

## **Implementation of the European Psychiatric Association (EPA) guidance on forensic psychiatry in Poland. Current state and required measures**

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### **Summary**

The article discusses the key aspects of the guidance of the European Psychiatric Association (EPA) on forensic psychiatry and the required actions to implement guidance into clinical practice. The authors pay attention to the discrepancies between the recommendations resulting from the guidance and clinical practice and current systemic solutions. The basic difficulties were discussed in relation to the implementation of the guidelines in the clinical practice in Poland as regards providing services as an expert by psychiatrists and psychologists, risk assessment and management, psychiatric therapy in detention centers, implementation of protection measures in inpatient and outpatient treatment conditions, efficiency of pharmacological and non-pharmacological interventions. We hope that discussing the content of the guidance will help to deepen the knowledge of clinicians in the field of work as court expert witnesses and persons responsible for the implementation of the preventive measure. Based on the clinical experience measures were proposed that enable implementation of the guidance, and thus improvement of the quality of care exercised over the mentally ill criminal offenders.

**Key words:** forensic psychiatric expertise, precautionary measures, guidance

### **Introduction**

Forensic psychiatry is the discipline of knowledge on the borderline of medicine, psychology and law, one of the goals of which is to treat mentally disordered offenders and other people who require similar care, including, among others, conducting pharmacological treatment, psychological assistance, assessment and management of the risk of violence, prevention of future violence, care for the quality of life of patients and corrective actions aimed at their safe restoration to the public. In judicial-psychiatric care systems in European countries, there are significant differences regarding legal

conditions, the tradition of forensic psychiatry, care organization, available resources, and accepted methods of treatment and conducting treatment of insane perpetrators of illegal acts [1, 2]. Criteria for admission to forensic psychiatry centers vary depending on the country and the legislative system. In some countries, including Poland, the existence of a relation of the illness with the act is required for the consideration of the use of a preventive measure, while in others, referral of the patient to psychiatric detention is possible in a situation when a mental illness and a criminal offence coexist. Forensic psychiatry in some countries is a separate medical specialty, in others it is included in general psychiatry or operates mainly in prison system [3]. It can be centralized in one or several large centers nationwide, or the therapy may be conducted in numerous smaller dispersed centers. In few European countries, including Poland, it is possible to implement a preventive measure in an outpatient setting. In some European countries, highly profiled centers are created for the needs of specific groups of patients, including, for example, long-stay centers. Also, the availability of places in forensic psychiatric institutions in European countries shows significant differences, for example < 3/100,000 (Italy, Switzerland, Spain) vs. 13/100,000 (Germany) [4].

In recent years, the number of patients admitted to centers of forensic psychiatry in Europe has increased [5]. In study covering eight countries [6], an increase of 110% in the number of places in forensic psychiatry centers in the years 1990–2006 was observed. Data from countries in which length-of-stay studies are conducted indicate that the stay in such centers has also been extended [7]. Although there are few studies in the field, the analysis of the length of stay indicates that the average length of detention may exceed the length of possible stays in prisons in the case of acts of a similar nature [8].

Taking into account, among others, the above data, within the framework of the European Psychiatric Association (EPA), the need was recognized to develop coherent guidelines for the procedure with mentally disordered people who committed an offence, treated in European countries. The key areas of the guidelines are defined as: sanity assessment, prerequisites for application of preventive measures, treatment in forensic psychiatry (pharmacological therapy, psychotherapy, other forms of influence), risk assessment and management, prevention of violence in the future, pathways for the return of forensic and psychiatric patients to the society.

The guidelines developed by EPA can become a valuable element of everyday clinical practice only when systemic and educational actions are undertaken to enable clinicians to apply them effectively. Such actions are proposed by the authors of this study, while discussing individual key points of the EPA guidelines.

## Material

### *Elaboration of the guidance:*

The works on the European Psychiatric Association (EPA) guidance on forensic psychiatry: Evidence based assessment and treatment of mentally disordered offenders

[9] commenced in 2016 under the direction of Prof. Birgit Völlm, from the university center in Nottingham. The work involved five forensic centers, including Department of Forensic Psychiatry of the Institute of Psychiatry and Neurology in Warsaw. The guidelines were published in the *European Psychiatry* journal in 2018.

