Part I
Introduction

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Forensic Mental Health Systems Internationally

Anne G. Crocker, James D. Livingston, and Marichelle C. Leclair[1]

Forensic mental health systems have evolved over time as a function of legal frameworks, health care environments, and broader social and cultural processes. The past 20 years has seen a general increase in demand for forensic services in many countries around the world (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011), a phenomenon that has sometimes been referred to as *forensication* (Seto et al., 2001). This increase has been attributed to a variety of factors such as significant changes of Mental Health Acts or civil commitment legislation, the successive downsizing of psychiatric institutions, a lack of community-based resources and supports, the criminalization of people with mental health and substance use problems, the increasingly complex clinical profiles of certain persons with severe mental illness, increased media reporting of violence, and public intolerance of nonconforming behavior (Jansman-Hart et al., 2011; Lamb, 2009; Priebe et al., 2008; Rock, 2001; Whitley & Berry, 2013; Whitley & Prince, 2005). It is also influenced by broader social phenomena linked to society's handling of risk, such as how modern societies are organized to respond proactively to risk and neoliberal tendencies to frame risk as a problem within individuals rather than a social problem. Authors have even suggested that, in some countries, forensic services may become the de facto mental health services (Seto, Harris, & Rice, 2004). In addition to posing a number of humanitarian questions as well as questions regarding the capacity of the regular mental health services to deal with sometimes more disruptive patients, this trend may also come at significant economic cost. In Alberta, Canada, the cost of forensic cases has been estimated about CAD$275,000 per year, which is almost five times the costs for any other psychiatric inpatient (Jacobs et al., 2014). This number compares to the cost of care in forensic psychiatric hospitals in the Netherlands (€388 per day, or €142,000/CAD$207,000 per year: Avramenko, Evers, Philipse, Chakhssi, & Ament, 2009) and in the United Kingdom (£131,000 per year, or CAD$243,000: Barrett et al., 2005). In England and Wales, treating forensic patients in secure hospitals costs 15 percent of the total adult mental health

investment (Wilson, James, & Forrester, 2011). To date, however, there remains relatively little research into the economic cost of forensic mental health services over time. The immense cost of forensic services should give rise to questions about the degree to which this is a wise investment; that is, are the potential benefits of the forensic mental health system being optimized?

The goal of this chapter is to review the scientific and gray literatures regarding the provision of forensic mental health services around the world. In particular, we attempt to address the following question: What system-level characteristics are important to consider in relation to the organization and structure of forensic mental health services? To do so, we first examine the general legal frameworks that provide the contours of the forensic populations and services in various countries. We then synthesize publically accessible information to describe how forensic systems are organized throughout the world. Following this, we examine the fundamental system-level principles for organizing forensic mental health systems. The question of how to assess the performance of forensic mental health systems is addressed before turning toward the identification of the major challenges facing the organization of forensic services moving forward and followed by emerging approaches in forensic mental health services.[2]

1 How Are Forensic Mental Health Systems Organized Internationally?

Forensic mental health services generally function to assess and treat the mental health and criminogenic needs of individuals who intersect with the legal and criminal justice systems, including those who are found unfit to plead, found not criminally responsible on account of mental disorder,[3] mentally ill offenders in correctional facilities, persons whose aggressive behavior is unmanageable in adult mental health services, and, in some jurisdictions, persons detained under mental health legislation such as a compulsion order.[4] The legal framework (civil and criminal) of a jurisdiction is a strong determinant of who receives forensic mental health services and how those services are organized.

For this section, we conducted an international review of the academic and nonacademic literature to examine how forensic services are organized around the world. Studies and reports were first identified by searching Academic Search Complete (EBSCO), ProQuest Central, Scopus, PsycInfo, Google Scholar, and Google. Keywords for the search included: forensic psychiatry, forensic services, forensic service provision, forensic mental health services, insanity defense, and mentally ill offenders, by themselves or with the name of a specific country or region. Selected publications and reference lists were then manually scanned.

Several notable efforts to review forensic systems in different parts of the world have been undertaken (special issue of *International Journal of Law and Psychiatry*, *23*, 2000; Every-Palmer et al., 2014; Mundt et al., 2012; Priebe et al., 2008; Salize, Dressing, & Kief, 2005; Taylor et al., 2013). Our current review brings together information from these previous reviews and adds information from other key

sources such as the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS)[5] reports, as well as stand-alone government reports and scientific papers.

Legal Frameworks

In this section, an overview of forensic services and provisions across four general legal frameworks is provided, including: common law, civil law, the legislation of former Communist countries (Soviet, Soviet-controlled, and the Balkans), and Islamic law. We summarize how they address the main issues of fitness to plead, the mental disorder defense, diminished responsibility, hospital discharge provisions, forensic population composition, and forensic service provision. Additionally, information available in English, French, or Spanish is reviewed to gain insight into issues such as the presence of dedicated forensic institutions, the degree of integration between forensic and general mental health, the centralization of services, the continuity of services at discharge, and the presence of dedicated housing support for the forensic population. It is important to note that the information presented below relies exclusively on academic and nonacademic literature, and is accurate, complete, and up-to-date to the extent that the source documents permitted. Information was readily available for some jurisdictions (e.g., Canada, United Kingdom), but it was scarce for many regions of the world.

Fitness to Plead

COMMON-LAW COUNTRIES

Most common-law countries provide procedures for raising the issue and evaluating the fitness of an accused to stand trial (see Table 1.1), which may bear a different name according to the jurisdiction. Although there are minor variations, most legal tests for unfitness are based on the incapacity to understand the nature and severity of the charges; to understand the nature, objects, or consequences of the proceedings; and to communicate with or instruct a lawyer in a defense (Brinded, 2000; Every-Palmer et al., 2014; Gunn et al., 2013; Mudathikundan, Chao, & Forrester, 2014; Scott, 2007; Taylor et al., 2013). Many jurisdictions factor in the severity of the offense as well as the probability that the accused has committed the offense (e.g., New Zealand, South Africa) in their decisions concerning dispositions following unfitness to stand trial (Taylor et al., 2013).

Jurisdictions use different settings and procedures for conducting fitness assessments or detaining those who are found unfit. In England and Wales, forensic assessments occur most often in prison, but treatment of those detained for reasons of fitness occurs in a general psychiatric facility or a specialized forensic facility (Salize et al., 2005). In South Africa, the assessment generally takes place in a forensic psychiatric hospital (Taylor et al., 2013). In Scotland, the assessment takes place in a hospital (Criminal Procedures Act 2016). In Canada, fitness assessments can take place in a

forensic hospital or jail (Criminal Code of Canada, 1992); when an individual is found unfit to stand trial, jurisdiction is transferred from the court to a provincial or territorial review board, which decides on future dispositions of the case.

It is possible for the duration of detention for persons found unfit to be indefinite (see Table 1.2), but many jurisdictions have special provisions for people who are deemed permanently unfit. In Canada, there are no time limits to the detention in hospital of an unfit accused; however, an individual declared permanently unfit to stand trial who is also judged to be nondangerous may be granted a stay of proceedings by a review board and, subsequently, discharged (Criminal Code of Canada, 1992). In New Zealand, permanently unfit individuals must be brought before court or committed civilly after serving half of the maximum custodial sentence that would have been given for their index offense (or 10 years if the offense is punishable by a life sentence; Taylor et al., 2013). In the United States, if the competency of an accused to stand trial is not restored within a reasonable amount of time, charges must be dropped and the individual must be either released or civilly committed (Bloom, Williams, & Bigelow, 2000; *Jackson v. Indiana*, 1972). In Australia, procedures differ from one jurisdiction to the next. Proceedings may be discontinued in Queensland when an accused is found permanently unfit or unlikely to regain fitness within a certain period. In New South Wales, Victoria, Tasmania, and the Northern Territory, a special hearing to determine guilt and detention will be held if a judge or a jury finds that the accused is unlikely to regain the capacity to stand trial within 12 months (Hunyor, 2012; Jager, 2001; Taylor et al., 2013). Such special hearings do not seem to exist in South Australia and Western Australia: if the accused is found unfit, they will be held indefinitely in a secure hospital and will be tried when they recover sufficiently (Taylor et al., 2013).

CIVIL-LAW COUNTRIES

Since civil law is more inquisitorial and less adversarial in nature than common law, thus leaving defendants with a more passive role, Continental European countries and other jurisdictions that belong to the Roman law heritage do not tend to test fitness to plead (Taylor et al., 2013).

Napoleonic Code legal family. In France and Brazil, accused persons may be tried and judged despite showing symptoms of severe mental illness (Salize et al., 2005; Taborda, Cardoso, & Morana, 2000). In Italy, if a psychiatric expert considers during the inquiry or the pretrial that the accused is ill and the offense is minor, the general attorney might not prosecute them and, instead, may prescribe community services or general psychiatric care. If the offense is serious and the person is considered dangerous, a trial will usually take place, despite the mental illness (Salize et al., 2005). In Chile, an accused who is unable to stand trial will be diverted to a forensic psychiatry network until they are ready to return to trial (Cid, 2010; St. Denis, 2008). Similarly, in Argentina, such individuals are sent to a special institution if their behavior is considered dangerous (Folino, Montero Vazquez, & Sarmiento, 2000).

The forensic assessment takes place in prison in France and Belgium. In Italy, it may take place in prison, in a forensic hospital or in a psychiatric facility. In Spain, the observation for the expert report regarding the mental disorder defense will take place in a psychiatric penitentiary hospital or a psychiatric penitentiary. A defendant suspected to be mentally ill may never be placed in a prison prior to trial in Portugal and the assessment must, instead, take place in a specialized forensic facility (Salize et al., 2005). In Chile, defendant assessment units (penitentiary units within civil hospitals) were recently created to provide forensic assessments (Cid, 2010).

Germanic legal family. Germany uses criteria similar to common-law jurisdictions to determine competence to participate in the trial. In addition, an accused can be found to have 'limited fitness to stand trial,' in which case the trial may proceed in such a way that allows the accused to participate, such as in the presence of a specialist (such as a psychologist), with extended breaks, or with limits on the duration of the proceedings (Edworthy, Sampson, & Völlm, 2016; Rothschild, Erdmann, & Parzeller, 2007). The forensic assessment will be carried out in a public psychiatric hospital or on an ambulatory basis if possible.

Nordic legal family. Sweden, Denmark, and Finland do not have the concept of fitness to plead; however, Finland does have provisions allowing for a forensic psychiatric assessment to determine whether an accused can be heard at the trial (Salize et al., 2005; Taylor et al., 2013).

In Denmark, forensic assessments may take place in a forensic psychiatric facility or in the community. In Finland, it can be carried out in a forensic psychiatric hospital, in forensic psychiatric wards, or in a prison psychiatric ward—rarely, the assessment can be performed based solely on the patient's record (Salize et al., 2005).

Other civil-law jurisdictions. In the Netherlands, fitness to stand trial does not exist in practice (de Ruiter & Hildebrand, 2003; van der Wolf, van Marle, Mevis, & Roesch, 2010). In Taiwan and Japan, fitness to stand trial exists as a legal concept, but is rarely successful. In Japan, mentally disordered offenders are generally not prosecuted, but are rather referred to the forensic mental health services (MTSA process; Every-Palmer et al., 2014; Fujii, Fukuda, Ando, Kikuchi, & Okada, 2014). In China, mentally ill accused may be found unfit to stand trial, in which case they will be referred to a psychiatric hospital or released into the care of the family (Every-Palmer et al., 2014).

FORMER COMMUNIST COUNTRIES

The legal concept of fitness to stand trial was mentioned in the literature for Russia, the Czech Republic, and Bulgaria (Ciszewski & Sutula, 2000; Every-Palmer et al., 2014; Tătaru, Marinov, Douzenis, Novotni, & Kecman, 2010; Vevera et al., 2009). In Russia, if the accused is found unable to stand trial—that is, if they are unable to understand the course of the proceedings or mount a defense—the trial will be suspended and the accused will be hospitalized. If the accused does not regain the capacity to stand trial within a reasonable time, there will be no trial and the accused will remain hospitalized.

Table 1.1 Availability of Fitness to Plead, Mental Disorder Defense, and Diminished Responsibility in Law by Legal Framework and Country

Legal Framework/ Country	*Fitness to Plead*	*Mental Disorder Defense (Insanity)*	*Diminished Responsibility (For Any Offense or For Homicide Only)*
Common Law			
Australia	Yes	Yes	No: SA, TAS, VIC, WA Yes: NSW, QLD, ACT, NT
Botswana	n/a	Yes	n/a
Canada	Yes	Yes	No
England and Wales	Yes	Yes	Yes
Ghana	Yes	Yes	n/a
Hong Kong	Yes	Yes	Yes
India	Yes	Yes	Yes
Ireland	Yes	Yes	Yes
Israel	Yes	Yes	No
Kenya	n/a	Yes	n/a
New Zealand	Yes	Yes	No
Pakistan	Yes	Yes	No
Scotland	Yes	Yes	Yes
Singapore	Yes	Yes	Yes
South Africa	Yes	Yes	Yes
Tanzania	n/a	Yes	No
Uganda	n/a	Yes	n/a
United States	Yes	Most states	Most states
Civil Law – Napoleonic			
Argentina	Yes	Yes	n/a
Belgium	n/a	Yes	No
Brazil	No	Yes	Yes
Chile	Yes	Yes	Yes
France	No	Yes	Yes
Italy	n/a	Yes	Yes
Luxembourg	n/a	Yes	Yes
Portugal	n/a	Yes	Yes
Spain	n/a	Yes	Yes
Civil Law – Germanic			
Austria	No	Yes	No
Germany	Yes	Yes	Yes
Greece	n/a	Yes	Yes
Switzerland	No	Yes	Yes
Turkey	n/a	Yes	n/a
Civil Law – Nordic			
Denmark	No	No	No
Iceland	n/a	Yes	n/a
Finland	No	Yes	Yes

Legal Framework/ Country	*Fitness to Plead*	*Mental Disorder Defense (Insanity)*	*Diminished Responsibility (For Any Offense or For Homicide Only)*
Norway	n/a	Yes	Yes
Sweden	No	No	No
Civil Law – Other			
China	Yes	Yes	Yes
Japan	Yes	Yes	Yes
Netherlands	No	Yes	Yes
Taiwan	Yes	Yes	Yes
Former Communist			
Bulgaria	Yes	Yes	n/a
Croatia	n/a	Yes	n/a
Czech Republic	Yes	Yes	Yes
Hungary	n/a	Yes	n/a
Poland	n/a	Yes	Yes
Russia	Yes	Yes	Yes
Ukraine	n/a	Yes	n/a

Note
n/a indicates that the information was unavailable or not expressly specified in the literature.

Mental Disorder Defense

COMMON-LAW COUNTRIES

The mental disorder or insanity defense is available in most countries belonging to the common-law legal system, though there is wide variation in its application. It is beyond the scope of this review to examine the insanity defense criteria in each country, but most have adopted some form or adapted form of the *M'Naghten* rule (Asokan, 2014; Brinded, 2000; Cheang, 1985; Edworthy et al., 2016; Every-Palmer et al., 2014; Gunn et al., 2013; Hassan, Nizami, & Hirji, 2015; Mullen & Chettleburgh, 2002; Shaidi, n.d.; Shea, 2001; Thomson, 2008; Yannoulidis, 2012; Yeo, 2008), sometimes with a volitional component. While most states in the United States do carry some version of insanity defense, Idaho, Kansas, Montana, and Utah have abolished this defense completely (Bureau of Justice Statistics, 2004; Greenberg & Felthous, 2007). Many states have adopted the ALI standard for the insanity defense, which comprises a volitional component (*American Law Institute: Model Penal Code*, 1962).

While a psychopathic disorder is grounds for a treatment sentence in England and Wales, it is not the case in most common-law jurisdictions. In Scotland, for example, despite the existence of a specific legal category allowing the commitment of people with a psychopathic disorder, there are, in practice, very few that are detained (Darjee & Crichton, 2003; Gunn et al., 2013). In Canada, personality disorders do not qualify for a defense of not criminally responsible (Sparr, 2009) and,

as a general rule, they do not qualify either in Australia and the United States; although the fact that states are autonomous on this matter gives rise to exceptions and ambiguities (Greenberg & Felthous, 2007). Personality disorders are excluded in the American states that have adopted the ALI test, as well as in a handful of other states, including Arizona, Colorado, California, New Mexico, and Oregon (Greenberg & Felthous, 2007). In New Zealand, the Mental Health Act excludes personality disorders, but this may differ in practice (Brinded, 2000). Most jurisdictions do not restrict the mental disorder defense to serious or violent offenses; however, in many countries the forensic populations are comprised mainly of people who have committed violent offenses (e.g., New Zealand, South Africa, India, Zimbabwe: Chadda, 2013; Marais & Subramaney, 2015; Mellsop et al., 2016; Menezes, Oyebode, & Haque, 2009; Skipworth, Brinded, Chaplow, & Frampton, 2006; Strydom et al., 2011), but this is not reflected in the forensic populations of other countries (e.g., Canada: Crocker, Nicholls, Seto, Charette, et al., 2015b).

