



Forensic Psychiatry and  
Psychology in Europe

A Cross-Border Study Guide

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*Editor*

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

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Thierry Pham and Pamela Taylor

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### 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 (MAPPAs) in England and Wales, as described and regularly updated by the Ministry of Justice ([www.mappa.justice.gov.uk](http://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 as 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 if 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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## 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](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](http://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](http://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/](http://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