## Methods

For the purposes of developing the guidelines, a review of the literature including, among others, MEDLINE, PsycINFO, EMBASE, COCHRANE databases was conducted. 4,422 articles that meet the established criteria were identified, and detailed analysis covered 188 references. The elaboration of the guidelines takes into account previously published guidelines and standards of conduct that directly or indirectly relate to forensic psychiatry, including, inter alia, documents of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the European Cooperation in Science and Technology, the European Psychiatric Association, the National Institute for Health and Care Excellence, the Royal College of Psychiatrists, and the World Psychiatric Association. Consultations with national psychiatric associations within EPA and members of the EPA forensic psychiatry section have been conducted. The final version was approved by the management of the EPA forensic psychiatry section. The text of the guidance was divided into four sections: the role of a psychiatrist as a court expert, risk, treatment of mentally ill offenders, and the effectiveness of treatment methods.

## Results

### Guidelines on the role of a psychiatrist/psychologist as a court expert

The guidelines define the role of a psychiatrist as a court expert in the area of sanity assessment, violence risk assessment, assessment of witnesses' testimony, and as an expert in the treatment of offenders, while respecting the highest substantive and ethical standards. An expert should clearly explain their role and clearly state that this is not the role of a therapist. Importantly, an expert should not be a physician providing treatment. An expert should obtain an informed consent, including the potential effects of cooperation and non-cooperation of the subject when issuing opinions. An expert is obliged to be impartial and not act as an 'advocate of the parties', however, as noted in the guidelines, the forensic expert's conclusions should be based on all relevant and sufficient information, including also information from third parties. Their work as an expert should be carried out in compliance with the principles of confidentiality, without disclosing information that is not necessary to prepare an expert opinion. According to the guidelines, it is up to the expert to assess whether the scope of expertise does not go beyond their scope of competence. An expert should conduct the examination in person, and the expertise should be written in a language understandable by non-professionals in the field of medicine. This applies in particular to the use of medical

terminology. The expertise should include a discussion of the data, including its synthesis in the context of the presumable cause-and-effect factors of the deed and the factors relevant to the risk assessment. An expert should explain the reasons for the use of psychometric tools, their limitations and whether they apply to the examined person. The expertise should highlight any doubts about the assessment, including any inconsistencies between the subjective assessment and objective findings and how this can affect the final conclusions.

The implementation of the EPA guidelines in our country requires significant legislative changes. In recent years, apart from increasing the responsibility associated with forensic psychiatry and introducing additional criminal sanctions, we do not observe any activities aimed at increasing the sense of security of experts or adequate financing of their work. Unfortunately, despite the code amendment, the status of an expert as a public official has not been legally regulated. However, criminal sanctions introduced recently against forensic experts are one of the reasons why doctors and psychologists do not undertake to act as an expert. They are deterrent to potential candidates. Concerns arise about, for example, such terms as 'inadvertently false opinion' and the related legal consequences. Unfortunately, as it happens quite often in practice, due to the divergent conclusions of several opinion-giving teams, there are fears that a part of the opinion may be considered 'inadvertently false'. An expert is the addressee of verbal attacks (sometimes also physical) from the evaluated person. It is incomprehensible for experts that the Court forces to conduct a forensic psychiatric examination in the place of residence of an evaluated person. The safety of experts delegated to carry out such an examination without any additional measures to ensure safety is not taken into account.

In practice, an expert psychiatrist is expected to work more and more intensively, sometimes under the threat of a financial penalty, which is particularly depressing and discouraging to undertake cooperation with the Court. Significant disproportions in the remuneration of experts, compared to clinical work (the hourly rate is now PLN 32.38 for an expert without a scientific degree and PLN 45.63 for an expert with a doctorate degree) discourage practitioners from acting as a court expert. Additional objections arise over the Court's decisions regarding the adjustment of the issued hourly time sheet, in which the number of hours needed to complete subsequent stages of the opinion is questioned. This, in our opinion, has a direct impact on the quality of issued opinions.

Although the authors of this study do not know the demographic statistics of expert psychiatrists and psychologists in Poland, practical experience indicates that in both groups the mean age increases with subsequent years. In recent years, the number of expert psychiatrists from the list of Presidents of District Courts has been significantly falling, which translates into an excessive workload for active experts. This is associated with numerous pressures from the courts to issue opinions, sometimes by appointing experts to draft an opinion without obtaining their consent. Such practice should not be accepted.

The guidelines clearly show that an expert should strive to reach the conclusions on the basis of all relevant and sufficient information. In our opinion, this is a sufficient basis for experts to request completing the evidence in terms of missing key information that cannot be found in the case files. Thus, such an action should not be understood as interfering with the procedure. Thus, in the event that an expert notices the need for justified changes regarding the scope of the opinion (investigated problems, source materials, e.g., documentation), they should submit their proposals to the court and undertake the execution of the expert opinion after explicit acceptance in the form of an extended decision. Then, an expert should conduct a personal examination after prior explanation of the purpose of the examination, presentation of its characteristics and obtaining the informed consent of an examined person. In the case of a personal examination, the expert decides on the selection of diagnostic tools and bears responsibility for this. The research tools used should meet psychometric values. In addition, they should be selected in such a way that it is possible to verify the research hypotheses, to take into account the capabilities of the subjects, their attitude towards the research and the competences of the examiner.