Dispositions available to the accused found not criminally responsible due to mental disorder vary from absolute discharge to hospital detention. In several American states a treatment order is mandatory (Bureau of Justice Statistics, 2004). In England and Wales, forensic services may be provided for individuals with personality disorders or mental impairments who have been found guilty of an offense and sentenced to mandatory treatment, known as a hospital order (Salize et al., 2005). Some jurisdictions adapt the dispositions to the seriousness of the offense. In the Australian Capital Territory, for example, if the offense is serious (i.e., involving actual or threatened violence or endangering life) the court must give a custodial order. If the offense is minor, the court can make other orders, as appropriate (Williams, 2000).

CIVIL-LAW COUNTRIES

Napoleonic Code legal family. Criminal irresponsibility owing to a mental disorder exists as a legal concept in most countries belonging to the Napoleonic Code legal family. The criterion for criminal responsibility is not entirely dissimilar to the *M'Naghten* rule, with most countries adopting a variation that includes a volitional prong (Folino et al., 2000; Salize et al., 2005; Taborda et al., 2000; Téllez, Arboleda-Flórez, Ortiz, & Navarro, 2004).

Personality disorders are excluded from the insanity defense in France and in Italy, but they are accepted, with different levels of success, in Belgium, Luxembourg, Brazil, Portugal, and Spain (Salize et al., 2005; Taborda, 2001). In terms of offense, the index offenses are mostly severe and against a person in Italy and Brazil (Russo, Salomone, & Della Villa, 2003; Taborda et al., 2000).

In France, offenders found not criminally responsible on account of mental disorder who are not considered a risk to society can be committed through an 'admission en soins psychiatriques à la demande d'un tiers' placement. If they are considered socially dangerous, they will receive an 'hospitalisation d'office' placement, which

requires mandatory assessment prior to release (Salize et al., 2005). Similarly, countries such as Portugal detain all convicted mentally ill offenders lacking criminal responsibility in specialized facilities (e.g., forensic units: Cartuyvels, Champetier, & Wyvekens, 2010; Salize et al., 2005). Brazil and Chile offer outpatient treatment to mentally ill offenders who are not considered harmful, in replacement of inpatient forensic detention (Cid, 2010; Taborda et al., 2000). In Spain, forensic patients may be placed under security arrangements, such as being detained in a psychiatric penitentiary hospital (Salize et al., 2005).

Germanic legal family. In Germany, mentally disordered accused persons can be considered not criminally responsible if they are "incapable of recognizing the injustice of the criminal act or unable to act according to this insight" (Müller-Isberner, Freese, Jöckel, & Gonzalez Cabeza, 2000). Austria, Switzerland, and Greece have also adopted a test based on cognition and volition (*Code pénal suisse*, 1937; Salize et al., 2005; R. J. Simon & Ahn-Redding, 2006; Tătaru et al., 2010). In Austria and Germany, mentally ill offenders with lack of criminal responsibility will be acquitted; however, if they are still dangerous due to their illness they will receive a criminal commitment (Edworthy et al., 2016; Schanda, Ortwein-Swoboda, Knecht, & Gruber, 2000). In Switzerland, mentally ill offenders are also acquitted but they can be given a hospital disposition only if (1) there was a direct connection between the illness and the offense; (2) they are at high risk of relapse; (3) their disorder is treatable; and (4) their prognosis is likely to improve with treatment. If they are not socially dangerous, the treatment may take place on an outpatient basis (Graf & Dittmann, 2007). In Greece, if the person is a danger to the public they will receive guardianship in a public hospital (Salize et al., 2005).

Severe personality disorders are included in the insanity defense in Germany, Austria, and Greece. In Germany, nearly 37 percent of the patients in forensic psychiatric hospitals have a primary diagnosis of personality disorder (Konrad, 2005), and around 85 percent have committed a serious offense (Müller-Isberner et al., 2000). In Austria, 40 percent of people found NGRI had committed an offense of homicide or severe bodily injuries (Schanda et al., 2000).

Nordic legal family. Denmark and Sweden are similar in that criminal responsibility does not exist as a legal concept. Rather, the mental state at the time of the offense is taken into consideration at the time of the sentencing (Taylor et al., 2013). In Iceland, the mentally disordered offender is found innocent (Pálsson, n.d.). The Norwegian legal system adopts a medical principle where the mere presence of psychosis at the time of the offense is sufficient to find an offender not criminally responsible (Måseide, 2012). In Finland, a person cannot be held criminally responsible if they were unable to understand the nature of the act or to control their behavior. Dispositions that are available for mentally ill offenders vary according to the risk they pose to society and the severity of the offense. In Denmark, a mentally ill offender found guilty can be given psychiatric treatment on an outpatient basis, on an inpatient basis, or as a patient in a psychiatric maximum-security institution, depending on whether they are given a treatment order or a placement order,[6] whereas in Sweden offenders are sentenced to forensic care with

most (about 80 percent) requiring a special assessment prior to discharge. In Finland, after an offender is found not criminally responsible, the jurisdiction passes on to the Authority for Medico-Legal Affairs (TEO), which issues a treatment order (Salize et al., 2005).

Finland excludes personality disorders from the mental disorder defense, and Denmark excludes them from the possibility of receiving a special provision (Kramp & Gabrielsen, 2009; Salize et al., 2005). In Sweden, where all are criminally responsible, an offender with a personality disorder may be sentenced to forensic care; however, efforts have been taken to reduce the number of offenders sentenced to forensic treatment (Belfrage & Fransson, 2000). In practice, almost all forensic psychiatric examinations in Finland take place for serious violent crimes (Eronen, Repo, Vartiainen, & Tiihonen, 2000).

Other civil-law jurisdictions. Criminal responsibility is a legal concept in the Netherlands, China, Taiwan, and Japan, although it is rarely used in Japan due to the principle of discretionary prosecution (Every-Palmer et al., 2014; Fujii et al., 2014; Hu, Yang, Huang, & Coid, 2011; Mellsop et al., 2016). While China, Taiwan, and Japan have adopted the cognition and volition prongs that are widespread in the civil-law tradition, the Netherlands does not have a standard for legal insanity (Radovic, Meynen, & Bennet, 2015). TBS-orders (disposals to be involuntarily admitted to a specialized maximum-security hospital on behalf of the state: de Ruiter & Hildebrand, 2003) are available to mentally ill offenders in the Netherlands who have committed a serious and violent offense and who are dangerous to others. Other offenders, whose offense was less severe but are still dangerous to themselves or others, are given a hospital order and admitted to forensic psychiatric hospitals or general psychiatric hospitals (de Ruiter & Hildebrand, 2007; Salize et al., 2005). In Japan, mentally ill offenders can be hospitalized, given outpatient treatment or released, while in Taiwan they will be put in criminal custody if they are a threat to public safety, which can translate into detention in a mental or general hospital, in charity group facilities, or under the next of kin (Every-Palmer et al., 2014). Two-thirds of mentally ill offenders in China are released to the family, who will be responsible for the arrangement and supervision of the treatment, although outpatient and inpatient treatment orders are also available (Gao, Reid, & Li, 2011; Hu et al., 2011; Wang et al., 2007; Zhao & Ferguson, 2013).

The Netherlands accepts personality disorders for the insanity defense, and about 80 percent of patients under a TBS-order have been diagnosed with a personality disorder as a primary or comorbid diagnosis (de Ruiter & Hildebrand, 2003; Salize et al., 2005; van Beek & Kröger, 2007). In China, personality disordered offenders are excluded from the defense. In Japan, offenders with personality disorders are not excluded from the insanity defense, but they are rarely successful, comprising only 1 percent of individuals under inpatient treatment order (Fujii et al., 2014; Kuo, 1983; Zhao & Ferguson, 2013).

The insanity defense is used for severe offenses against a person in the Netherlands, in Japan, and in China (Edworthy et al., 2016; Every-Palmer et al., 2014; Zhao & Ferguson, 2013). A study found that 57 percent of a Chinese cohort of persons found not criminally responsible had committed or attempted to commit

murder (Wang, Livingston, Brink, & Murphy, 2006). In the Netherlands, for a judge to impose a TBS-order the offense committed must result in an imprisonment sentence of at least four years in cases where the offender is fully responsible (Edworthy et al., 2016).

FORMER COMMUNIST COUNTRIES

Criminal responsibility is a legal concept in many former Communist countries (Ciszewski & Sutula, 2000; Douw et al., 2015; Every-Palmer et al., 2014; Margetić, Ivanec, Zarković Palijan, & Kovacević, 2012; Mellsop et al., 2016; Ruchkin, 2000; R. J. Simon & Ahn-Redding, 2006; Tătaru et al., 2010; Vevera et al., 2009). Most of these countries have criteria that contain a cognitive and a volitional prong, such as in Russia, Poland, Hungary, and Bulgaria (Ciszewski & Sutula, 2000; Ruchkin, 2000; R. J. Simon & Ahn-Redding, 2006). In Croatia, offenders with a primary diagnosis personality disorder do not generally have access to the insanity defense (Margetić et al., 2012; R. J. Simon & Ahn-Redding, 2006).

Dispositions available to mentally ill offenders found not criminally responsible are usually comprised of some variations of inpatient treatment, although Russian and Bulgarian courts may also order outpatient compulsory psychiatric treatment (Ruchkin, 2000; Tătaru et al., 2010). In Croatia, an offender found not criminally responsible will be sent to a forensic hospital and treated under the civil law (Margetić et al., 2012). In Poland, the offender will be detained in a psychiatric hospital under a 'protective measure' if the offense is considered seriously socially harmful and the risk of recidivism is high (Ciszewski & Sutula, 2000). In the Czech Republic, offenders who are socially dangerous will receive 'forensic protective treatment' (Vevera et al., 2009).

ISLAMIC LAW COUNTRIES

Criminal responsibility as a legal concept is present in many Islamic countries, but little information is available on the exact processing and treatment of individuals (El Hamaoui, Moussaoui, & Okasha, 2009; Elsayed, Al-Zahrani, & Rashad, 2010; Milner, 1966; Muslim & Chaleby, 2007; Qureshi, Al-Habeeb, & Koenig, 2013). In Iraq, the insanity defense is primarily used for offenses punishable by death and is primarily used for people with schizophrenia (Muslim & Chaleby, 2007).

Diminished Responsibility

COMMON-LAW COUNTRIES

The availability of diminished responsibility for offenses other than homicide is not widespread in the common-law legal system. Generally, a plea of diminished responsibility can be effective when the defendant argues that, while they did commit the offense, they should not be held fully criminally liable owing to the

partial impairment of their mental state (Every-Palmer et al., 2014). Since the only sentence available for murder in many common-law jurisdictions is life imprisonment, reducing the category of crime from murder to manslaughter allows to impose a lighter sentence to those whose mental disorder played a substantial role in their offense (Salize et al., 2005).

CIVIL-LAW COUNTRIES

Napoleonic Code legal family. Diminished responsibility is available in many countries within this legal system, which typically results in a diminished sentence (Davidson, 2015; Salize et al., 2005; St. Denis, 2008). In addition to diminished responsibility, Portugal has three other levels of responsibility: full responsibility, slightly diminished responsibility, and lack of responsibility. In Italy, two options are available following a finding of diminished responsibility: (1) the sentence can be mitigated by one-third, or (2) the offender can receive inpatient treatment for half the period imposed if they completely lacked responsibility and then serve the remaining half in prison. In Spain, judges can also order a forensic placement prior to the imprisonment, but, in the event that the forensic placement yields good results, the imprisonment can be suspended. There is variability with respect to whether forensic treatment occurs before (e.g., Italy, Portugal), during (e.g., Luxembourg, Spain), or after (e.g., France) a person's imprisonment.

Germanic legal family. In Germany, diminished responsibility may result in a sentence of incarceration and indeterminate treatment if the offense was serious and the criminal acts were symptomatic of the disorder. The time spent in hospital is set against the imprisonment sentence (Edworthy et al., 2016; Müller-Isberner et al., 2000; Salize et al., 2005). Similarly, in Switzerland a mentally ill offender with reduced responsibility will receive a decreased sentence and possibly a hospital disposition (Graf & Dittmann, 2007). In Greece, the offender will be detained in a forensic hospital or imprisoned if they are dangerous to the public; however, their sentence will be reduced (Salize et al., 2005; Tătaru et al., 2010).

Nordic legal family. In Finland, a mentally ill offender found to have diminished criminal responsibility will receive a sentence reduced by 25 percent, and cannot receive a life sentence; however, treatment cannot be imposed by the court (Eronen et al., 2000; Salize et al., 2005).

Other civil-law jurisdictions. The Netherlands has five levels of criminal responsibility; 'partially' responsible offenders can receive a TBS-order if the severity of the offense and the risk to society justifies it, often in addition to a prison sentence. The forensic care most often takes place after the imprisonment and, while the time spent in an institution can be counted toward the imprisonment sentence, the offender must serve at least one-third of their sentence (de Ruiter & Hildebrand, 2007; Salize et al., 2005). In China and Japan, the offender will receive a lighter sentence or compulsory treatment (Every-Palmer et al., 2014; Fujii et al., 2014; Hu et al., 2011; Mellsop et al., 2016). In Taiwan, they can receive criminal custody after their prison term or be granted pardon (Every-Palmer et al., 2014).

FORMER COMMUNIST COUNTRIES

In Russia, diminished responsibility may be argued when an individual was not able, on account of mental disorder, to completely realize the nature of his or her actions or to completely control them. In this situation, the court must take into account the mental disorder when ordering a sentence, and, if they are still considered a danger to others or to themselves, they may receive an outpatient treatment order (Ruchkin, 2000). In Poland, mentally ill offenders with seriously limited accountability may receive lighter penalties, but may only receive treatment in prison (Ciszewski & Sutula, 2000). In the Czech Republic, individuals with diminished responsibility will be sentenced to both prison and forensic protective treatment, with the forensic care occurring most often after the imprisonment (Vevera et al., 2009).

Discharge Provisions

COMMON-LAW COUNTRIES

Discharge from hospital following treatment in forensic institutions may be the responsibility of various entities and is more or less centralized, depending on the jurisdiction. On one end of the spectrum, the discharge of mentally ill offenders requires ministerial assent (e.g., New Zealand, several Australian states: Brinded, 2000; Mullen & Chettleburgh, 2002). On the other end of the spectrum, this responsibility lies with the treating psychiatrist or hospital, sometimes unless the offense was serious or violent (e.g., England: Salize et al., 2005). The responsibility for making discharge decisions may also rest with the courts or administrative tribunals (e.g., Canada, Ireland, Israel; see Table 1.2 for a review: Bauer, Rosca, Grinshpoon, Khawalled, & Mester, 2005; Every-Palmer et al., 2014; Gordon, Kirchhoff, & Silfen, 1996; Hands, 2007; Queensland Government, 2012; Salize et al., 2005).

The duration of detention also varies across jurisdictions; it can be indefinite or fixed. In some jurisdictions, such as Ireland and some Australian states and territories (Hands, 2007; Hunyor, 2012; O'Donahoo & Simmonds, 2016; Salize et al., 2005), the length of the hospitalization is related to the seriousness of the offense. For example, a nominal term based on the maximum imprisonment sentence possible for the same offense may be set to prevent arbitrary and indefinite detention. The review of detention occurs most often every six months in the common-law legal system (Bauer et al., 2005; Brinded, 2000; Every-Palmer et al., 2014; Salize et al., 2005; Sarkar & Dutt, 2006). In Canada, however, the detention must be reviewed at least every year, every three years if the offender is designated a 'high-risk accused.'

ROMAN LAW COUNTRIES

Napoleonic Code legal family. Discharge can be the responsibility of the court (e.g., Spain, Portugal, Brazil, Argentina: Salize et al., 2005; R. J. Simon & Ahn-Redding,

Table 1.2 Hospital Discharge Provisions by Legal Framework and Country

Legal Framework/Country	*Duration and Frequency of Review*	*Authority Regarding Discharge*
Common Law		
Australia	State-specific	State-specific (ministerial assent or Mental Health Review Tribunal)
Canada	Unlimited, reviewed every year (every three years if 'high-risk accused')	Provincial/Territorial Review Board
England and Wales	Six months (must be renewed after six months, then annually)	Treating psychiatrist/hospital (unless restriction order)
India	Reviewed every six months	Court
Ireland	Related to seriousness of the offense, reviewed every six months	Mental Health Review Board
Israel	Reviewed every six months	Regional psychiatric board
New Zealand	n/a	Ministerial assent
Scotland	Six months (must be renewed after six months, then annually)	Mental Health Tribunal
Singapore	Reviewed every six months	Visitors board of independent psychiatrists and members of the public
South Africa	n/a	Treating hospital (ministerial assent if index offense was violent)
United States	n/a	Court (most states)
Civil Law – Napoleonic		
Argentina	n/a	Court
Belgium	Reviewed every six months	Social Protection Committee
Brazil	Minimum duration imposed by judge	Court

France	Reviewed every six months	'Hospitalisation d'office': Two different experts (mandatory assessment for release) 'Hospitalisation à la demande d'un tiers': Psychiatrist from treating facility
Italy	Minimum duration depends on severity of the crime	n/a
Luxembourg	Review two months after admission, then each year	Special commission
Portugal	Limited, based on diagnosis, severity of the offense, and clinical state, review at any time as required by the patient or the public prosecutor but at least every two years	Court
Spain	Reviewed every six months	Court
Civil Law – Germanic		
Austria	Unlimited, reviewed at least once a year	Court
Germany	Unlimited, but must be related to severity of the offense; reviewed at least once a year	Court
Greece	Minimal duration established (lower than half the maximum sentence for the offense), reviewed every 2 years after minimal duration (detention cannot continue beyond 10 years for misdemeanors or 15 years for felonies)	Court
Switzerland	Unlimited	n/a
Turkey	n/a	Court
Civil Law – Nordic		
Denmark	Placement order: Unlimited, reviewed at least five years after sentence, then every second year Treatment order: Time-limited (three or five years, can be extended by court order), reviewed every year	Placement order: Court Treatment order: Psychiatrist

continued

Table 1.2 Continued

Legal Framework/Country	*Duration and Frequency of Review*	*Authority Regarding Discharge*
Finland	Unlimited, reviewed every six months	Final decision by the Authority of Medico-Legal Affairs (TEO)
Iceland	Depends on psychiatric state, reviewed after a year	Court
Norway	Unlimited	n/a
Sweden	Reviewed every six months	Court
Civil Law – Other		
China	Unlimited	Treating psychiatrist (with approval of local police station)
Japan	Every six months	Court
Netherlands	Two years, then extended for one or two years each time, independent expert report every six years	Court
Taiwan	Limit of five years	n/a
Former Communist		
Bulgaria	Every six months	Court
Croatia	Depends on psychiatric state, should not exceed upper limits of imprisonment	n/a
Czech Republic	Unlimited	n/a
Poland	Unlimited, reviewed at least every six months	Court
Russia	Limit is duration of the sentence, reviewed after six months, then annually	Court
Ukraine	Related to nature of the offense	n/a

Note
n/a indicates that the information was unavailable.

