1736 A.D., Matthew Hale publishes "History of the Pleas of the Crown."

- In 1760 A.D., there was the trial of Lawrence Shirley, the fourth Earl Ferrers. He was charged and convicted of killing his estate steward John Johnson. Insanity was raised at his trial by people who knew him and described him as insane. He was convicted and subsequently hanged. What is significant was that Dr. John Monro, the superintendent of Bethlehem Hospital [commonly known as Bedlam], testified at the trial as an expert witness in the first forensic psychiatric testimony.

- In 1736 A.D., Matthew Hale published"History of the Pleas of the Crown."

- In 1800 A.D. was the Hadfield case. Hadfield was a soldier fighting for the Duke of York in the Crimean war when he suffered severe injuries. As a result of these injuries, he developed a chronic psychotic condition. He had a grandiose delusional belief that the world was about to end and that he was the only person to be the world's saviour. He had a delusional

belief that if he killed the King of England, George III, and he was executed as part of martyrdom, the world would be saved. He used a firearm [pistol] in this attempt to assassinate the King but failed in the effort. Hadfield had an outstanding lawyer, Thomas Erskine, who got an acquittal based on a mental disorder. Erskine expanded the insanity defence to the presence of a delusional or deranged state of mind.

- In 1838 A.D., Isaac Ray, at age 31, wrote the "Treatise on the Medical Jurisprudence of Insanity." This was one of the first efforts to deal with the interface between the Law and psychiatry. The famous trial of Daniel M'Naghten, became an essential part of the M'Naghten verdict and trial in 1843 in London. It became the most influential publication of psychiatry and the law in the 19th century. Sir Alexander Cockburn, the defence counsel for M'Naghten, quoted extensively from Ray's book at the trial. Before writing this book, Isaac Ray visited asylums in Europe. He is generally regarded as the founder of forensic psychiatry. After writing his book, he published extensively on psychiatry and its legal implications.

- In 1844 13 superintendents of mental asylums founded the Association of Medical Superintendents of American Institutions for the Insane. This organization evolved into the American Psychiatric Association. In honour of his contribution, the American Psychiatric Association established the Isaac Ray Award with the American Academy of Psychiatry and the Law in 1951. This recognizes an outstanding contribution to forensic mental health or psychiatric jurisprudence. Persons receiving the award do not have to be psychiatrists (Prosono, 2016).

- In 1840 A.D. Edward Oxford attempted to assassinate Queen Victoria. An insanity plea was raised and was successful. The Lord Chief Justice reaffirmed the question of establishing criminal responsibility.

- In 1843 the case of Daniel M'Naghten came before the British courts. This is the case where British and American forensic psychiatry jurisprudence overlapped. Daniel M'Naghten shot a man he believed to be the British prime minister Sir Robert Peel, but he was his private secretary, Edward Drummond. M'Naghten suffered a complex set of delusions related to Sir Robert Peel, the British government, the Vatican and other entities. This trial had medical experts [9 in total]. This trial resulted in the development of the M'Naghten rules [now known as the MacNaughton rules], and he was found not guilty by reason of insanity. This was a request of the House of Lords to a convention of English judges. The judges of the Queen's Bench were asked five questions and the answers to these questions became the M'Naghten rules. These rules