The opinion should be prepared in a clear and transparent manner in terms of form and content. Individual parts should be separated adequately to the presented problems and titled according to their content. All specific terms used by the expert should be explained or given the source data to which the experts referred. In the case of a psychological opinion, it should be clearly indicated that both raw and calculated scores cannot be included in the content because it violates the ethical standards of a psychologist and can lead to misinterpretations made by people who are not professionally prepared, which in turn may prove detrimental for the subject.

The practice of forensic psychiatric evaluation in our country is largely in contradiction with subsequent EPA recommendations. Assessment of the possibility to carry out an expert opinion should be made by an expert who, better than the Court, knows their professional competence. The practice of appointing experts from expert lists for competent courts only takes into account formal education and not the scope of competence. The introduction of certification for expert psychiatrists and psychologists, postulated for several years by the Polish Society of Forensic Psychiatry, preceded by educational activities, would undoubtedly raise the quality of opinion-making. According to the EPA guidelines, an expert should not be an attending physician or therapist. The legal regulations applicable in our country, however, somehow enforce such a situation. This applies to the issuance of written opinions and appearance in courts of teams conducting treatment of patients during the implementation of the preventive measure. This is not conducive to the establishment of a therapeutic relationship and puts the treating teams in a dual role. The solution implemented in some countries is the introduction of an audit, e.g., every 2–3 years, carried out by external experts, regarding the indications and form of implementing a preventive measure.

The guidance also stressed the need to note inconsistencies between the findings of the study and the records. In the opinion-making practice, in particular regarding

declarations of will, often the data from the files, including the testimonies of witnesses, are contradictory. In such situations, it seems reasonable to consider issuing alternative opinions, depending on the opinion of courts regarding the credibility of the testimony of witnesses.

### Guidelines for risk assessment

The guidelines pay a lot of attention to the risk assessment issues in the context of issuing specialist opinions and preventing the phenomenon of re-offending among mentally disordered offenders. The risk assessment process includes unstructured clinical assessments, actuarial risk assessments (ARA) and structured professional judgements (SPJ). As the clinical evaluation is burdened with a small predictive capacity [10], it is recommended to use the ARA or SPJ tools. Actuarial risk assessment (ARA) is a statistical method based on algorithms, and the results are presented in the form of probabilities (numerically). On the other hand, the structured professional assessment tools (SPJ) also take into account the dynamic factors and the current state of the examinee, thus giving the opportunity to set therapeutic goals and risk management (risk assessment at the beginning of the treatment process) and follow the progress of the treatment process (periodic assessment).

The authors of the systematic review devoted to risk assessment tools [11] identified over 80 variables and 20 formal tools to assess the risk of re-offending in relation to violence and sex offences. A meta-analysis of 68 studies on the risk assessment of violence [12] showed a comparable predictive ability of the actuarial risk assessment and structured clinical evaluation. Attention was paid, among others, to the greater predictive power of tools developed for specific groups, for example sex offenders, as compared to the tools dedicated to general population. In clinical settings, due to the properties allowing their use in planning the therapy, SPJ tools are more willingly chosen by clinicians. The HCR-20 scale is currently the tool with the highest prevalence (Historical Clinical Risk Management 20), versions 2 and 3. In penitentiary conditions, ARA-type tools find a wider application, in particular with respect to sexual offenders, where their predictive value exceeds the SPJ-type tools [13]. The EPA guidance underlines that the use of psychometric assessment tools also entails the risk of false positive results (finding high risk in people with actually low risk), and thus extending the period of deprivation of liberty. The meta-analysis results showed that the most frequently used tools are effective in identifying people with low risk, however, poorly or moderately effective in identifying people demonstrating high risk (low or moderate positive predictive value).

The authors pointed out that psychometric tools may be important in the therapy planning process, but they warned against treating the results of the use of tools as the only factor determining making the decision to initiate or release from the treatment under the conditions of a preventive measure. Special attention should be paid to certain groups, including women and people with intellectual disabilities.