2006; Taborda et al., 2000) or of special commissions or committees (e.g., Belgium, Luxembourg: Salize et al., 2005). There is variation within this group of countries regarding whether the length of hospitalization should be related to the severity of the offense or to the treatment needs and safety issues. In Italy, the severity of the crime determines the minimum duration of the hospitalization. However, if the individual is no longer considered dangerous it is possible to transform the order into an outpatient treatment order or even to revoke it (Traverso, Ciappi, & Ferracuti, 2000). In Brazil, the judge imposes a minimum duration to the treatment, regardless of what the most appropriate interventions are, but a maximum duration is not imposed (Taborda, Folino, & Salton, 2007). In Portugal, the placement for treatment is time-limited and the duration is established based on the diagnosis, the severity of the offense, and the clinical needs of the individual (Salize et al., 2005).

Germanic legal family. In countries belonging to the Germanic legal family, the discharge decisions are most often made by a court. The hospital order tends to be unlimited in time (e.g., Austria, Germany, Switzerland: Edworthy et al., 2016; Graf & Dittmann, 2007; Müller-Isberner et al., 2000; Schanda et al., 2000). In Germany, the length of the commitment must be related to the severity of the offense: the patient's right to be released intensifies as the length of hospitalization increases (Müller-Isberner et al., 2000). In Greece, the court will establish a minimum duration, and the hospitalization will not be allowed to continue beyond 10 years for misdemeanors or 15 years for felonies (Salize et al., 2005).

Nordic legal family. In Denmark, the decision to discharge rests with the treating psychiatrist for cases in which the accused received a treatment sanction instead of a placement sanction (in which case the decision rests with the court); the same is true in Finland, although the decision must be approved by the Authority of Medico-Legal Affairs (the TEO: Kramp & Gabrielsen, 2009; Sestoft & Engberg, 2000). A court must make discharge decisions in Iceland and in Sweden, where, if the accused were considered to pose a risk to society at the time of the verdict, they may only be released after trial in a county administrative court (Sigurjónsdóttir, n.d.; Silfverhielm, 2005). The duration is unlimited in Denmark, Finland, and Norway (Eronen et al., 2000; Kleve, 1996; Sestoft & Engberg, 2000).

Other civil-law jurisdictions. A court is responsible for discharges in the Netherlands and in Japan, but the treating psychiatrist decides with approval from the local police station in China (de Boer & Gerrits, 2007; de Ruiter & Hildebrand, 2003; Edworthy et al., 2016; Fujii et al., 2014; Hu et al., 2011). In the Netherlands, a TBS-order is initially imposed for two years and may be extended for one or two years at each reassessment. When the risk of recidivism has decreased to an acceptable level, the TBS-order must be terminated. After six years of detention, a forensic report written by two independent experts must be submitted to inform the court of the individual's mental state and risk of recidivism (de Ruiter & Hildebrand, 2007; Edworthy et al., 2016; Salize et al., 2005). In Taiwan, the maximum duration of criminal custody for offenders found not criminally responsible is five years (Every-Palmer et al., 2014). The treatment order is unlimited in China, but the

average stay is one to three months before they are released under the care of their family (Chen, Ou, & Wang, 2013; Topiwala, Wang, & Fazel, 2012).

FORMER COMMUNIST COUNTRIES

The decision to discharge from forensic services belongs to the court in Russia and Poland (Ciszewski & Sutula, 2000; Ruchkin, 2000; Vevera et al., 2009). In Russia, the duration of the detention is restricted to the duration of the sentence. In Croatia, it depends on the mental state of the patient, with the maximum duration of treatment not exceeding the upper limits of imprisonment unless there is a serious risk of recidivism. In Ukraine, the duration of treatment is mostly related to the nature of the offense instead of the patient's mental state or social risk (Douw et al., 2015; Margetić et al., 2012; Ruchkin, 2000). The duration of forensic treatment is unlimited in Poland and the Czech Republic (Ciszewski & Sutula, 2000; Vevera et al., 2009).

Forensic Mental Health Service Provision

Common-Law Countries

EUROPE AND THE UNITED KINGDOM

In England and Wales, forensic services are organized by level of security and are provided by the National Health Service (NHS) or the private sector. Hospitals and wards are not divided into forensic and nonforensic; as such, offenders and aggressive nonoffenders may be treated on the same wards. There are three high-security hospitals (sometimes called 'special hospitals'). They provide services to individuals who are formally detained under the mental health legislation and who present a grave and immediate danger to the public (McMurran, Khalifa, & Gibbon, 2009). Medium-security units receive patients who present a risk to others. Patients who have committed minor offenses are treated in general psychiatric hospitals, where about 3,700 beds belong to the NHS (National Health Service, 2013). Forensic services are delivered through five distinct forensic care pathways, which have been developed in order to ensure that patients' needs are met at the right time and that care decisions are evidence-based (Care Pathways and Packages Project, 2009).

In Ireland, forensic services are organized by levels of risk and security, and admit mentally ill offenders and nonoffenders. High-security forensic units provide treatment to patients who pose a grave and immediate danger to others. The National Forensic Mental Health Service (NFMHS) is based at the Central Mental Hospital Dublin, with a capacity of about 90 secure beds, some of which are available to women offenders, distributed across three levels of security. Other mentally ill offenders may be treated in psychiatric centers and in district or private psychiatric hospitals. Regional forensic mental health teams are established to support continuity of care. Housing support is put in place by the NFMHS recovery and

rehabilitation team, as patients first move to a low-security hostel situated near the Central Mental Hospital (Mental Health Commission, 2006; O'Neil, 2012; Salize et al., 2005; Taylor et al., 2013).

In Scotland, forensic services are also organized by level of security and are provided by the National Health Service (NHS), under the coordination of the Forensic Mental Health Services Managed Care Network. Offenders and nonoffenders are treated on the same wards. High-security services, for those who present a grave and immediate danger to others, are provided nationally at the State Hospital in Carstairs (Forensic Network, 2016; McMurran et al., 2009; Thomson, 2016). Medium-security services, for patients who pose a serious but less imminent danger to others, are delivered regionally (Crichton et al., 2004; Forensic Network, 2016; Thomson, 2016). Finally, low-security services and community services are offered locally. Women requiring high-security services are transferred to England and are detained at Rampton Hospital, while women requiring medium-security services may be treated at the Rowanbank Clinic and at the Orchard Clinic.

AUSTRALASIA AND NORTH AMERICA

In Australia, the jurisdiction of mental health services belongs to each state and, hence, the organization of forensic services varies from one region to the next. For example, New South Wales's forensic facilities are under the authority of the Justice and Forensic Mental Health Network. Forensic services are delivered in correctional, inpatient, and community settings with one high-security facility as well as medium-security facilities that are operated by local health districts (Mental Health Coordinating Council, 2015). In South Australia, forensic services are delivered in a forensic hospital by Forensic Mental Health Services, a component of the Statewide Mental Health Service, but all patients are under the administrative control of the Department of Correctional Services (Jager, 2001). In Victoria, Forensicare[7] provides forensic psychiatric services at the Thomas Embling Hospital (Jager, 2001; Mullen et al., 2000). Continuity of care is ensured by transferring discharged service users to the Community Forensic Mental Health Services, where they receive assertive follow-up and the support of a case manager for approximately two to three years (O'Donahoo & Simmonds, 2016). In the Australian Capital Territory, forensic mental health services are under the responsibility of the Corrections Health Board and they are provided in dedicated, secure beds of a psychiatric unit. In the Northern Territory, inpatient forensic services are primarily delivered within the prison system (Jager, 2001).

In New Zealand, forensic services are decentralized, regionally configured, with no overarching organization and are entirely integrated to civil mental health services. All regions provide medium-security services and most also operate low-security units. Most of these forensic services offer outpatient services for those that have been discharged but are not ready yet to be transferred to general mental health services, with the exception of Auckland Regional Forensic Service, which

transfers discharged service users to general mental health services with liaison services from the forensic system (Brinded, 2000; Ministry of Health, 2007).

Canada is much like Australia, in that there is no national structure of forensic services and the organization of forensic and general mental health is a provincial or territorial responsibility and part of the public health system (Crocker, Nicholls, Seto, Charette, et al., 2015a; Livingston, 2006). In addition to their core services, most forensic services also offer support and treatment to mentally disordered offenders in provincial prisons.[8] Models for organizing forensic services in Canada vary from a highly centralized, integrated network of forensic mental health services in British Columbia (BC Mental Health & Substance Use Services, 2013; Livingston, 2006), to a small number of dedicated forensic facilities in Ontario to highly distributed regional services in Québec (Crocker, Nicholls, Côté, Latimer, & Seto, 2010). All provinces have a high-security facility, or forensic units in psychiatric hospitals for less populous provinces. Supportive housing is available but limited across the country (Livingston, Wilson, Tien, & Bond, 2003; Salem et al., 2015).

In the United States, forensic service provision varies widely from one state to the other; however, they are all part of the public mental health systems. A survey conducted by the National Association of State Mental Health Program Directors indicates that approximately two-thirds of the states have a dedicated forensic facility, with the remaining states treating forensic patients in either forensic or nonforensic units located in general psychiatric facilities. Eighty percent of states have established conditional release programs that aim to facilitate the reentry and reintegration of forensic service users into the community (Fitch, 2014).

ASIA

Many Asian countries have a number of dedicated forensic beds in psychiatric hospitals or forensic inpatient units (World Health Organization, n.d.). Hong Kong's forensic services are under the authority of the Department of Forensic Psychiatry. Inpatient treatment is delivered in forensic wards and a Community Reintegration Unit offers predischarge services to ensure successful community reintegration for mentally ill offenders. Community services for discharged forensic service users are provided by forensic outpatient clinics, forensic community services, and a multiactivity center (Every-Palmer et al., 2014). In India, patients found not guilty by reason of insanity may be detained in 'safe custody,' which most often results in being detained in a prison, but sometimes includes detention in a psychiatric hospital or under the charge of family members. In Bangalore, forensic inpatient treatment is delivered in a male forensic psychiatric ward embedded within the National Institute of Mental Health and Neurosciences in Bangalore, or in psychiatric hospitals, where forensic and civil psychiatric patients are treated together (Kumar et al., 2014; Sarkar & Dutt, 2006). In Israel, forensic services are provided by four departments of a designated maximum secure unit of the Sha'ar Menashe Mental Health Center; there are no medium- or low-security units (Bergman-Levy, Bleich, Kotler, & Melamed, 2010). In Pakistan, some psychiatric hospital beds are dedicated

to forensic patients, but they are distinct from general psychiatric services and administrated by the prisons (Hassan et al., 2015). In Singapore, the Institute of Mental Health Department of Forensic Psychiatry (originally named Woodbridge Hospital), under the authority of the Ministry of Health, receives mentally disordered offenders (Chan & Tomita, 2013; Every-Palmer et al., 2014). Information for Bangladesh, Kyrgyzstan, and Myanmar is provided in Table 1.3.

OTHER COMMON-LAW JURISDICTIONS

In the common-law Caribbean countries, forensic services are likely to be provided in psychiatric hospitals (Maharajh & Parasram, 1999; World Health Organization, n.d.) or sometimes in a forensic unit (e.g., Jamaica). Information for Barbados and Trinidad and Tobago is provided in Table 1.3.

Forensic services are significantly underdeveloped in Africa (Ogunwale, De Wet, Roos, & Kaliski, 2012). There is variability across countries, with many having only rudimentary services provided in prisons. Some African countries have established forensic beds or units in psychiatric hospitals, with dedicated forensic institutions being instituted in South Africa and a few North African countries (Adjorlolo, Chan, & Mensah Agboli, 2016; Hooper & Kaliski, 2010; Mangezi & Chibanda, 2011; Menezes, Oyebode, & Haque, 2007; Strydom et al., 2011; World Health Organization, n.d.). Information for Ghana, Nigeria, Uganda, and Zambia is provided in Table 1.3.

According to the World Health Organization, there are no forensic facilities in the following countries: Anguilla, Antigua & Barbuda (as of 2009, four forensic patients were detained in the psychiatric hospital), Belize, Bhutan (some beds in prison medical services), British Virgin Islands (patients treated in prisons or in general hospitals), Cayman Islands (treated in prisons), Grenada, Nepal, Saint Kitts and Nevis (detained in designated prison cells), Saint Lucia, St. Maarten, and Turks & Caicos Islands.

Civil-Law Countries

EUROPE

The Austrian forensic system is centralized and forensic institutions are under the responsibility of the Ministry of Justice. Mentally ill offenders may be treated in a high-security forensic hospital (male only), in small forensic departments within civil psychiatric hospitals, or in closed wards of regional psychiatric hospitals. Forensic outpatient services are available after discharge in a large forensic aftercare institution in Vienna and in forensic outpatient clinics, but continuity of care depends mostly on civil psychiatric services (Salize et al., 2005; Schanda et al., 2000; Stompe, Frottier, & Schanda, 2007).

In Belgium, forensic services are federalized and, as such, there are large disparities between the organization of care in Wallonia (primarily French-speaking), and

Flanders (primarily Dutch-speaking). In Wallonia, mentally ill offenders found not criminally responsible may be held in three types of institutions, without any overarching authority: psychiatric units in prison, institutions of social defense (*établissement de défense sociale*; EDS), and rarely used civil psychiatric hospitals for patients awaiting discharge (Cartuyvels et al., 2010). EDS are not centralized and may either be overseen by the Department of Justice or by the Department of Health (Cartuyvels et al., 2010; Cartuyvels & Cliquennois, 2015; Mary, Kaminski, Maes, & Vanhamme, 2011). In Flanders, there were no EDS until very recently, and mentally ill offenders found not criminally responsible were instead held in civil psychiatric hospitals and psychiatric units in prison (Salize et al., 2005). In 2010, it was estimated that two-thirds of forensic patients could be found in civil psychiatric wards, and the remaining third in the correctional system (Cartuyvels et al., 2010). Given this context, two EDS were planned for: one forensic institution was opened in Gand in 2014 and another is planned for 2016 in Anvers. Medium-risk patients are still handled in civil psychiatric hospitals (Cartuyvels et al., 2010; Cartuyvels & Cliquennois, 2015; "Centre de psychiatrie légale Anvers," n.d., "Centre de psychiatrie légale Gand," n.d.).

In Denmark, forensic services are locally-based: each county, as well as the municipalities of Copenhagen and Frederiksberg, are responsible for providing the services to their residents. Many counties treat all forensic patients within the civil psychiatric system. While some have put in place small forensic units for patients that are difficult to treat, others have large forensic facilities where most forensic patients are treated and receive outpatient services upon discharge. There is one high-security facility (Salize et al., 2005; Sestoft & Engberg, 2000). In Finland, forensic services are offered in psychiatric hospitals operated by the state or health care districts, some of which have a forensic ward. State psychiatric hospitals receive both mentally ill offenders and dangerous high-risk nonoffenders. After six months, a patient's municipality of residence must decide whether their local health care facilities are able to continue the treatment or if they will continue paying for the offender to receive services in state psychiatric hospitals. In cases where the mentally ill offender is not considered at high risk of violence, the Authority of Medico-Legal Affairs (TEO) might send the offender directly to a local psychiatric hospital, some of which have a dedicated forensic ward. The patient will have to consult a psychiatrist of the municipal mental health center on a monthly basis for the first six months following the discharge and will then be considered a civil psychiatric patient, with no obligations, unless the TEO renews the follow-up period (Eronen et al., 2000; Salize et al., 2005).