The authors of the guidance also drew attention to the importance of protective factors, for example, by providing SAPROF (Structured Assessment of PROtective Factors for violence risk), a tool developed for combined use with the HCR scale. The results of the research bring contradictory results relating to the increase of the predictive value when using SAPROF in comparison to the risk factors assessment tools, nevertheless the assessment and evaluation of protective factors in the clinical practice may increase the motivation for treatment, the process of social rehabilitation and return to society. The results of the study published after the guidance were issued [14] seem to support the statement of an increase in the predictive value with the combined use of the HCR-20 and SAPROF. The authors of the studies devoted to risk assessment point out that the assessment of the predictive effectiveness of tools is hampered by inadequate monitoring of the re-offending phenomenon. The guidance emphasize that the risk assessment should be inextricably linked to the implementation of specific therapeutic procedures (risk management).

In Poland, a significant limitation in the use of risk assessment tools is both their low availability and the lack of awareness of the need to use them in a group of professionals. With the exception of the HCR-20 and related instruments, including SAPROF, which are translated into Polish, there are no Polish versions of other commonly used tools, such as the Dundrum, Sexual Violence Risk – 20 (SVR–20), Forensic Psychiatry and Violence Oxford (FoVox) Tool or similar tools. As the authors emphasize, the HCR-20 is available free of charge. However, due to the specificity of risk assessment, it is highly justified to participate in trainings devoted to the use of this tool. The dissemination of risk assessment tools would undoubtedly facilitate the development of individual treatment plans, and thus more effective risk management. This requires significant financial outlays from entities running forensic psychiatry wards, financed by a national payer. Costs related to risk assessment should be included in the valuation of service provisions in psychiatry. The development of guidelines for risk assessment in the Polish reality by the forensic psychiatry environment would certainly have a positive impact on the quality of care (through risk management) and would also be an argument in enforcing the necessary expenses for training and professional development of psychiatrists and psychologists. It also seems necessary to gradually introduce Polish versions of further risk assessment tools, including those dedicated to individual groups of patients and their implementation in the clinical practice.

#### Guidelines for treatment in non-confinement conditions

The authors of the guidance emphasize that the group of patients treated under open settings (outpatient detention) is a group with diverse and complex problems, as well as health and social needs. These are patients manifesting, among others, mental disorders, personality disorders, border intellect or mental retardation, or cognitive dysfunctions. It has been pointed out that patients in this group often exhibit disorders of subliminal severity, such as transient psychotic disorders, harmful use of psychoactive

substances and alcohol, moderately severe learning disorders, which may disqualify them from treatment in the community conditions. This group of patients should be guaranteed the same access to care as non-offending patients. The proceedings should also include a number of non-medical influences, including, for example, social skills training. Considering the complexity of the needs, the assertive models of wide-range care have been used in this group of patients, adapted to the conditions of forensic psychiatry (assertive community treatment – ACT). Although the results of the studies showed the effectiveness of these programs in the therapeutic sense, they did not unambiguously confirm any high effectiveness in reducing the number of recommitted offences. So far, the results of the studies [15–17] have not unambiguously confirmed that compulsory treatment in outpatient settings is significantly more effective in preventing re-offending than standard community care.

In Poland, the implementation of a preventive measure in outpatient settings has been possible since 2015. Unfortunately, the change of law did not entail the necessary changes in the organizational structure of the psychiatric care system. It remains a matter of argument whether the implementation of the preventive measure should be carried out by specialized entities, e.g., outpatient clinics related to forensic psychiatry wards, or care and supervision should be carried out within the district mental health outpatient clinics or mental health centers. It will be necessary to enter this health service into the list of guaranteed services. The clinical experience speaks for the former solution. The specifics of working with a forensic patient requires not only treatment but also risk assessment of the patient's behavior for the public. It also requires providing appropriate safety conditions for staff. It seems unrealistic to expect that the risk assessment carried out by psychiatrists unrelated, on a daily basis, to forensic psychiatry will have similar reliability compared to the one carried out by the practitioners in this area.

Another issue requiring legal regulations is the possibility of referring a detention patient during the deterioration of the mental state to hospital treatment – in the form of a critical, intervention hospitalization. Deterioration of the mental state is not identical with the necessity to restore detention in hospital conditions. In our opinion, clear regulations are also required for defining the principles under which outpatient detention is financed and the real valuation of this service. As mentioned above, we believe that carrying out outpatient detention requires special supervision over the patient's mental condition and compliance with therapeutic recommendations. It becomes possible in the conditions of regular visits, even at intervals of several days, ensuring full access to pharmacological treatment, including in the form of depot preparations, in conditions enabling safety for other patients and employees in the health care sector. Doctors conducting treatment are also required to develop periodic forensic-psychiatric opinions regarding the course of treatment, or appear in relevant courts. For these reasons, it is impossible to agree with the statement that the care of a patient referred by a court generates the same costs as the care of a patient coming to the clinic voluntarily. Not without significance for further optimization of the care

system is also the fact of conducting prospective studies on the effectiveness of outpatient detention in the prevention of re-offending. Summing up, in the current situation, the first step to organize the system should be drafting the secondary legislation for the implementation of the preventive measure in an outpatient form, including regulations on ensuring adequate expenses related to this form of care.