In France, as of 2005, forensic patients may be treated in one of the four secure units in psychiatric hospitals (*unités pour malades difficiles*), along with dangerous nonoffenders (Salize et al., 2005). In Germany, forensic services are federalized and are thus organized differently across the country. Mentally ill offenders can generally be treated either in general psychiatric hospitals and facilities, with or without a forensic department, or in forensic psychiatric hospitals that are distinct from the civil psychiatric services (Steinert, Noorthoorn, & Mulder, 2014). Forensic hospitals receive only mentally ill offenders: aggressive or violent mentally ill nonoffenders

are not treated there. When there are forensic bed shortages, forensic patients are sometimes placed in general psychiatric facilities, alongside both voluntarily placed and involuntarily placed nonoffenders. Some of these are high-security hospitals that take specifically the most serious and dangerous offenders. But, in most of the German states, a single forensic hospital comprises all levels of security (e.g., Haina Forensic Psychiatric Hospital: Edworthy et al., 2016; Kamara & Müller-Isberner, 2010). As probation conditions, the court can order a person to present themselves to outpatient treatment or receive aftercare from forensic outpatient centers. All 16 states operate forensic outpatient centers (Edworthy et al., 2016; Konrad & Lau, 2010; Müller-Isberner et al., 2000; Salize et al., 2005).

Greece has a high-security forensic psychiatric hospital in Athens for male offenders and high-risk nonoffenders detained under civil legislation; those who are judged less dangerous are held in one of the six general psychiatric hospitals with forensic beds. Women have no forensic facilities, so they are either treated in the female prison or in psychiatric hospitals. The Greek forensic setting is not considered to be integrated with the national health system (Salize et al., 2005).

In Iceland, Sogn is the only forensic psychiatric hospital; two or fewer people are sentenced to forensic care each year. It was recently administratively incorporated to the psychiatric ward of the Landsspitalinn University Hospital. As of 2010, a psychiatric hospital at Kleppur was attempting to establish a closed ward with additional beds that could serve as a low-security ward. At discharge, the court orders a strict follow-up, which may involve regular visits to the psychiatrist or medication adherence (Ilorleifsson, 2010; Pálsson, n.d.; Sigurjónsdóttir, n.d.).

Prior to 2008, there were six forensic psychiatric hospitals in Italy, with around 1,000 to 1,200 beds. They were entirely separated from the civil health system and were run, except for one, by the Ministry of Justice. In April 2008, the Italian government introduced a program to progressively downsize and/or close the forensic hospitals and to refer patients to the national health system. The forensic hospitals were closed completely in the spring of 2015, and were replaced by smaller community facilities located in each of the 20 Italian regions, each with about 20 beds that were adapted for socially dangerous offenders. Offenders who are less socially dangerous may be transferred to a civil psychiatric facility (Barbui & Saraceno, 2015; Carabellese & Felthous, 2016; Peloso, D'Alema, & Fioritti, 2014; Salize et al., 2005; Traverso et al., 2000). In Luxembourg, forensic services are highly centralized: mentally ill offenders may only be treated in the Neuropsychiatric Hospital Center in Ettelbruck. They may not be placed in general mental health institutions and they are not treated alongside nonoffenders (Salize et al., 2005).

Forensic services are federalized in the Netherlands; thus, each district has its own service system. TBS-patients may either be treated in specialized forensic facilities, such as one of the nine TBS-hospitals (as of 2005), or in one of the three forensic psychiatric hospitals, or in forensic units of general psychiatric hospitals. TBS-hospitals are under the authority of the Ministry of Justice, while forensic psychiatric hospitals are under the authority of the Ministry of Health and receive TBS-patients with psychiatric disorders (instead of personality disorders) along with

high-risk nonoffenders. When TBS-patients reach later phases of their treatment, they may be detained in a forensic psychiatric unit of a general psychiatric hospital. There are also long-stay beds in the TBS sector for patients who may not realistically have a positive prognosis but who are still socially dangerous. The Netherlands has highly developed aftercare services, with each TBS hospital having a forensic outpatient clinic and sheltered accommodation for discharged forensic patients (Salize et al., 2005; van Marle, 2000).

Norway's forensic services are highly decentralized. There are three regional secure units (Oslo, Bergen, and Trondheim) and they are considered forensic hospitals because, despite being physically integrated to civil psychiatric institutions, their organizational structures are different. In parallel, many counties have their own forensic psychiatric services. Patients can be admitted under a civil order or a criminal order (Almvik, Hatling, & Woods, 2000; Helse Bergen Haukeland University Hospital, n.d.; Kleve, 1996; Ystad, 2013). In Portugal, mentally ill offenders judged not criminally responsible must be detained in one of the five special forensic units in the country, three of which are attached to psychiatric hospitals. Mentally ill offenders and nonoffenders do not mix: there are no offenders in general facilities and there are no nonoffenders in forensic facilities (Salize et al., 2005). In Spain, forensic services are centralized in three psychiatric penitentiary hospitals. They are outside the national health system and receive both mentally ill offenders who are not criminally responsible and criminally responsible offenders whose mental illness is untreatable in prison. While discharged patients have, in theory, access to general health care resources provided by the autonomous regions, civil services are often unwilling to admit patients who require ongoing hospital treatment (Martinez-Jarreta, 2003; Salize et al., 2005).

Since criminal responsibility does not exist as a legal category in Sweden, custodial placement of mentally ill offenders depends entirely on their risk level. Mentally disordered offenders may be treated in regional forensic hospitals or general psychiatric facilities, some of which have forensic wards. Mentally ill offenders are treated alongside civilly detained nonoffenders. Six regional maximum-security forensic facilities receive high-risk offenders (i.e., one-third of all forensic patients). In some forensic hospitals, patients are rarely absolutely discharged: as long as the mental disorder at the source of the crime is still present, it is recommended that support and control be provided on an outpatient basis by the staff of the establishment (Belfrage & Fransson, 2000; Salize et al., 2005). Finally, in Switzerland, as of 2007, there are five centers for compulsory commitment and three institutions for hospitals orders (Manetsch, 2010). However, in the Romandy region, there are no forensic inpatient facilities and forensic patients are most often detained in jail or prison (Niveau & Dang, 2008).

SOUTH AMERICA, CENTRAL AMERICA, AND THE CARIBBEAN

In Argentina, forensic services are provided either by the public health system when the unimputable[9] patients are considered low risk (Folino et al., 2000) or by the

penitentiary service in one of its forensic psychiatric hospitals (Almanzar, Katz, & Harry, 2015; World Health Organization, n.d.). In the province of Buenos Aires, there are at least three institutions treating unimputable patients, one of which is dedicated to women. Another institution has been established in the province of Córdoba (J. F. Folino, personal communication, August 21, 2016). Postdischarge outpatient services are often delivered by the forensic hospital where the patient had received inpatient care (Folino et al., 2000; Taborda et al., 2007). In Brazil, forensic services differ from one region to the next, owing partly to legal differences and partly to socioeconomic differences. The 31 forensic hospitals and units in the country are not distributed uniformly and many states have no forensic facilities (Almanzar et al., 2015; Taborda et al., 2007; World Health Organization, n.d.). In the latter case, forensic patients are either detained in general psychiatric hospitals or in prisons (Taborda et al., 2007). Ties to the forensic system are severed when forensic service users receive a hospital discharge (Taborda et al., 2000). In Chile, forensic services are under the authority of the New Forensic Psychiatry Network, which comprises forensic facilities across the country, including one high-complexity forensic unit in the Philippe Pinel Hospital and three medium-complexity units in three hospitals (Cid, 2010). In less than 10 years, the number of forensic beds has increased fourfold (World Health Organization, n.d.). Information about Cuba, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Peru, and Uruguay is summarized in Table 1.3.

ASIA

China's organization of mental health services differs from Westernized countries. There are three groups of general psychiatric hospitals: (1) general psychiatric hospitals under the authority of the public health system; (2) civil psychiatric hospitals under the authority of the civil administration system for people with no family, legal guardian, or income (patients are often elderly, disabled people, or chronic psychiatric patients); and (3) Ankang hospitals, which are run by the public safety system for patients who pose a risk to others or themselves. While they are not forensic hospitals per se, half of admitted mentally ill offenders are treated in these Ankang hospitals, which have medium- and high-security facilities within a single hospital. Patients are rarely followed-up at discharge (Chen et al., 2013; Every-Palmer et al., 2014; Hu et al., 2011; Topiwala et al., 2012; Wang et al., 2007). In Japan, specialized forensic services have recently been developed. Prior to 2005, mentally disordered offenders found to be insane would simply be detained in general psychiatric hospitals and treated with nonoffenders. In 2005, the forensic mental health system was transformed to address the needs of mentally disordered serious offenders. These forensic patients are to be treated in a designated inpatient treatment facility that can be administered by the state, by local municipalities, or by public corporations as long as they meet the Ministry of Health and Welfare standards. Follow-up and outpatient treatment after discharge is planned by rehabilitation coordinators, who also work to transition forensic service users to the

Table 1.3 Forensic Service Provision by Country

Countries and Their Adult Resident Population Estimates (18 and Over, Unless Specified)	*Location of Forensic Services*	*Forensic Beds*	*Forensic Beds per 100,000 Adult Population Rate*
Americas and the Caribbean			
Argentina (30,173,000 in 2015)	Forensic hospitals or psychiatric hospitals	150 (2015)	0.5[a]
Barbados (223,000 in 2010, 15+)	Psychiatric hospital	80 (2009)	35.9[b] (15+)
Brazil (134,466,000 in 2010)	Forensic hospitals and units, psychiatric hospitals, prisons	3,677 (2015)	2.7[a]
Canada (26,579,000 in 2011)	Province-specific (at least one high-security forensic psychiatric hospital per province or a secure unit in psychiatric hospitals for smaller provinces)	1,523 (2006)	5.7[a,c]
Chile (12,774,000 in 2012)	Forensic units	209 (2012)	1.6[b]
Cuba (8,885,000 in 2011)	Forensic units of psychiatric hospitals	205 (2011)	2.3[b]
Ecuador (9,086,000 in 2010)	Forensic units	42 (2008)	0.5[b]
El Salvador (4,081,000 in 2014)	No forensic hospital	40 (2015)	1.0[a]
Guatemala (8,393,000 in 2010, 15+)	Forensic unit in psychiatric hospital	36 (2011)	0.4[b] (15+)
Jamaica (1,820,000 in 2011)	Forensic units	n/a	13.0[d] (2009)
Mexico (73,110,000 in 2015)	Forensic hospitals or forensic beds in prison	1,096 (2015)	1.5[a]

Paraguay (2,898,000 in 2002)	Prison mental health facilities	45 (2006)	1.6[b]
Peru (17,399,000 in 2007)	Primarily in prison, also in psychiatric hospitals	42 (2015)	0.2[a]
Trinidad and Tobago (998,000 in 2011)	Psychiatric hospital	58 (2007)	5.8[b]
United States (Data available for 32 states: 138,079,000 in 2015)	State-specific (dedicated forensic facility in most or forensic or non-forensic units)	7,835 (2015)	5.7[a]
Uruguay (2,585,000 in 2015)	Psychiatric hospitals	191 (2015)	7.4[a]
Europe			
Austria (6,614,000 in 2005)	Forensic hospital, forensic departments in psychiatric hospitals or closed wards of psychiatric hospitals	384 (2005)	5.8[a]
Belarus (7,745,000 in 2009)	n/a	n/a	6.4 (2009, crude population) 7.9[e] (estimated, adult population)
Belgium (8,229,000 in 2004)	Psychiatric units in prisons, institutions of social defense or civil psychiatric hospitals	400 (2005)	4.9[a]
Bulgaria (6,375,000 in 2005)	Security hospital or locked wards of psychiatric hospitals	80 (2005)	1.3[a]
Croatia (3,495,000 in 2008)	Forensic departments	n/a	7.8 (2008, crude population) 9.6[e] (estimated, adult population)
Czech Republic (8,577,000 in 2009)	Psychiatric hospitals or prisons	n/a	3.5 (2009, crude population) 4.3[e] (estimated, adult population)
Denmark (4,353,000 in 2011)	Forensic units or psychiatric hospitals	361 (2011)	8.3[a]

continued

Table 1.3 Continued

Countries and Their Adult Resident Population Estimates (18 and Over, Unless Specified)	*Location of Forensic Services*	*Forensic Beds*	*Forensic Beds per 100,000 Adult Population Rate*
England and Wales (44,812,000 in 2013)	Secure hospitals	795 high secure 3,192 medium secure (2013)	HS: 1.8 MS: 7.1[a]
Finland (4,338,000 in 2013)	Psychiatric hospitals, some of which have a forensic ward	450 (2013)	10.4[a]
France (48,410,000 in 2005)	Secure units in psychiatric hospitals or psychiatric hospitals	486 (2005)	1.0[a]
Germany (67,596,000 in 2013)	Forensic hospitals and psychiatric hospitals, with or without forensic department	10,471 (2013)	15.5[a]
Greece (9,109,000 in 2005)	Forensic hospital or psychiatric hospital (also prison for women)	250–330 (estimate, 2005)	2.7–3.6[a]
Hungary (8,185,000 in 2009)	n/a	n/a	1.9 (2009, crude population) 2.3[e] (estimated, adult population)
Iceland (237,000 in 2010)	Forensic hospital or psychiatric units	7–8 (2010)	3.0–3.4[a]
Ireland (3,440,000 in 2011)	Forensic facilities and psychiatric facilities	89 (2006)	2.6[a]
Latvia (1,769,000 in 2009)	Forensic units	n/a	0.7 (2009, crude population) 0.9[e] (estimated, adult population)
Macedonia (1,591,000 in 2009)	Psychiatric hospitals	123 (2009)	7.7[b]
Netherlands (13,154,000 in 2011)	Forensic facilities (TBS-hospitals or forensic hospitals) or forensic units in psychiatric hospitals	1,867 (2013)	14.2[a]

Norway (3,983,000 in 2014)	Secure units administered by counties and health regions	180 (2014)	4.5[a]
Poland (30,825,000 in 2009)	Psychiatric wards or secure institutions	n/a	3.8 (2009, crude population) 4.7[e] (estimated, adult population)
Portugal (8,532,000 in 2005)	Forensic units, often attached to psychiatric hospitals	189 (2005)	2.2[a]
Romania (17,506,000 in 2009)	Psychiatric hospitals or penitentiary psychiatric hospital	n/a	7.2 (2009, crude population) 8.8[e] (estimated, adult population)
Russia (116,486,000 in 2012)	Secure hospitals and psychiatric hospitals	5,440 high secure 6,582 medium secure (2014)	HS: 4.7 MS: 5.7[a]
Scotland (4,293,000 in 2015)	Secure hospitals	140 high secure 160 medium secure (2016)	HS: 3.3 MS: 3.7[a]
Slovenia (1,685,000 in 2009)	n/a	n/a	1.2 (2009, crude population) 1.4[e] (estimated, adult population)
Spain (35,630,000 in 2005)	Psychiatric penitentiary hospitals	593 (2005)	1.7[a]
Sweden (7,564,000 in 2011)	Forensic facilities, psychiatric facilities, or general hospitals	1,113 (2011)	14.7[a]
Switzerland (5,973,000 in 2005)	Forensic facilities or prisons	n/a	1.3 (2005, crude population) 1.6[f] (estimated, adult population)
Ukraine (37,382,000 in 2013)	Secure hospitals, psychiatric hospitals	709 high-security (2015)	1.9[a]

continued

Table 1.3 Continued

Countries and Their Adult Resident Population Estimates (18 and Over, Unless Specified)	*Location of Forensic Services*	*Forensic Beds*	*Forensic Beds per 100,000 Adult Population Rate*
Asia			
Armenia (2,323,000 in 2011)	Forensic unit in psychiatric hospital	60 (2009)	2.6[b]
Azerbaijan (6,286,000 in 2009)	Forensic unit	n/a	3.6 (2009, crude population) 5.1[e] (estimated, adult population)
Bahrain (943,000 in 2010)	Forensic unit in psychiatric hospital	18 (2010)	2.0[b]
Bangladesh (94,162,000 in 2011, 15+)	Forensic unit	15 (2007)	0.02[b] (15+)
China (1,054,898,000 in 2010)	Ankang hospitals, run by the public safety system	7,000 (2012)	0.7[a]
Hong Kong (6,437,000 in 2014, 15+)	Forensic wards in psychiatric hospital	220 (2016)	3.4[a] (15+)
Iraq (28,750,000 in 2006, total population)	High-security unit of psychiatric hospital	250 (2006)	0.9[b] (per total population)
Israel (4,793,000 in 2007)	Maximum-security unit of psychiatric hospital	200 (2007)	4.2[a]
Japan (107,438,000 in 2011)	Forensic units	666 (2011)	0.6[a]
Jordan (2,863,000 in 2004)	Forensic unit in psychiatric hospital	78 (2011)	2.7[b]
Korea (36,201,000 in 2005)	Forensic units	1,000 (2006)	2.8[b]
Kyrgyzstan (3,382,000 in 2009)	Special forensic facilities and psychiatric hospitals	249 (2008)	7.4[b]

Myanmar (33,126,000 in 2014)	Forensic units	120 (2006)	0.4[b]
Oman (1,387,000 in 2003)	Psychiatric hospital and prison	5 (2008)	0.4[b]
Pakistan (87,509,000 in 2007, 15+)	Psychiatric hospitals administered by prisons	n/a	0.02[d] (2009)
Philippines (55,720,000 in 2010)	Psychiatric hospital	400 (2007)	0.7[b]
Saudi Arabia (21,199,000 in 2014)	Forensic units	50 (2013)	0.2[a]
Singapore (2,959,000 in 2010)	Forensic hospital	140 (2013)	4.7[a]
Sudan (19,709,000 in 2015)	Prison medical facilities	200 (2009)	1.0[b]
Tajikistan (4,357,000 in 2010)	Forensic units	25 (2009)	0.6[b]
Uzbekistan (19,932,000 in 2013)	Psychiatric hospitals	890 (2007)	4.5[b]
Vietnam (59,617,000 in 2009)	Forensic units	300 (2006)	0.5[b]
Oceania			
Australia (18,205,000 in 2014)	State-specific	616 (2013–14)[a]	3.4[g]
New Zealand (2,974,000 in 2006)	Forensic units	221 (2005)	7.4[a]
Africa			
Ghana (13,627,000 in 2010)	Psychiatric hospital or general hospital	79 (2011)	0.6[b]
Nigeria (104,268,000 in 2006, 15+)	Forensic units or prisons	22 (2006)	0.02[b] (15+)

continued

Table 1.3 Continued

Countries and Their Adult Resident Population Estimates (18 and Over, Unless Specified)	*Location of Forensic Services*	*Forensic Beds*	*Forensic Beds per 100,000 Adult Population Rate*
South Africa (36,670,000 in 2011, 15+)	Forensic wards in psychiatric hospitals	1,676 (2007)	4.6[b] (15+)
Tunisia (8,372,000 in 2014, 15+)	Psychiatric hospital	60 (2008)	0.7[b] (15+)
Uganda (14,267,000 in 2002)	Psychiatric hospital	116 (2006)	0.8[b]
Zambia (6,222,000 in 2010)	Psychiatric hospital	120 (2009)	1.9[a]

Notes

n/a indicates that the information was unavailable. When multiple sources of information were available for a country, the most recent was used. Adult population estimates were retrieved or calculated from governmental websites, the United Nations Statistics Division, or the Organisation for Economic Co-operation and Development.

a Total number of beds was retrieved from various sources (Almanzar et al., 2015; Bergman-Levy et al., 2010; Bjørkly, Hartvig, Roaldset, & Singh, 2015; Chan & Tomita, 2013; Department of Mental Health and Substance Abuse – World Health Organization, n.d.; Douw et al., 2015; Edworthy et al., 2016; Every-Palmer et al., 2014; Ilorleifsson, 2010; Koskinen, Likitalo, Aho, Vuorio, & Meretoja, 2014; Livingston, 2006; Mental Health Commission, 2006; Ministry of Health, 2007; Nakatani, 2012; National Association of State Mental Health Program Directors Research Institute, 2015; National Health Service, 2013; Ngungu & Beezhold, 2009; Nielsen, van Mastrigt, & Wobbe, 2016; Pálsson, n.d.; Qureshi et al., 2013; Salize et al., 2005; Sigurjónsdóttir, n.d.; Thomson, 2016; Topiwala et al., 2012; World Health Organization, 2005; Yee Ho & Kwan Yan, 2016) and the number of beds per 100,000 population was hand-calculated.

b Total number of beds was made available by the WHO-AIMS reports on mental health systems and the number of beds per 100,000 population was hand-calculated.

c This number represents a minimum.

d The number of beds per 100,000 population was made available by the WHO-AIMS reports on mental health systems. It is not known whether this number was calculated using the adult population or the total population.

e The number of beds per 100,000 crude population was retrieved from Mundt et al. (2012). The number of beds per 100,000 adult population was estimated using the total population retrieved from the United Nations Statistics Division.

f The number of beds per 100,000 crude population was retrieved from Priebe et al. (2008). The number of beds per 100,000 adult population was estimated using the total population retrieved from the United Nations Statistics Division.

g Total number of beds and beds per 100,000 population retrieved from the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, n.d.).

general mental health care system. This outpatient treatment usually lasts three years (Every-Palmer et al., 2014; Fujii et al., 2014; Nakatani, 2000, 2012; Nakatani, Kojimoto, Matsubara, & Takayanagi, 2010). Information for Korea, Vietnam, and the Philippines is provided in Table 1.3.

AFRICA

In Algeria, the Frantz Fanon Hospital is the designated forensic hospital, but a regionalization process has recently been taking place (El Hamaoui et al., 2009; Ogunwale et al., 2012). Information for Tunisia is provided in Table 1.3.

As published by the World Health Organization's AIMS Report on Mental Health Systems, there are no forensic facilities in Benin, Bolivia, Burundi, Djibouti, Dominican Republic, Eritrea, Guyana, Haiti, Honduras, Laos, Lebanon, Suriname (where patients are treated in the long-stay unit of a psychiatric hospital), Panama, or Venezuela.

Former Communist Countries

There are forensic inpatient units and dedicated forensic beds and housing in several former Communist countries (Mundt et al., 2012; World Health Organization, n.d.). Bulgaria's forensic services are delivered to offenders that are found not responsible in a maximum-security psychiatric hospital or on locked wards of civil psychiatric hospitals, depending on the level of dangerousness. A university forensic psychiatry unit exists in Sofia entirely dedicated to assessments. Some patients are referred to a prison with a mental health unit (Tătaru et al., 2010). The Czech Republic provides forensic services in civil psychiatric hospitals, or in prisons. In civil psychiatric hospitals, forensic patients are placed on standard wards (Vevera et al., 2009). In Croatia, mentally ill offenders found not legally responsible are sent to forensic institutions that are well integrated with the civil health care system and some supported housing services are available (Margetić et al., 2012; Mundt et al., 2012).

Poland's forensic services are divided according to security level. Some offenders may be detained in general psychiatric wards, others who are socially dangerous may be detained in an institution with a reinforced security system, and those who are considered extremely dangerous must be treated in maximum-security wards (Ciszewski & Sutula, 2000).

In Russia, forensic inpatient services are divided into three levels: ordinary, specialized or medium-security, and specialized with intensive observation or high-security 'special hospitals.' Most offenders found not criminally responsible are placed in ordinary care, and it usually takes place in regional psychiatric hospitals, along with nonoffenders. Nearly all regional hospitals have special units for forensic inpatients. All psychiatric hospitals in Russia provide compulsory treatment to offenders. Specialized care services are provided to patients who are more difficult or dangerous. Finally, there are seven high-security special hospitals, run directly by

the Federal Ministry of Health, that receive highly socially dangerous patients. Nonoffenders may not be admitted to these hospitals. The tendency in the last year has been to centralize the forensic services. When the patients are discharged, they are followed-up by outpatient psychiatric clinics, ensuring continuity of care (Every-Palmer et al., 2014; Ruchkin, 2000).

In Ukraine, forensic services are also offered at different levels of security. Mentally ill offenders are often first treated in the Special Psychiatric Hospital in Dnepropetrovsk, which is the only high-security forensic hospital. Eventually, they are transferred to medium-security units of general psychiatric hospitals. However, there is a critical lack of continuity of care between levels of security (Douw et al., 2015). Information for Armenia, Azerbaijan, Belarus, Hungary, Latvia, Macedonia, Romania, Slovenia, Tajikistan, and Uzbekistan is provided in Table 1.3.

Islamic Law Countries

Forensic services in Iraq are only provided in the high-security unit of the Al-Rashad Mental Hospital in Baghdad and there is no outpatient treatment or follow-up care after discharge (Muslim & Chaleby, 2007; World Health Organization, n.d.). The World Health Organization's AIMS Reports on Mental Health Systems indicates that there are no forensic facilities in the following countries: Afghanistan, Iran (forensic patients are detained in prison or in the psychiatric hospital), the Maldives, and Somalia. Information for Bahrain, Jordan, Oman, Saudi Arabia, and Sudan is provided in Table 1.3.

Summary

The review above clearly shows the wide variation in legal frameworks around such issues as fitness to plead and criminal responsibility, as well as the absence of clear processing patterns, both within and across large legal systems. No straightforward conclusion about the organization of forensic services and the actual comparability across nations can be made. Despite these limitations, some trends do emerge. Fitness to stand trial is much more common in common-law countries in comparison to civil-law countries, where it is nearly nonexistent, with the exceptions of Germany, Chile, Argentina, Japan, China, and Taiwan. This could be explained by the fact that common law is more adversarial in nature, whereas civil law adopts an inquisitorial approach. The concept of fitness was also available in some former Communist countries. The insanity defense, on the other hand, is a legal concept that is both deeply embedded in countries of civil-law tradition and of common-law tradition, despite being rarely used in England. The Nordic countries of Denmark and Sweden instead sentence criminally responsible offenders to treatment.

In most countries, a defendant found unfit could be either detained in a hospital (either forensic or general) or released, depending on the risk level and on the severity of the offense. Many common-law countries have put in place safeguards

to prevent indefinite or arbitrary detention permanently of unfit defendants. After a given amount of time, if found permanently unfit, the defendant would either be released, civilly committed, or submitted to a special hearing.

The population characteristics of the forensic population can also vary in terms of diagnosis and type of index offense. The types of mental disorders that might be considered as a basis for partial or full lack of criminal responsibility (or for a treatment sentence in some cases, including England) were rarely explicitly stated in the law, and most often were at judges' discretion, which resulted in many countries being 'on the fence.' The pattern shows that psychotic illnesses (mainly schizophrenia) are accepted, along with severe affective disorders and organic mental disorders. The inclusion of personality disorders, however, varies widely. Offenders with a personality disorder are an important proportion of forensic patients in England and Wales, the Netherlands, Belgium, Germany, Austria, and Greece, but they are rarely admitted elsewhere. The severity of the offenses committed range from mostly misdemeanors (Israel) to mostly severe violent crimes (the Netherlands). Sexual offenders rarely reach forensic services through a mental disorder defense, with the exception of South Africa.

While the duration of the forensic hospitalization is, in many jurisdictions, unlimited and subject to regular reevaluation, other countries embedded safeguards, either to ensure that forensic patients are detained a minimum amount of time or no longer than a maximum amount of time, often in relation to the level of severity of the offense. While in Italy the minimum length of treatment must be related to the seriousness of the offense, it is the maximum length that is related to the seriousness of the offense in Ireland and most of Australia. The court may also establish the duration, such as in Portugal (maximum), Brazil, and Greece (both minimum). The decisional power to discharge a patient most often rests with the court, but sometimes rests with the treating psychiatrist (for instance, in England and Wales, South Africa, and China) or is subject to ministerial assent (in New Zealand and most of Australia). Independent bodies or mental health tribunals have been put in place in Canada, Ireland, Scotland, Queensland, Belgium, and Israel. In a minority of countries, such as in England and Wales, the courts cede all powers over a mentally disordered offender once they are admitted to a hospital, and the patient is essentially treated like a civilly detained patient.

One of the bases of the organization of forensic services is the extent to which they are integrated with the civil mental health services. In some cases, forensic facilities are entirely distinct from the health system; sometimes, they are under the authority of another department altogether. In other cases, there are virtually no distinction between forensic services and general mental health services and allocation is based on security rather than legal status, mentally disordered offenders being treated on the same wards as aggressive or high-risk nonoffenders, such as in Finland and England. In general, the less populous a country is, the more likely it is that the services will be centralized in one national forensic hospital.

There is an important dearth in the literature when it comes to postdischarge forensic services, including continuity of care and supportive housing. When

information is available about the follow-up programs, performance indicators and outcomes are rarely available, which makes drawing conclusions about the actual continuity of care nearly impossible. It is worth noting that the United Kingdom is arguably the jurisdiction where forensic services are the best documented in the literature. Clear pathways of care have already been developed and put in place, putting the country at the forefront of evidence-based policies.

The general portrait of forensic mental health frameworks around the world remains limited by the significant variability in the availability and specificity of information. No studies were identified that could indicate which kind of organization of services is most effective or efficient—an endeavor that would certainly be of interest for future research and require the development of an international consortium. Such massive heterogeneity in the design of forensic systems likely produces major variation in forensic mental health outcomes; however, the nature and magnitude of this variation is not well understood. Some attempts have begun in this direction in relation to long-term forensic patients by the COST team.[10] Despite being unable to draw conclusions about the superiority of one approach for organizing forensic services over another, key system-level principles can be extracted from this review as well as the wider literature on the organization of mental health services in order to propose a model for the organization of forensic services.

2 What Are the Key Organizing Principles for Forensic Mental Health Systems?

As was evidenced above, the manner in which forensic mental health services are governed and organized varies considerably between—and even within—nations. Some jurisdictions have constructed self-contained, specialized forensic mental health systems with resources and mandates that are detached from general mental health. Other jurisdictions have deliberately blended the role and function of forensic and general mental health systems. The systems also vary in relation to their stage of evolution, with low-resource countries working to establish rudimentary services to meet forensic service users' basic needs (Ogunwale et al., 2012) and high-resource countries contemplating sophisticated redesigns to maximize the effectiveness and efficiency of their complex forensic systems (Wilson et al., 2011). As mentioned earlier, such wide variation and disparities in the configuration of forensic systems are the product of a multitude of historical and ongoing sociopolitical, cultural, and economic forces.

The lack of consensus about how to most effectively organize forensic services, notwithstanding variations in legal frameworks, also contributes to systems being molded into unique shapes in different parts of globe. Although scholars have speculated about the relative advantages and limitations of different models for configuring forensic mental health services (Humber, Hayes, Wright, Fahy, & Shaw, 2011; Salize et al., 2005), this area has not been subjected to empirical scrutiny. Consequently, there is no evidence-based template for how forensic systems ought

to be designed. However, there are guidelines for organizing general mental health and substance use systems (Hogan et al., 2003; McDaid & Thornicroft, 2005; National Treatment Strategy Working Group, 2008; *Organization of Services for Mental Health*, 2003; Roberts & Ogborne, 1999; Rush, 2010; Thornicroft & Tansella, 2004; U.S. Department of Health and Human Services, 2009). With some adaptation to the unique role and function of forensic services (i.e., involuntary, public safety-focused), these system-level principles are transferable to the forensic mental health arena.

According to these guidelines, an effectively organized forensic mental health system would include elements such as: (1) providing a comprehensive and balanced continuum of services, (2) integrating services within and between systems, (3) matching services to individual need, (4) adhering to human rights, (5) responding to population diversity, and (6) using the best available evidence to make system-wide improvements. Though all of these system-level principles are important, the discussion below will focus on how the first three (service continuum, system integration, and service matching) may be applied to the organization of forensic mental health services.

A Balanced Service Continuum

As evidenced in our international review, contemporary forensic mental health systems tend to be aligned with a 'custodial paradigm' (McKenna, Furness, Dhital, Park, & Connally, 2014), whereby resources and services are concentrated in institutional settings, such as stand-alone forensic institutions, specialized units in general mental health hospitals, or inpatient services offered in correctional settings. Forensic institutions play a vital role in containing and mitigating public safety risk, enabling justice-involved people with mental disorders access to therapeutic processes and interventions, and facilitating community reintegration, crime desistance, and personal recovery. At the same time, forensic institutions also embody the oppressive features of a 'total institution' (Goffman, 1961), whereby detainees (or inpatients) are, to varying degrees, exposed to deprivations of liberty, autonomy, material goods, intimate relations, and security. Forensic institutions are also a very costly means of providing services that could be delivered in community-based settings with equal, if not greater, effectiveness.

Emerging from similar concerns regarding institutional care is the proposal that mental health and substance use systems are most effective when they provide access to a comprehensive and balanced continuum of services and supports. In a balanced care approach, a flexible range of services is primarily provided in community-based, local settings that span the specialized and nonspecialized sectors and emphasize features such as providing care close to home, tailoring treatment to individual need, supporting the choices of service users, ensuring that care is coordinated between providers and agencies, and offering mobile services (Thornicroft & Tansella, 2013). A balanced care model that provides ready access to evidence-based treatment interventions would prevent some people with mental illnesses

from unnecessarily becoming involved in the criminal justice system. It would also ensure that high-quality services reach those with mental health needs who are in the criminal justice system (e.g., arrested by police, detained or incarcerated, on parole or probation) in order to prevent further criminalization (Munetz & Griffin, 2006).

One conceptual framework that is used to portray what balanced care systems look like is the 'tiered model' (National Treatment Strategy Working Group, 2008; *Organization of Services for Mental Health*, 2003; Rush, 2010). A fundamental aspect of the tiered model is that mental health and substance use systems contain logical groupings of services that have comparable levels of intensity, specialization, and restrictiveness. Comparable services can be clustered into tiers that are most appropriate for meeting the needs of distinct groups of people based on the acuity, complexity, and chronicity of their mental health and substance use problems. For instance, highly specialized and intensive (and costly) services are most suitable for people with severe (i.e., highly acute, complex, and chronic) problems, and least appropriate for people experiencing low to moderate levels of distress or impairment. Another feature of the tiered model is that the distribution of services should align with the population distribution of problem severity. Those with lower-level problem severity are more numerous in the population and, as such, the demand (i.e., volume) for less intensive, less specialized services is great. Conversely, severe mental health and substance use problems are less common in the population and the demand for highly specialized, highly intensive services is small. The shape of service systems should correspond with the demand for different service levels.