### Guidelines for treatment in inpatient settings

Treatment in specialist psychiatric centers requires more expense than a therapy carried out in prisons, however, it results in a smaller percentage of re-offending [18]. The results of meta-analyses [19] indicate that in preventing the risk of re-offending, as in the case of mentally healthy offenders, the general criminogenic factors may, however, be more important than the existence of a mental illness. In most European countries, the implementation of the preventive measure is carried out as several levels of protection, depending on the risk and specific needs of patients. On the one hand, this solution allows for better tailoring of the care to the needs of patients, on the other, it poses the risk of extending the time of stay in the shortage of places in other centers.

Clinical characteristics of forensic psychiatry patients in individual European countries is also significantly varying. For example, in the Netherlands, a high proportion of forensic patients are people diagnosed with personality disorders. Patients diagnosed with psychotic disorders predominate in other countries. Due to the nature of social expectations and the heterogeneous character of the group of patients, in addition to the specific impacts described in the further part of the guidance, the forensic psychiatry should pay special attention to the therapeutic environment (therapeutic community) of the institution and to guarantee safety. The authors of the guidance cite the results of the expert opinion analysis [20] carried out using the Delphi method concerning key elements of care in high security conditions including safety issues, some pharmacological (clozapine), psychological (CBT-based) and social (e.g., off-ward activities) interventions, and general elements of care delivery (a multidisciplinary approach, patient involvement). The same authors carried out a systematic review of the study regarding high security treatment, identifying 22 studies, including 13 from European countries [21]. The results of the study confirmed the effectiveness of, among others, cognitive behavioral interventions, psychoeducation and antipsychotic treatment. However, as the authors emphasize, the evidence of efficacy came mainly from individual, non-randomized studies conducted on small groups of patients.

In Poland, a preventive measure in hospital conditions, in relation to mentally disordered offenders, is carried out in centers with three levels of security. The number of hospital beds over the past years has fluctuated between 2.1–2.3 thousand. Clinical experience and the results of a pilot study conducted at IPIN indicate that the majority of patients suffer from schizophrenia spectrum disorders (63% in the IPIN Department of Forensic Psychiatry in 2013–2018). There is no widely published population data regarding the implementation of the preventive measure in Poland, characteristics

of the group of patients and specific therapeutic interventions that are carried out in this group. In Poland, the realization of detention in centers with different levels of security is undoubtedly a response to the diverse needs of patients, especially in the aspect of security. However, clinical practice indicates that due to the length of court proceedings, there are cases of several months waiting for being transferred to another center. A particular threat here is a situation where the preventive measure should be implemented in a higher security facility, which is usually associated with aggressive or autoaggressive behavior of the patient and thus the inability to ensure safety for the patient, other patients and the environment in the current place of residence, and several-week court proceedings effectively make it impossible to being transferred. The introduction of a quick legal path to change the place where the preventive measure was implemented in such situations would significantly improve security in court wards.

Another solution to optimize the system of forensic psychiatry in Poland would be the introduction, on the model of other European countries, of the possibility of re-evaluation of the diagnosis in the preventive measure realization conditions. It is not difficult to imagine a situation where the diagnosis given in, e.g., the period of intoxication with psychoactive substances or as a result of simulation during a forensic psychiatric examination or even a forensic psychiatric observation, is not confirmed during a several-month implementation of the preventive measure. In such cases, as forensic psychiatry centers, according to their nature, do not have the possibility of effective rehabilitation – we are of the opinion that the court should be able to direct such a person to prison. In some countries (e.g., in the Netherlands), there are centers dedicated to carrying out forensic psychiatric observation as regards the further implementation of the preventive measure.

An important problem for forensic psychiatry institutions is the need for urgent medical intervention outside the institution. At the moment there are no legal regulations in place regarding the decision to escort a patient to another medical facility, outside of the hours of the Courts' work. There is no doubt about the need for urgent consultation or treatment of a patient in another medical facility in a life-threatening situation. Doubts refer to the supervision of a person temporarily leaving the center for other medical consultations or treatments. During the implementation of the preventive measure, the patient should be escorted during the transport by the Police due to their own safety, safety of the environment and the risk of escaping. This supervision should also be continued during the stay in another institution, which unfortunately is not always implemented. There are expectations that the employees of the detention ward are to supervise the transport and stay of the patient in another medical facility, which is usually not in line with the scope of their duties. In addition, they should not leave the workplace because of the threat to the safety of patients remaining in the wards.