According to the principles of the tiered model, a balanced forensic mental health care continuum would resemble the figure below.

Drawing from other frameworks (e.g., Kennedy, 2002; Mullen, 2000; O'Dwyer et al., 2011; Thornicroft & Tansella, 2013; World Health Organization, 2003), this conceptual model is designed with six tiers that contain three clusters of custodial-based forensic mental health services (Tiers 4–6) and three clusters of community-based services (Tiers 1–3). Each service cluster would contain evidence-based interventions corresponding with the particular function of that cluster. The menu of interventions available within each cluster will vary between jurisdictions. Compared with other tiered service models designed for general mental health and substance use systems, the model depicted here is weighted more heavily toward institutional services in order to reflect the distinct nature of forensic populations and the risk management function of forensic systems. Nonetheless, striking a balance between custodial- and community-based services is vital for forensic mental health systems (Mullen, 2000), with some suggestion that the investment in community services should be equal to or greater than the amount being spent on custodial care (Thornicroft & Tansella, 2013).

As was revealed by our review of forensic systems, the upper half of the pyramid (Tiers 4–6) parallels with how parts of the world currently distribute

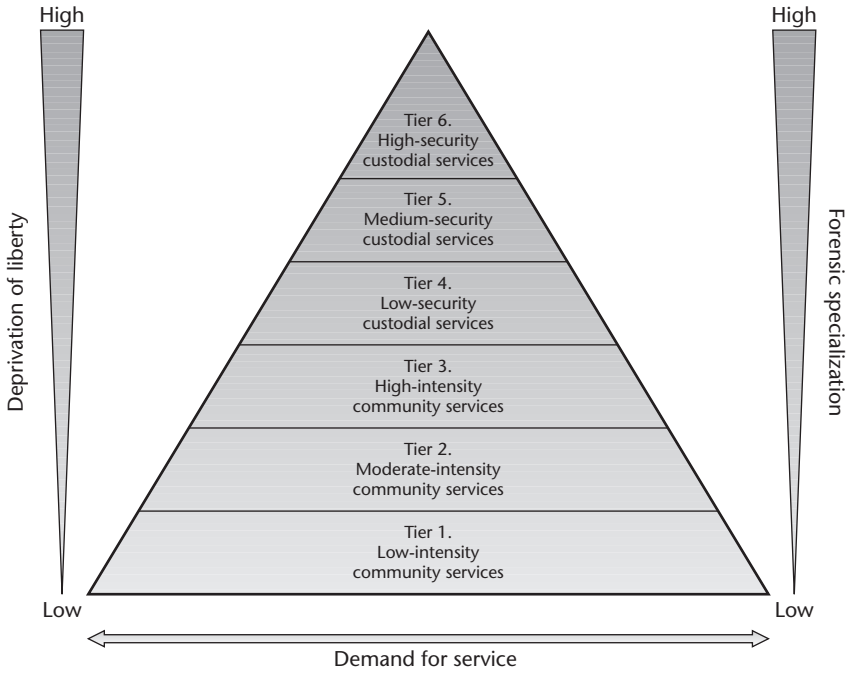

Figure 1.1 Balanced Forensic Mental Health Care Continuum

custodial populations in low-, medium-, or high-security settings (Pillay, Oliver, Butler, & Kennedy, 2008). Tier 6's high-security, custodial services are the most restrictive, intensive, specialized, and costly in the forensic mental health system; it also serves the smallest portion of the forensic population. The focus of services in Tier 6 is on stabilizing acute mental health and substance use problems, while also targeting specific criminogenic needs in order to enable a safe transition to a lower security level. In contrast, Tier 4's low-security, custodial services comprise the least intensive and least specialized services within custodial care settings. Tier 4 services are generally designed to prepare service users for transitioning into the community, for instance building self-management, relapse prevention, and independent living skills. The lower half of the pyramid (Tiers 1–3) provides a continuum of care in the community that is appropriately matched to service users' level of criminogenic, mental health, and substance use treatment needs. Tier 3's high-intensity community services likely include supportive and structured living environments (e.g., supported housing, residential facilities) combined with assertive outreach and treatment provided by specialized, multidisciplinary forensic mental health service providers (e.g., forensic assertive community treatment teams). Tier 1's low-intensity community services require the least forensic specialization and would focus on bridging people to nonforensic systems of care.

Matching Services to Needs

Integral to the tiered model is the principle that systems are best organized in a manner that allows individuals to access a full range of services according to their level of need (National Treatment Strategy Working Group, 2008; Thornicroft & Tansella, 2003; World Health Organization, 2003). A system that offers services tailored to an individual's needs, also known as a 'stepped care' model, can effectively respond to varying levels of illness chronicity, acuity, and complexity, and is responsive to a person's changing needs (Bower & Gilbody, 2005; Rush, 2010). Comprehensive and regular assessments of needs that match people with the appropriate services (type and intensity) is an essential feature of a system that is organized around a stepped care approach (Goldman, Thelander, & Westrin, 2000). A well-designed system provides individuals with the least restrictive, least intensive, least expensive, and least intrusive interventions, with individuals stepped up to higher intensity care or stepped down to lower-intensity care based on current service need (McDaid & Thornicroft, 2005; Von Korff & Tiemens, 2000).

These system-level principles are well aligned with evidence-based practice for correctional interventions (Andrews & Bonta, 2010; Lipsey & Cullen, 2007; Prins & Draper, 2009; Romani, Morgan, Gross, & McDonald, 2012). Of particular relevance is the risk–need–responsivity (RNR) theoretical framework, which posits core principles for correctional services to effectively treat offending behavior (Andrews, Bonta, & Hoge, 1990; Andrews, Bonta, & Wormith, 2011; see review in Chapter 16 of this book). The RNR model indicates that service intensity should match the level of risk for reoffending presented by an offender, with intensive correctional services being reserved for higher-risk offenders (risk principle). Alongside this, services should target and address criminogenic needs—the dynamic risk factors with an established empirical linkage to reoffending (need principle). Furthermore, interventions should be oriented toward cognitive behavioral strategies and the offenders' learning style, motivation, abilities, and strengths (responsivity principle).

Another applicable theoretical model, developed by Prins and Draper (2009) and subsequently elaborated on by others (Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012; Skeem, Manchak, & Peterson, 2011), has applied RNR principles to the management of individuals with mental illness under community corrections supervision. This framework posits that criminogenic needs and functional impairment should determine the intensity of, and degree of coordination between, criminal justice and mental health services. An increase in criminogenic needs and risk levels should be matched by intensive supervision. Similarly, higher levels of functional impairment should be matched with intensive mental health treatment. Concomitantly, increases in service intensity should necessitate greater coordination and integration between mental health and correctional services.

A forensic mental health system that is organized according to the tiered model and the Prins and Draper (2009) framework would match service clusters, containing distinct therapeutic interventions and security measures, to target groups based

on their risk and need profile, as is depicted in the table below. Others have proposed similar strategies for distributing resources based on the needs of adults with behavioral health problems who are under correctional supervision (Osher et al., 2012). Additionally, the 'stratified risk and care' model described by Pillay and colleagues (2008) outlines a similar way that forensic service users are distributed across security levels according to their level of clinical need and risk for violence and crime.

Custodial forensic services (Tiers 4–6) are most appropriate for forensic service users who are assessed as being at moderate to high levels of criminogenic risk, as well as those with severe mental health and substance use problems. The Prins and Draper (2009) model suggests that persons with higher levels of criminogenic needs accompanied by more serious mental health and substance use problems would be the most likely to benefit from a highly specialized forensic mental health service, with its integration of risk assessment, risk management, and mental health and substance abuse treatment. Community forensic services (Tiers 1–3) may be most appropriate for forensic service users assessed as being at low to moderate levels of criminogenic risk and have low to moderate mental health and substance use treatment needs. The needs of forensic service users who have lower levels of criminogenic, mental health, and substance use needs are likely to be met by services with lower levels of forensic specialization. Those with higher criminogenic needs who are living in the community may be best served by highly specialized forensic services, such as forensic assertive community treatment.

Much of the literature in this area focuses on criminogenic risk and need factors, but a recent body of scholarship has cast doubt on the validity of using criminogenic risk to inform decisions regarding the assignment of service users to different security levels in a forensic mental health care continuum (O'Dwyer et al., 2011).

Table 1.4 Target Group by Service Cluster

Tier	*Service Cluster*	*Appropriate Target Group*
6	High-security custodial services	• High criminogenic risk and low, moderate, or high mental health/substance use treatment needs
5	Medium-security custodial services	• Moderate criminogenic risk and high mental health/substance use treatment need
4	Low-security custodial services	• Moderate criminogenic risk and moderate mental health/substance use treatment needs
3	High-intensity community services	• Moderate criminogenic risk and moderate mental health/substance use treatment needs
2	Moderate-intensity community services	• Moderate criminogenic risk and low mental health/substance use treatment needs • Low criminogenic risk and moderate mental health/substance use treatment needs
1	Low-intensity community services	• Low criminogenic risk and low mental health/substance use treatment needs

A set of instruments, known as the DUNDRUM quartet, have been developed to inform decisions concerning the placement and movement of service users in the forensic mental health system (Kennedy, O'Neill, Flynn, & Gill, 2010). These instruments rely on a different set of variables, compared to those used by criminogenic need and violence risk appraisal instruments, to assess the appropriateness of security level placement. Although more research is needed on the effectiveness of instruments such as the DUNDRUM quartet to improve system-level processes and outcomes, adjustments to the above table may be warranted, such that the service clusters and security levels (especially in custodial settings) are matched to a target groups' therapeutic security needs, rather than their criminogenic, mental health, and substance use treatment needs. The latter batch of variables may be more appropriate for matching individuals to appropriate interventions (type and intensity), rather than determining their placement within the forensic mental health care continuum.

Integrating Systems

Forensic service users need to access different systems and subsystems to have their intersecting needs appropriately met. Many obstacles prevent services from achieving optimal levels of integration and coordination, such as fragmented funding mandates. The complexity of the criminal justice, psychiatric, and social problems existing within the forensic mental health population present challenges for coordinating and integrating services for this group—especially since forensic service users are undesired, unwanted, and rejected by other service systems (Wolff, 2002).

Receiving care from different systems, or different components of a system, is very problematic in a population with co-occurring, complex needs, and that has experienced severe social ruptures and interrupted care trajectories. A fundamental principle for effectively organizing mental health and substance use services is that systems should be integrated (Craven & Bland, 2006; Thornicroft & Tansella, 2003). In the forensic mental health context, system integration refers to bridging the service delivery gaps that exist within and between mental health, substance use, criminal justice, corrections, housing, and other essential service sectors. The purpose of systems integration is to encourage seamless service delivery, to promote efficiency, to optimize the use of scarce resources, and to improve outcomes. Systems integration is promoted through structures and processes that facilitate collaborations, partnerships, and communication between professionals and agencies.

Models of systems integration between mental health, criminal justice, and community support services have been developed (Lamberti, Deem, Weisman, & LaDuke, 2011; Osher et al., 2012; Weisman, Lamberti, & Price, 2004). Our review of forensic systems also shows various ways in which different jurisdictions throughout the world have tried to build systems integration in order to meet the needs of forensic service users. One aspect of systems integration focuses on linkages and coordination among the various components of the mental health, substance use,

and correctional service continuum. Integration between the custodial and community settings is also essential for the efficient and effective delivery of forensic mental health services. Opportunities for multi-system collaboration and system integration exist throughout the tiered model. For instance, the needs of forensic service users at the lower tiers (e.g., 1 or 2) could be effectively met by the general mental health system, since the need for specialized forensic services may no longer exist (Humber et al., 2011), an approach that has been adopted by many countries. Integrating risk management strategies and transferring forensic skills into the general mental health system, or transitioning forensic service users to the general mental health system when appropriate has a number of advantages (Jansman-Hart et al., 2011), including freeing up space in the forensic system but also avoiding unnecessarily restricting the liberty of forensic service users.

As our international review of frameworks demonstrated, numerous options exist for organizing forensic mental health systems. In addition to population differences, the models vary in the degree to which services are integrated with the other sectors, such as the general, nonforensic mental health system as well as the correctional system. One approach, which we call a 'specialized' model, offers specialized forensic services to all forensic services users throughout their care pathway in custody (e.g., forensic hospital) and the community (e.g., forensic outpatient care). In contrast, a 'mixed' model provides access to specialized care based on need whereby only some forensic service users (e.g., moderate–high risk) receive specialized forensic services, while others receive hospital- or community-based services in the general mental health system. This model's focus on tailoring care (specialized or integrated) based on individual need is consistent with the principles of the tiered model. Lastly, in a 'general' model, forensic service users receive services either entirely (i.e., hospital and community) or partly (i.e., community only) in the general mental health system—an arrangement that is primarily based on the availability of resources rather than people's needs. There are theoretical strengths and weaknesses of these different ways of integrating systems, but their relative effectiveness requires further study.

3 How Can the Performance of Forensic Mental Health Systems Be Evaluated at a Systems Level?

The integration of the best available evidence into practice and the measurement outcomes have been, and continue to be, ongoing challenges in all areas of health care—forensic mental health services are no exception. Many organizations have developed quality and performance indicators in order to assess the functioning of their services, level of effectiveness and areas for improvements. However, the field of forensic mental health, with a few exceptions, has been slow to move into the era of identifying and applying quality standards and performance indicators in a systematic fashion (Australian Commission on Safety and Quality in Health Care, 2014; Barbaree & Goering, 2007; Coombs, Taylor, & Pirkis, 2011; Haque, 2016; Lauriks, Buster, Wit, Arah, & Klazinga, 2012; Müller-Isberner, Lichtenfels, & Imbeck, 2016;

Parameswaran, Spaeth-Rublee, Huynh, & Pincus, 2012). Very little substantive documentation about performance measurement is currently available in the gray literature and even less so in the scientific literature. We were able to locate variable degrees of information from Canada (Ontario and British Columbia), England and Wales, Scotland, Germany, the Netherlands, and Australia. A few key initiatives are being disseminated, particularly through the International Association of Forensic Mental Health Services' special interest group of service development, organization, strategy, and delivery, which meets regularly at the association's annual conference.

As was clearly illustrated by Müller-Isberner et al. (2016), forensic mental health services are complex organizational structures embedded in an elaborate mesh of media and public scrutiny, legal frameworks, administrative contexts, institutional contexts, and general risk management interventions. Managing all of these components is an important and challenging endeavor. The development of quality standards can help organizations in measuring outcomes, standardizing procedures, and facilitating the integration of evidence-based practices into services. Whether organizations choose to follow the guidelines of the International Organization for Standardization (Müller-Isberner et al., 2016), quality standards developed by accrediting bodies for general health care organizations,[11] or their own quality standard network approaches (Barbaree & Goering, 2007; Haque, 2016; Thomson, 2016), it is becoming increasingly clear that forensic mental health services can and should implement systematic quality management processes.

The United Kingdom's Quality Network for Forensic Mental Health services has been particularly active.[12] From recent reports, they now have participants from 100 percent of all English, Irish, and Welsh medium-security units and 88 percent of English low-security units (Haque, 2016). This network has produced a series of accessible documentation booklets on standards for medium-security units, low-security units, community forensic mental health, prison mental health services, and a series of supplementary aids on such themes as intellectual disabilities and substance misuse (Haque, 2016). For medium-security units, the standards focus on four main themes: (1) Patient safety, which includes physical security,[13] procedural security,[14] relational security,[15] and the safeguarding of children and vulnerable adults; (2) patient experience, which includes patient focus, family and friends, and environment and facilities; (3) clinical effectiveness, which is comprised of patient pathways and outcomes, physical health care, and workforce; and, finally, (4) governance, which includes such indicators as accountability processes, incident reporting, and accessible complaints procedure (Quality Network for Forensic Mental Health, 2007). For low-security units, the quality network has developed standards around six main themes: (1) Models of care, including admission, recovery, physical health care, and discharge; (2) a safe therapeutic environment building on physical security, relational security, and procedural security; (3) service environment, which includes environmental design, risk assessment and management, de-escalation and seclusion, access to external spaces, and facilities for visitors; (4) workforce, which includes capacity and capability as well as training and continuing professional development; (5) governance, such as reporting and managing adverse

incidents and what is coined 'business continuity' relating to contingency plans; and, finally, (6) equality, which includes for example such indicators as compliance with mental health and human rights legislation and access to advocacy programs for service users (Quality Network for Forensic Mental Health, 2012). The network has also developed a series of initial standards for community forensic mental health services: (1) Models of care, including for example referral processes and care pathways; (2) safe working environment, which include physical, procedural, and relational security; and (3) governance, which includes among other things, audit structures, access to advocacy services for service users, and employment of service users in the organization (Quality Network for Forensic Mental Health, 2013). As of mid-2016, another national commissioning body is working toward the development of quality standards for the three high-security units.

Scotland's Quality Framework[16] for forensic mental health services has similar themes that were identified as important in the development of quality standards and practice indicators but are organized along slightly different themes: (1) Assessment, care, planning, and treatment, which include such indicators as admission assessment, care program approach, patient involvement, person-centered care, Mental Health Act compliance (this is a nonexhaustive list); (2) physical health, including drug testing protocols, physical health needs, and weight management; (3) risk (assessment, detention, compulsion, and patient safety), which includes structured professional judgment, patient involvement, and timescales for risk assessment; (4) management of violence, which includes de-escalation procedures, seclusion procedures, post-incident debrief, and patient support; (5) physical environment such as security system design and construction, visiting, technology, and contingency plans; and, finally, (6) team skills and staffing, which includes multidisciplinary teams, research, further education and development, and personal safety (Thomson, 2016). As with the rest of the United Kingdom, the Scottish network has also organized its standards around low-, medium-, and high-security units.

Müller-Isberner et al. (2016) conclude that the introduction of a quality management system facilitates better structure, standardization of procedures, continuous improvement processes, implementation of new best practices such as new risk assessment and management measures, transparency of the organization, and the survival of the knowledge within organizations, particularly when there is staff turnover. Moving from a stand-alone organizational model toward networks of forensic systems seems to be helpful for establishing and supporting the implementation of quality standards (Solomon, Day, Worrall, & Thompson, 2015). All of these initiatives pertaining to quality indicators and standards are helpful for organizations to structure, manage, and improve their services with the aim of providing better care and effective risk management of forensic mental health service users. They are also probably more likely to occur in high-income countries, where greater resources and expertise allow for a more intensive focus on institutional structures and measurement processes.

In the end, improving mental health and reducing risk for the well-being of service users and their loved ones, health care staff, and the general public are the

main goals of forensic mental health services. As with mental health services in general, other intervention attributes need to be taken into account (Thornicroft & Slade, 2014). These may include accessibility, acceptability, efficiency, cost-effectiveness, and evidence-informed practices. It is also suggested that outcome measurement be comprehensive and multidimensional—evaluating humanitarian, psychosocial, health, and public safety outcomes—and take into account the perspectives of multiple stakeholder groups (e.g., patients, caregivers, clinicians: Cohen & Eastman, 2000; Epperson et al., 2014). All of the abovementioned attributes may pose some challenges in forensic mental health as there are delicate balances to maintain between meeting the needs of the individual service users, in terms of both well-being and human rights, and satisfying the needs of other interest groups, including victims, the public, and the state. Very little research to date has examined these issues and together.

Many outcomes will be shaped by factors outside the control of the forensic mental health system, particularly institutional forensic mental health services, unless strong continuing links are created and care pathways are maintained in community-based services. In a recent meeting of mental health, justice, and safety stakeholders in Canada, the chronic lack of appropriate housing for forensic service users was identified as a major challenge for forensic services to transition people safely and promptly into the community (Crocker, Nicholls, Seto, Roy, et al., 2015c). Although there is ongoing debate, the available research argues against the development of parallel forensic mental health community services, but rather supports investing in better integration with general mental health services (Coid, 2007). Others have also called for a retooling or scaling up of practices in the general mental health care system in order to better address the needs, goals, and capabilities of forensic service users (Hodgins, 2009). It is hypothesized that a more integrated approach would foster a better understanding of forensic issues among general mental health care practitioners and would help reduce the stigma of receiving services from specialized forensic programs. It could also facilitate dissemination and adoption of quality standards across the continuum of care for forensic service users. We must also acknowledge that distal outcomes, such as recidivism and mental health recovery, are strongly associated with social and environmental factors, such as trauma exposure, environmental stressors, deprivation, poverty, and inequality, as well as access to and continuity of meaningful care and support in the community (Epperson et al., 2014; Seto, Charette, Nicholls, & Crocker, n.d.; Tew et al., 2012). Increased attention to these determinants in regards to assessing forensic mental health outcomes, including the processes that influence outcomes, is essential for better organizing the continuum of care and addressing the balance between public safety and individual rights and freedoms.

Despite a clear interest and need in implementing quality management strategies and developing cultures of outcome measurement in forensic mental health services, one must remain aware of potential invariance in the measurements; that is, the same outcome is measured for everybody irrespective of its importance for a particular person (Thornicroft & Slade, 2014). What is considered to be ultimate positive

outcome, such as recidivism reduction, may not be what is perceived as most important for the people who receive or provide forensic services (Livingston, 2016), or for other stakeholder groups, such as families. Reduction of symptoms may be important and helpful for the service users to start engaging in more meaningful activities, but perhaps the most important components of risk reduction or strengths development for a particular service user may be the possibility of developing significant relations with others. We must, therefore, remain cognizant of the recovery path of each individual service user and integrate the appropriate recovery components in the quality of care assessment process, which can be a challenge in light of some risk and criminogenic attributes that must be addressed. In their review on recovery in mental health, Tew and colleagues (Tew et al., 2012) propose a paradigm shift from "individualized 'treatment-oriented' practice to one in which working with family and friends, and promoting social inclusion, are no longer optional extras" (p. 455), focusing on enabling people to reach their aspirations by working not only with the individual but his or her social environment. The performance of modern forensic systems should be systematically evaluated with respect to their alignment with recovery-oriented or patient-centered principles (Livingston, Nijdam-Jones, & Brink, 2012), as is evident in the quality frameworks of England and Wales and Scotland, or their adherence to whichever model (e.g., the balanced care approach depicted in Figure 1.1) has been chosen to guide the organization and delivery of services.

4 What Are Some Major Challenges Concerning the Organization of Forensic Mental Health Systems?

Risk-Averse Society

The concept of risk refers to the probability of an event and the magnitude of its consequences; risk and probabilities can be difficult to grasp and can lead to a variety of responses in society. "Risk events interact with psychological, social and cultural processes to heighten or attenuate public perceptions of risk and related risk behavior" (Kasperson et al., 1988, p. 178). Sociologists argue that modern society is increasingly being structured around risk, with social institutions constituted to protect the population from perceived dangers (e.g., terrorism, climate change, infectious diseases, and financial crises: Beck, 1992). Some very low-risk phenomena, such as violent behavior toward a stranger by a person with a mental illness, can elicit strong public concern and insecurity (Monahan & Steadman, 2012). A fearful and anxious public turns to their government for protection, and, in turn, government officials (e.g., politicians) maintain social order by convincing the public of their capability to manage and control risk. Some politicians strategically use such opportunities to gain popularity and political advantage by promoting punitive and coercive measures (e.g., incarceration) to suppress 'risky problems' (Pratt, 2007). These harsh punitive measures are problematic in that they are largely symbolic and undermine the rehabilitative objectives of the criminal justice, forensic, and correctional systems.

Most Westernized or high-income societies are increasingly risk-averse—the current political situation around the world regarding the influx of Syrian immigration in many countries is probably one of the most obvious examples at this time. Closer to our current subject, one only has to think of the 'Not In My Backyard' (NIMBY)[17] phenomenon that persons with mental illness are often up against when trying to find housing in their preferred neighborhood. This risk aversion plays an important role in the organization of forensic mental health services, in particular regarding security levels, discharge planning and decisions for patients as well as legislation and policies pertaining to mentally ill offenders. In Canada, for instance, the Not Criminally Responsible Reform Act, which came into law in July 2014 under the conservative government, created a 'high-risk accused' category, mostly based on the severity of the offense, which increased and prolonged the restrictions placed on the subgroup of people found NCRMD. This type of reform is risk aversion-based, not rooted in any evidence, and the product of a penal populist style of governing (Tersigni, 2016). Penal populism is generally understood as a policy framework based on public opinion and fear rather than expert advice or an evidence base and leads to policy and legislation that are tough on crime. The tough on crime approach plays on its appeal for the public to have 'safe communities' and reduced violence and criminality regardless of the evidence (Bousfield, Cook, & Roesch, 2014; Cook & Roesch, 2012). A recent simulation study was conducted by applying retrospectively the criteria of the legislation on a sample of individuals found not criminally responsible on account of mental disorder. Results indicate that individuals who would potentially be designated high-risk accused reoffended at similar or lower rates than non-high-risk accused individuals (Goossens et al., 2016), thereby demonstrating that the new legislation may not in fact have the intended effects. Zero risk of course does not exist and can never be ensured in regards to human behavior, but the dangers of the risk-averse culture are the increased stigmatization, marginalization, and intolerance of persons with a mental illness who become involved with the criminal justice system. This, in turn, makes it increasingly difficult to assist individuals who need it most.

Even within the mental health services, some community service providers (e.g., mental health, housing, employment) are reluctant to work with discharged forensic service users who are perceived as being a risk of violence. Community forensic services are, thus, not always available or able to follow up patients that are returning to the community. In Ontario and British Columbia, two of the largest provinces in Canada, the civil health care systems are allowed to refuse to treat forensic patients. As a result, the patients may be staying in the forensic system for longer than necessary and thus occupy forensic beds that are otherwise greatly needed (Crocker, Nicholls, Seto, Roy, et al., 2015c).

The Perceived Dichotomy Between Recovery and Public Safety—Fuel for Penal Populism

The generally poor understanding of the relationship between mental illness and violence in the general public is partly due to the fact that, historically, the research

has not always been clear about this relationship (Monahan, 1992) and researchers have not effectively communicated what is known about justice-involved mentally ill persons in general (Crocker et al., 2015c). It may also be partially reinforced by an emphasis on a deterministic biomedical model of mental illness that can create dualistic thinking between individual recovery and public safety, in the eyes of the public and politicians. In fact, when it comes to violence and mental illness, there is a general tendency to view recovery and public safety as opposites, when the evidence has shown that it is through rehabilitation and recovery that one can achieve a reduction in risk (Dvoskin, Skeem, Novaco, & Douglas, 2012). The risk–need–responsivity model research also shows that excessive intervention that is disproportionate to risk can actually have the inverse effect of increasing risk (Andrews, 2012) and, consequently, decreasing public safety. Research has clearly shown that punitive policies and coercive practices tend to, in the long term, exert a negative effect on public safety. Some of the best examples were observed in the United States through the tough on crime legislation of the 1990s (Blumstein, 2012). Traditionally, conservative governments have argued for more incarceration/punitive approaches, while liberals tend to promote crime prevention strategies based on social development (Blumstein, 2012). The resurgence of conservative, right-wing governments around the globe will continue to pose challenge for forensic mental health services in striving for recovery-oriented approaches despite increasing pressures to be punitive, often fueled by highly mediatized cases to use punitive and coercively driven approaches. It will become increasingly important to develop clear messaging around short-, medium-, and long-term outcomes and programs that reduce recidivism rates in forensic populations and improve public safety in order to guide policy-making and reduce stigma. Future research could explore what are the most effective strategies for educating policy-makers and the general public around justice-involved persons with mental illness (Crocker et al., 2015c).

Forensic Mental Health Stigma

Stigma is a social process that aims to exclude, reject, shame, and devalue groups of people on the basis of a particular characteristic (Weiss, Ramakrishna, & Somma, 2006). It is conveyed by the widespread perception among the general public that individuals with mental illnesses are dangerous (Jorm, Reavley, & Ross, 2012; Mestdagh & Hansen, 2014; Parcesepe & Cabassa, 2013; Pescosolido, 2013; Schomerus et al., 2012). It manifests when people with mental illness feel as though they are devalued and discredited members of society, which can lead to hopelessness, poor self-esteem, disempowerment, reduced self-efficacy, poor treatment adherence, and decreased quality of life (Livingston & Boyd, 2010) and it ultimately leads to numerous structural barriers for accessing social and economic opportunities, such as employment, education, and housing, ultimately restricting the rights of people with mental illness and hindering their recovery.

Forensic mental health service users face substantial stigmatization, which results from intersecting psychiatric and criminal labels as well as other forms of

marginalization (e.g., poverty, racism). Roskes and colleagues (1999) identified 'double stigma'—the co-occurring statuses of being mentally ill and a convicted criminal—as a barrier to community reintegration. Similarly, in a study with ex-offenders who had co-occurring mental health and substance use problems, Hartwell (2004) provided evidence to suggest that problematic community reintegration is compounded by the intersection of these three statuses (mentally ill, addicted, ex-con), which she called 'triple stigma.' A small body of research has investigated stigma in the forensic mental health system (Margetić, Aukst-Margetić, Ivanec, & Filipčić, 2008; West, Vayshenker, Rotter, & Yanos, 2015; West, Yanos, & Mulay, 2014; Williams, Moore, Adshead, McDowell, & Tapp, 2011). The results of one study indicate that receiving specialized forensic services is associated with increased exposure to social stigma, such as being perceived by others as potentially violent. Additionally, forensic service users commonly experience instances of structural stigma, such as being refused access to services (e.g., housing, day programs) on account of the 'forensic' label (Livingston, Rossiter, & Verdun-Jones, 2011). These barriers are in addition to those that are directly related to mental illness and other forms of social and economic disadvantage.

Stigma is a major challenge for many mental health service users, including those who are in the forensic system. Obtaining employment, housing, and necessary services is made more difficult through the interlocking effects of multiple statuses and labels that combine to create oppression, disempowerment, and marginalization. To protect themselves from stigmatizing experiences, forensic service users may engage in behaviors, such as social withdrawal, that are unproductive for recovery from mental illness and desisting from crime. They may also be blocked from accessing vital resources (e.g., housing, social network) that are required for living a prosocial, healthy life in the community. Although more research is needed, the existing evidence suggests that stigma is influenced by the policies and practices of forensic mental health systems. The fact that forensic services users are exposed to greater levels of social and structural stigma is a factor that decision-makers should be aware of so that they can work toward mitigating such negative effects of the forensic system. At an individual level, this might include making programs available to help service users cope with negative effects of stigma, or, at a structural level, this would involve rectifying policies and practices that arbitrarily restrict forensic service users' access to social and economic opportunities.

5 What Are Some Emerging Approaches in Relation to Organizing Forensic Mental Health Systems?

In this section, we present a selected sample of emerging models and approaches that challenge the traditional or orthodox ways (i.e., custodial, biomedical, and sometimes coercive orientations) in forensic mental health. We chose to address four contemporary issues that are at the core of the forensic mental health business: safety, rehabilitation, knowledge exchange, and the role of the service user in forensic mental health services.

Providing Increased Ward Safety—The Safewards Model

Challenging behaviors such as verbal and physical aggression, self-harm, suicide, and medication refusal are relatively common occurrences in forensic settings (Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009). These behaviors place patients and staff at risk of serious harm and hamper rehabilitative efforts. Various 'containment' strategies have been used, from chemical and mechanical restraints to seclusion and special observation by staff in an attempt to manage these behaviors or improve outcomes (Bowers et al., 2015). Whereas some health care professionals defend these practices as necessary measures for protection, others have described the practice of seclusion and restraint as dangerous violations of human dignity and rights (van der Schaaf, Dusseldorp, Keuning, Janssen, & Noorthoorn, 2013).

The Safewards model is one of the most recent approaches for reducing and even eliminating seclusion and restraints in civil psychiatric settings (Bowers, 2014). The reciprocal relationship between conflict and containment are at the center of the model, whereby conflict triggers containment and containment procedures trigger conflict. In this model, conflict refers to the risk behaviors that service users engage in that could threaten their own safety and the safety of others. Containment refers to the prevention strategies that seek to minimize harmful outcomes or prevent conflict events from occurring at all. The model is constructed around the following six domains, which identify the main influences on conflict and containment rates: the staff team, the physical environment, outside hospital, the patient community, patient characteristics, and the regulatory framework (Bowers, 2014). The staff team domain includes the internal structure of the ward, which is composed of rules of service user conduct, daily and weekly routine (i.e., what happens and where), and the overall ideology asserted by the staff to highlight the purpose of the ward and what it offers to service users. The physical environment domain refers to the built environment's quality (i.e., better-quality environments evoke greater respect for patients, more comfort, and greater care) and complexity (i.e., more difficult to observe environments make supervision by the staff harder). The outside hospital domain highlights the stressors from outside the hospital relating to the service users' friends, family, or home. The patient community domain pertains to the collective values, beliefs, and behavior among service user groups and their relevance for producing contagion or discord. Moreover, the patient characteristics domain expresses a large variety of patient characteristics that can give rise to conflict behavior (i.e., symptoms, personality traits, demographic features). Finally, the regulatory framework domain refers to the external structure of the ward and includes the constraints on the service users' behavior dictated largely from outside the ward itself (i.e., Mental Health Acts, coerced detention, national policies, hospital policies).

With the aforementioned factors in mind, the Safewards approach seeks to reduce conflict as well as reduce the use of seclusion and restraints through workforce training, service user involvement, debriefing techniques, senior management commitment to change, and the use of audits to inform practice (Bowers et al.,

2015). The model also enables the creation of a list of interventions that could enhance the staff modifiers (i.e., actions of the staff as individuals or teams) that can influence the frequency of conflict and containment, thereby reducing conflict and containment rates (Bowers et al., 2015).