Significant heterogeneity of the patient group, including, e.g., people suffering from psychotic disorders, mental retardation, disorders associated with irreversible damage to the CNS, co-existing addiction and psychotic disorders associated with the use of psychoactive substances – forces forensic psychiatry centers to provide a range

of specialized interventions. Considering the significant dispersion of forensic institutions in Poland, the number of places in individual centers, safety requirements and financial expenses of the payer (directly – per capita and indirectly – in comparison to expenditure on general psychiatry, disproportionate in relation to other European countries), creating centers formally dedicated to particular groups of patients seems to be the most rational solution. Groups requiring special, highly specialized support are patients diagnosed with mental retardation, patients with co-existing addiction to alcohol and psychoactive substances and with the diagnosis of coexisting profound personality disorders. Another condition for the effective implementation of the EPA guidance is the provision of an adequate estimate by the payer of labor costs in forensic psychiatry centers. The working conditions, both for medical personnel, including doctors, psychologists, nursing staff and auxiliary staff, due to the specificity of working in a group of more dangerous patients and in relation to the liability resulting from risk management, should be an incentive to work in the conditions of forensic psychiatry.

#### Guidelines for prison psychiatry

The authors of the guidance cite the results of the analysis of 62 tests covering 23 thousand prisoners, which revealed in this population more than 3.7% of people with symptoms of psychosis, more than 10% with symptoms of depression, 65% with personality disorders (of which 42% have antisocial personality features). The percentage of alcohol addicts ranges between 18–30%, from drugs and other psychoactive substances in the range of 10–48%. Suicidal rate: 58–147/100,000 in the group of prisoners compared to 16–31/100,000 in the general population. The treatment of mentally ill prisoners varies from one country to another, including obligatory transfer to a forensic psychiatry institution (Ireland), treatment only in the prison ward (Belgium, Lithuania), or both are possible. The authors of the guidelines point out that access to psychiatric care should be implemented, among others, in accordance with UN recommendations (The United Nations Standard Minimum Rules for Treatment of Prisoners), recommendations of the Council of Europe (Recommendation No. R (98) 7) and guidelines of the World Medical Association and the World Psychiatric Association.

Although the problem of the functioning of psychiatric departments within the Polish penitentiary system undoubtedly requires a separate study, attention should be paid to the personnel, pay and accommodation problems of the said units and the declining number of beds within psychiatric wards in prisons reported by clinicians.

#### Guidelines for psychological interventions

Over the last years, there has been a significant change in the perception of the importance of psychological interventions in forensic psychiatry. Evidence of the effectiveness of psychological interventions in the group of mentally disordered offenders concerns both the reduction of aggressive behaviors as well as sexual offences. In the

latter case, due to small differences in the test results compared to the control groups, they still evoke lively discussion. The starting point in dealing with offenders may be the risk-need-responsivity (RNR) model [22], including the rules of the risk, need and responsivity, although due to the specificity of the forensic psychiatry conditions, the assumptions of this model are often adjusted to the group of recipients. Other models of guidelines cited by the authors include, among others, strengths-based good lives model [23] focusing on strengthening the functioning of the offender as a person by increasing their ability to achieve goals and meet their needs in a socially acceptable way. Systematic reviews of interventions aimed at reducing aggression and violence [24, 25] have demonstrated the effectiveness of, among others, social support, training of social skills, cognitive behavioral methods (including the Reasoning & Rehabilitation program, developed by E. Ross and E. Fabiano). E.g., training of cognitive functions, communication skills training and music therapy may be helpful in increasing patients' involvement and cooperation in therapy. Among women, effectiveness in preventing re-offending has been additionally demonstrated in relation to interventions aimed at early traumatic experience and co-existing addiction to psychoactive substances. In the group of sex offenders, there is no incontrovertible evidence regarding the effectiveness of highly specialized therapeutic programs. In relation to patients with personality disorders, a certain effectiveness of dialectic behavioral therapy, emotion recognition training, psychoanalytic therapy (also in borderline patient groups), CBT or short-term psychodynamic therapy in mixed personality disorders was demonstrated. Interpretation of the results of comparative tests is hampered by the high percentage of people who have not completed therapy, relatively short observation time and inconsistency of therapeutic programs.

At present in Poland, in the wards of forensic psychiatry, the lack of unified therapeutic programs seems to be the main problem due to the very diverse level of functioning of patients in each department (regardless of the degree of security) and a wide spectrum of psychiatric disorders including schizophrenia spectrum disorder, mood disorder, neurodevelopmental disorder, co-existing addiction to psychoactive substances, sexual preference disorders, and personality disorders.