A body of research supports the domains in the Safewards model. Eggert et al. (2014) examined the person–environment interaction effects of environmental design on ward climate, safety, job satisfaction, and treatment. With regards to treatment outcomes, as perceived safety increased so did patient discharges, although only to a small degree. This result suggests that, when people feel safe in the treatment environment, treatment is more likely to have a positive impact, resulting in earlier discharge from the hospital. In another study, conducted by van der Schaaf et al. (2013), the 'presence of an outdoor space,' 'special safety measure,' and a large 'number of patients in the building' increased the risk of being secluded. On the other hand, design features such as 'total private space per patient,' a higher 'level of comfort' and greater 'visibility on the ward' decreased the risk of being secluded. Some support was also found in a literature review by Alexander and Bowers (2004) on ward rules, providing evidence that service users were in fact calmer and less disruptive on wards with clear, consistent rules, and clear roles for staff. Finally, service users' perceptions about the social climate of the ward were found to have a significant relationship with their satisfaction with forensic services. However, the variables most strongly associated with satisfaction with forensic services were their perceptions about the nature of therapeutic relations with staff (Bressington, Stewart, Beer, & MacInnes, 2011). Moreover, in a study of participant observation coupled with interviews of 131 staff collected over 38 months on four acute and two chronic wards, Katz and Kirkland (1990) concluded that violence was in fact more common in wards with unclear staff functions. Violence was less frequent in wards with strong psychiatric leadership, clear staff roles, and events that reflect the Safewards model's main principles.

Bowers et al. (2015) conducted a large-scale clustered randomized controlled trial over a three-month period to test a series of interventions to increase safety and reduce coercion. The results indicate that simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment. Furthermore, relative to the control intervention, when conflict events occurred, the Safewards intervention reduced the rate of conflict events by 15 percent and containment events by 26 percent (Bowers et al., 2015). Price, Burbery, Leonard, and Doyle (2016) used a service evaluation incorporating a nonrandomized controlled design to analyze the effects of Safewards on conflict and containment between and within wards. Informal feedback sessions with staff were conducted to explore views on the acceptability of the interventions and the adherence to the interventions was measured. The benefit of using the Safewards intervention in a between-ward analysis by measuring conflict and containment rates failed to reach significance. However, there was a significant association between ward, conflict, and containment. Furthermore, overall views of the interventions were valued more highly on female wards than on male wards. Staff from female

wards reported increased confidence in their role, increased psychological understanding of patient behavior, and reduced fear of patients. On the other hand, in male wards, the perception was that the interventions were only of use for patients who were receptive to care and that many of the patients were resistant to engagement with nursing staff at any level beyond having their basic needs met. Hence, interviews of patients and staff about the causes of patient violence gave strong support to the importance of positive appreciation, emotional regulation, teamwork skill, technical mastery, moral commitments, and effective structure (Bensley, Nelson, Kaufman, Silverstein, & Shields, 1995; Bond & Brimblecombe, 2004; Finnema, Dassen, & Halfens, 1994; Lowe, 1992; Spokes et al., 2004). In sum, the Safewards model is showing some promising results for a safer future for patients and staff in forensic mental services and merits further empirical inquiry.

Rehabilitation—The Good Lives Model

Offender rehabilitation has been a topic of continuous debate, with a profound shift in attitudes in the last few decades (Ward & Brown, 2004). As discussed earlier in this chapter, the risk-need-responsivity (RNR) model (Andrews & Bonta, 2006) has been a prevailing approach to treatment of offenders in Canada, as well as other parts of the world (e.g., Australia, the United Kingdom, and New Zealand), for the last three decades. As its underlying assumption, the model highlights that offenders are bearers of risk for recidivism, and that the primary aim of offender rehabilitation should be to reduce this recidivism risk. Although meta-analyses provide support for the efficacy of this model in reducing recidivism among general and sexual offenders (Andrews et al., 1990; Andrews & Dowden, 2005; Hanson et al., 2002), some researchers have argued that this evidence is insufficient to conclude that this treatment-based program is in fact effective. More specifically, Ward and Stewart (2003) argue that the RNR model does not pay enough attention to the individual and the idiosyncratic goals and preferences of service users.

The model proposed by Ward and his colleagues is highly influenced by the area of positive psychology rather than the cognitive behavioral/social learning framework of the RNR oriented programs. This theory of rehabilitation is known as the good lives model (GLM) and it represents a strength-based approach to offender rehabilitation. The model promises to enhance the effectiveness of current efforts by addressing limitations of the risk management approach and helping reduce recidivism rates (Andrews, Bonta, & Wormith, 2011; Lindsay, Ward, Morgan, & Wilson, 2007; Ward & Brown, 2004; Ward & Gannon, 2006; Whitehead, Ward, & Collie, 2007). The dual focus of GLM is to help offenders to live better by promoting personally important goals and equipping them with the skills, values, and attitudes necessary to reduce and manage their likelihood of committing further crimes (Ward & Gannon, 2006).

GLM identifies the primary 'human goods' that ultimately lead to an individual's sense of happiness, such as healthy living and functioning, knowledge, excellence in agency, inner peace, friendship, spirituality, and creativity (Ward & Gannon,

2006). The achievement of these primary goods is highly dependent on internal factors, such as skills and abilities, and external factors, such as opportunities and support networks, unique to the individual (Barnao et al., 2010). An individual seeking inner peace may, for instance, turn to substance use if they are unable to attain this 'human good' in more socially acceptable ways. The GLM integrates personal preferences into treatment planning through the completion of a comprehensive assessment to gain an understanding of how each offender conceptualizes a 'good life.' On the basis of that information, a treatment plan is designed to increase the person's capacity to achieve their version of a 'good life' using socially acceptable and legal means. By focusing on providing offenders with the necessary internal and external conditions for meeting their human needs in more adaptive ways, the assumption is that they will be less likely to harm themselves or others.

Proponents of GLM argue that it offers a unique approach to rehabilitating mentally ill offenders. Specifically, GLM conceptualizes people with mental illness as being no different from others insofar that they, like everybody, are attempting to achieve primary goods and live worthy lives. However, the presence of mental illness negatively impacts the salience of primary goods and compromises the means (i.e., cognitive, psychological, and social skills) by which they are obtained—all of which are further impacted by external variables (e.g., level of distress, financial resources: Barnao, Robertson, & Ward, 2010). Under the GLM framework, interventions and programming in forensic settings can establish new normative means by which individuals seek (and obtain) primary goods by assisting to increase an individual's capabilities and transition antisocial means to ones that are more socially acceptable (Barnao et al., 2010). However, the author suggests that for some cases, medical-modeled care remains the most realistic approach to achieving primary goods (e.g., inner peace: Barnao & Ward, 2015). Introducing GLM into forensic settings is timely given recent trends toward more holistic approaches to rehabilitation as well as efforts to reduce the negative effects of mental illness and criminal identities. GLM is also in keeping with human rights perspectives of offender rehabilitation for its concentration on service users as self-determining agents, rather than objects of risk management.

The most commonly cited criticism of GLM is its lack of strong empirical support. Recent programs using GLM have demonstrated positive results. For instance, Lindsay et al. (2007) reported that the GLM approach was an effective way of motivating sexual offenders with intellectual disabilities and encouraging them to engage in the difficult process of changing entrenched maladaptive behaviors. Furthermore, they also found that utilizing the principles of this model enabled therapists to make progress with particularly intractable cases (Lindsay et al., 2007). Additional research, principally with sex offender populations, has also confirmed the principles underlying the GLM model (Barnett & Wood, 2008; Harkins & Woodhams, 2012; Whitehead et al., 2007; Willis & Grace, 2008). Research with non-mentally ill offender populations demonstrate improved treatment engagement and therapeutic alliance, reduced dropout rates, and improved outcomes as a result of incorporating GLM principles into treatment programs (Barnao, Ward, &

Casey, 2015; Ware & Bright, 2008). Early research with forensic populations has found that GLM helped forensic service users discover their motivation for change through supporting the development of personally meaningful goals (Barnao et al., 2015) and has allowed practitioners to integrate various treatment theories into their work with patients (Barnao & Ward, 2015). Bouman, Schene, and de Ruiter's (2009) study of the short- and long-term effects of subjective well-being among forensic service users in the community found that satisfaction with health and fulfillment of life goals were associated with decreased offending (self-reported) in the short term. Moreover, in the long term, satisfaction with health and general life satisfaction were associated with reduced reconvictions for violence among those who were assessed as high risk. These findings support the notion that fulfillment of primary goods is associated with reduced recidivism as well as desistance. In sum, GLM has demonstrated preliminary effectiveness in enhancing treatment engagement, fostering desistance, and paying increased attention to environmental contexts. GLM has the promise to supply forensic mental health practitioners with the tools needed to engage difficult patient populations, and to strengthen the capacity of forensic service users to overcome tremendous challenges in their lives.

Providing Forensic Expertise Upstream in Mental Health

Research has shown that as many as three-quarters of individuals entering forensic services had previously received some form of psychiatric service (Crocker et al., 2015a). Studies have also reported patterns of individuals' unsuccessful attempts to obtain the help of health care providers during times of crisis and immediately preceding the commission of violent acts (Stanton & Skipworth, 2005). This points to an opportunity for violence or criminality prevention strategies to be put in place. To do so, forensic expertise and experience must be shared upstream by bringing the risk assessment and management knowledge to community-based and civil psychiatric services and programs in order to target risk factors and potentially prevent criminal behavior and violence. This is consistent with a key recommendation of a large Canadian group of stakeholders who gathered in Montreal in 2014 to establish a set of priorities for research and knowledge transfer in the field of mental health, justice, and safety (Crocker et al., 2015c). When forensic mental health and general mental health services work in different subsystems of care, this knowledge transfer is likely to be more onerous. Targeted and well-supported knowledge transfer strategies must, therefore, be implemented to share the forensic expertise. Knowledge exchange is a two-way dialogue and exchange of information between those who receive and use knowledge and those who generate and transfer it (Mitton, Adair, McKenzie, Pattent, & Perry, 2007). Effective knowledge transfer strategies are meant to draw upon existing relationships, resources, and networks to the maximum extent possible, while at the same time building new resources as needed by users. Crocker et al. (2015) suggested that current knowledge exchange initiatives in forensic mental health remain insufficient for the systematic use of empirically based risk assessment methods; only through a collaborative process of elaboration and

implementation of these tools will they be widely implemented and used (Scullion, 2002). Stronger partnerships between forensic and general mental health services could increase the cross-pollination of evidence-based risk assessment and management strategies with the aim of preventing the involvement of people with mental illnesses, especially those at risk for criminality and aggressive behavior, in the criminal justice, forensic, and correctional systems. In turn, these partnerships can provide increased opportunities for general adult mental health services to infuse forensic mental health services with recognized evidence-based practices such as integrated concurrent disorder (severe mental illness and substance use disorder) treatment strategies (Mueser, Noordsy, Drake, & Fox, 2003) and progressive therapeutic approaches (e.g., recovery-oriented). In turn, this would lead to increased continuity of care between the systems.

Patient Engagement/Service User Involvement

Over the past decade, there has been a strong push internationally toward models of mental health service delivery that are patient-centered and recovery-oriented (Mental Health Commission of Canada, 2012; U.S. Department of Health and Human Services, 2009). Patient engagement refers to the active participation and meaningful involvement of patients in a range of activities and decision-making processes in the health care system (Tambuyzer, Pieters, & Van Audenhove, 2011). It aims to provide patients with self-determination and control over health care decisions, and to move away from paternalistic health care practices toward systems of care that support patients' choices and acknowledge the value of their lived experiences (Forbat, Hubbard, & Kearney, 2009; Liberman & Kopelowicz, 2005; Tambuyzer, Pieters, & Van Audenhove, 2011).

In many ways, forensic mental health systems may seem to be unsuitable places for patient engagement. Certain characteristics of forensic services, such as the public safety and involuntary orientation, complicate processes aimed at building engagement and facilitating power sharing. The real potential for dangerous situations to occur means that containment and control practices are prioritized in forensic settings, and patient engagement activities may feel unsafe and uncomfortable for forensic mental health service providers. The characteristics of some forensic service users, such as antisocial personality disorder, criminal or violent histories, susceptibility to mental decompensation, poor illness insight, treatment nonadherence, suicidality, and risk of aggression or violence, can present serious impediments to adopting patient engagement strategies in a forensic mental health hospital (Green, Batson, & Gudjonsson, 2011).

For the aforementioned reasons, patient engagement historically has not been prioritized in the forensic mental health system. Nevertheless, a growing number of scholars and practitioners, who recognize the value of patient engagement practices and recovery principles, are wrestling with the issues associated with incorporating them into forensic mental health settings (Drennan & Alred, 2012; Gudjonsson, Webster, & Green, 2010; McKenna et al., 2014; Simpson & Penney,

2011). The service user movement in some jurisdictions, such as the United Kingdom, is particularly strong and has made substantial gains in the forensic system (Bowser, 2012; Spiers, Harney, & Chilvers, 2005). In order to support patient engagement at a systems level, organizations must place value on the lived experiences of service users and meaningfully involve them in the planning and delivery of services. Forensic service users would be supported to collaborate in their own care and to help others in similar situations (e.g., co-facilitation, peer support). They can also be integrated into quality improvement processes, involved in the hiring and training of staff, and engaged as peer researchers (Bowser, 2012; Livingston, Nijdam-Jones, & Team P.E.E.R., 2012; Livingston, Nijdam-Jones, Lapsley, Calderwood, & Brink, 2013).

Studies in this area are demonstrating that, despite the challenges, forensic service users can be engaged in ways that are consistent with recovery-oriented, patient-centered care approaches (Livingston, Nijdam-Jones, & Brink, 2012; Staley, Kabir, & Szmukler, 2013). Enhancing patient engagement in a custodial setting has the potential to enhance forensic service users' experiences of care (Livingston et al., 2013) and improve safety (Polacek et al., 2015). Greater research is needed to better understand how patient engagement and related approaches (e.g., recovery) influence forensic mental health processes (e.g., risk management) and outcomes (e.g., recidivism).

6 Conclusion

This review has exposed the breadth and variety of legal frameworks, processes, and pathways through forensic mental health services around the world. The term *forensic* contains many different kinds of services, populations, and systems, depending on where they are located in the world. Understanding that such heterogeneity exists is important for researchers to consider in relation to the generalizability of their findings to other contexts, and for administrators and clinicians to consider in relation to evidence-based practices. With this in mind, there is an obvious need to assess the performance of different models for organizing forensic mental health systems, fostering international comparisons, and controlling for population characteristics.

This review also demonstrated the interest of bringing forensic mental health research, practice, and administration closer to current trends in general adult mental health care, which is increasingly strengths-based, consumer participation-based, quality measurement-based, and community-oriented. We further propose a balanced care approach to the organization of forensic services, in line with general mental health services. Moreover, we also identified significant gaps in the literature in the area of community integration services for justice-involved people with severe mental health problems. A great deal can be learned by looking at complementary systems within nations, but also by looking outward—across nations—to find solutions for the urgent, transnational problems shared by forensic mental health service providers and administrators around the world.

Beyond the system-level characteristics identified in this review, the field would benefit from greater interdisciplinary (e.g., history, sociological, political science, social psychology, cultural studies) work to understand how the organization and structure of forensic mental health systems are influenced by, and reproduce, historical and ongoing social, economic, political, and cultural factors. A robust body of scholarship exists to understand the connection between punishment (and penal institutions) and society, and to trace this through history and compare it between different nations (Simon & Sparks, 2013). Connecting this body of theory and research to the context of forensic mental health systems would allow us to reach a deeper understanding of contemporary trends. There are, therefore, many future opportunities to expand the field of forensic mental health services by growing international, interdisciplinary collaborations.

Notes

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2 Although we focus our review on adult forensic mental health services, we acknowledge a growing need for research and thought into the youth forensic population. Furthermore, we do not specifically address the issue of forensic intellectual disabilities services, most of which are under forensic mental health services with some specialized services particularly prominent and well documented in the United Kingdom (Lindsay et al., 2010).

3 Equivalent of *not guilty by reason of insanity* in other jurisdictions.

4 A court-ordered detention of a convicted individual for treatment (e.g., www.nes-mha.scot.nhs.uk/people1e.htm).

5 The World Health Organization has published reports on the mental health systems of over 80 countries. They may be accessed here: www.who.int/mental_health/who_aims_country_reports/en

6 The difference between a placement order and a treatment order lays in the level of security: patients under placement orders are admitted to a forensic facility and may only be discharged by a court order. They are nearly always unlimited in duration and are most often given to patients who have committed a severe offense against a person. A patient under a treatment order is treated largely like a civil patient.

7 Also called the Victorian Institute of Forensic Mental Health.

8 In Canada, provincial correctional facilities are for individuals whose sentence is less than two years.

9 Most South American countries use the word unimputable to describe not criminally responsible offenders.

10 www.cost.eu/COST_Actions/isch/IS1302

11 https://accreditation.ca/hospitals-and-health-systems
12 www.rcpsych.ac.uk/quality/qualityandaccreditation/forensic/forensicmentalhealth.aspx
13 Usually includes physical environments such as the structure and design of buildings, fences, locks and keys, camera system circuits, communication technologies, alarms, etc.
14 Usually involves policies and procedures, search procedures, incident reporting procedures, debriefings, etc.
15 Usually involves staff motivation and training, knowledge of patients (strengths and vulnerabilities), multidisciplinary communications between security staff and clinical staff, etc.
16 www.forensicnetwork.scot.nhs.uk/quality-improvement
17 Acronym used by neighborhood residents to oppose the development or change in occupancy or a dwelling to house or support individuals who are 'undesirable' or 'unwanted' in a sector. Examples include supportive housing for persons living with a mental illness and safe injection sites.

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