At the moment, there are no dedicated therapeutic programs, strictly taking into account the specificity of forensic psychiatry wards. Despite the known models aimed at reducing aggressive behavior, the process of their implementation is largely determined by the dynamics of the course of mental disorders in individual patients. This requires great flexibility from psychologists/psychotherapists in choosing and modifying methods of intervention due to the changing state of the patient (e.g., withdrawal from the group due to deteriorated functioning of the patient and therefore intensified individual interventions), and also because of the risk of aggressive behaviors of the patient.

Another problem seems to be the lack of relevant training that would be dedicated to psychologists working in forensic psychiatry departments. The specificity of working in a forensic psychiatry ward requires from a psychologist, among others, a wide spectrum of knowledge in the field of overall psychological diagnosis, proficiency in

forensic psychological assessment, therapeutic work with a patient who has committed a criminal offence and often still exhibits aggressive behavior. This illustrates the need to create a comprehensive training integrating issues from very different areas of psychology (knowledge in the field of psychopathology, psychotherapy, forensic-psychological evaluation and dealing with a potentially aggressive patient). In addition, as in the case of physicians working in this type of departments, psychologists are imposed a dual role, on the one hand – therapist, and on the other hand – issuer of an opinion on the need for further use of a preventive measure. This obviously distorts the therapeutic relationship when the opinion, as understood by the patient, is not beneficial for them. Thus, it would be extremely important to introduce a rule, properly regulated by law, that the psychologist attending to the patient is not at the same time the person issuing the opinion in the patient's case.

Diversified, individual course of disorders, varying severity of aggressive and autoaggressive behaviors and, which is related, the necessity to create individual therapeutic strategies, illustrates the need to increase the number of psychologists in the departments. This would enable the creation of a patient-oriented strategy. It should be emphasized that the implementation of therapeutic tasks in court wards is difficult due to the fact that they are not profiled wards. Patients with a full spectrum of mental disorders are staying in them. Therefore, in this type of wards, the number of psychologists/psychotherapists should be clearly higher in relation to the wards profiled in specific areas of disorders. In the forensic psychiatry wards, it is reasonable to use a spectrum of interventions, from pre-therapeutic (dedicated to people currently found in active psychosis) to psychotherapeutic (dedicated to people with dual diagnosis, psychotic episodes in the past and with personality disorders). Additionally, drug rehabilitation, individual and group therapy, as well as training of social skills and cognitive functions tailored to the needs of patients with different levels of functioning are one of the key ways of interventions. Due to the fact that the victims of criminal offences are often the closest people, it seems reasonable to use systemic therapeutic interventions.

Another aspect of the psychologist's work in the area of forensic psychology is forensic psychological assessment, which additionally requires, beyond the knowledge of therapeutic models, psychological diagnostic skills for the needs of court proceedings. It would seem reasonable to introduce regular trainings constantly improving the qualifications of psychologists working in this area. It should be emphasized that at the moment most of the trainings for psychologists require significant financial outlays on their part, which, due to the obtained compensation, often makes it difficult or impossible to improve professional qualifications.

### Guidelines for pharmacological intervention

The authors of the guidance relate to both the proceeding in the case of aggressive behaviors and pharmacological prevention of aggression, paying special attention to the fact that non-pharmacological procedure (including de-escalation techniques, ensuring

a safe environment) should precede pharmacological interventions used in the event these measures prove ineffective. The authors cite the results of studies confirming that adequately early pharmacological interventions prevent both the use of coercion [26] and reduce the risk for personnel [27].

In the case of aggressive behavior, antipsychotic drugs, benzodiazepine derivatives, combinations thereof, and other sedative medications are used. While selecting the drug, the patient's general condition, possible complications (including water and electrolyte disorders, carbohydrate disorders, NMS risk), possible drug interactions, route of administration of the drug, as well as, if possible, patient's preference should be taken into account. The authors point out that there is no ideal medicine. Some guidelines (among others NICE in the UK) recommend using lorazepam im., haloperidol im., promethazine im. There is no convincing data on the higher efficacy of combination therapy compared to monotherapy. Lorazepam may be the first-choice drug in patients with unknown history of treatment and in people with cardiological disorders. It was emphasized that there is a significant risk of serious side effects in combination therapy with olanzapine and benzodiazepine im. derivatives (including hypotension, bradycardia, depression of the respiratory center). In the case of agitation associated with the use of psychoactive substances, in alcohol withdrawal syndrome and in the case of an unknown cause of agitation, benzodiazepine derivatives may be the first-choice drugs. Particular attention should be paid to the risk of respiratory center depression and hypotension, especially in people with respiratory diseases and those under the influence of alcohol. During pharmacological sedation one should monitor, among others, the patient's state of consciousness, heart rate, respiration rate, blood pressure, temperature, and possible side effects of the drug.

Regarding the pharmacological prevention of aggressive behaviors, the results of the research [28] prove that pharmacological treatment in people suffering from psychotic disorders reduces aggressive behavior. In pharmacological treatment antipsychotic drugs are used, and because of the risk of side effects and pharmacological profile, second-generation antipsychotics are preferred. Pharmacological interventions should be supported by psychoeducation and strengthening the therapeutic relationship (adherence therapy). The authors cite the results of studies [29] showing that the use of preparations in the depot form significantly reduces the risk of subsequent aggressive behaviors in the group of forensic patients. Drugs with a strong anticholinergic potential should be avoided due to the negative effect on cognitive functions, which significantly weakens the patients' ability to benefit from therapeutic interventions. In cases of emotional control disorders associated with comorbidities, treatment should be directed to the treatment of basic diseases, among others, in the case of Alzheimer's disease. In patients with high impulsiveness, e.g., antiepileptic drugs, lithium, SSRIs find their application. Most data refer to antiepileptic drugs including valproate, carbamazepine, oxcarbazepine, and phenytoin. For patients with acquired CNS damage, propranolol has been shown to be more effective in reducing aggressive behaviors than carbamazepine and valproate [30].

In Alzheimer's disease, olanzapine and risperidone may reduce the severity of aggressive behavior [31]. There is insufficient data to confirm the effectiveness of pharmacological treatment in the prevention of aggression in people with personality disorders. Single studies have demonstrated the efficacy of antiepileptics, nortriptyline, bromocriptine, and phenytoin in reducing impulsive aggression in perpetrators with antisocial personality disorders. Few studies have demonstrated the efficacy of second-generation antipsychotics (including quetiapine, aripiprazole) and antiepileptic drugs (including sustained-release valproate, topiramate, lamotrigine) in the prevention of aggression in people with borderline disorders. Individual studies have demonstrated their effectiveness in preventing aggression in people with SSD, in people with personality disorders of the antisocial type. Few studies have shown that clozapine is more effective than other psychotics in reducing the re-offending rate, although the authors of the systematic review [32] conclude that there is insufficient evidence to date that clozapine is superior to other antipsychotics. Regarding the treatment of sex offenders, the authors recommend that they follow the recommendations of the World Federation of Societies of Biological Psychiatry, including the use of serotonin reuptake inhibitors and anti-androgen drugs depending on the level of risk.

Due to the general European nature of the EPA guidance, the study included medicines available in various European countries, some of the preparations or routes of administration are not available in Poland. Clinical experience shows that the methods suggested in the guidelines do not differ from the practice adopted in Poland. The importance of using de-escalation techniques in the prevention of aggressive behavior is certainly worth emphasizing. Certainly, educational activities in this area, including training of medical and auxiliary staff, would have a positive effect. The practice of forensic psychiatric evaluation indicates that the need to strictly monitor the mental state and basic parameters of a patient under the influence of sedating drugs, in particular taken without the need of coercion, is not fixed in the consciousness of practitioners. The guideline reminds us of this. As regards the prevention of aggressive behavior in people with psychotic disorders, the guidance pays special attention to the safety of drug use. However, for individual formulations, the recommendations remain on a general level, which seems reasonable in the context of individual patient needs. In addition, the guidance draws attention to pharmacological interventions aimed at neurochemical and neurostructural mechanisms of agitation and aggression other than in psychotic disorders, including interactions with the serotonergic system, the stabilizing potential of antiepileptic drugs, and the properties of beta-blockers. Nevertheless, as the authors emphasize, the availability of research results in this area is still insufficient.

### **Recapitulation and conclusions**

The intention of the authors of this study was to present the content of guidelines for the work of people involved in forensic psychiatric care and to discuss the basic problems related to the implementation of the guidance in clinical practice. We hope

that discussing the content of the guidance will help to deepen the knowledge of clinicians in the field of work as court expert witnesses and persons responsible for the implementation of the preventive measure. We have tried to draw attention to the frequently significant differences between the recommendations included in the guidance and the current clinical practice and system solutions. We hope that some of the problems identified by us will draw the attention of decision-makers to the necessity to have a closer look at legal regulations, work organization and ensuring adequate financial resources in the scope of participation of psychiatrists and psychologists/psychotherapists in the process of court proceedings and taking care of mentally disordered offenders. The issues indicated and discussed by us certainly do not exhaust the list of problems related to the implementation of preventive measures, however, we hope that the gradual introduction of the guidance will help to improve the quality of care, both from the point of view of patients and society.

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