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### **Publisher**

McMaster University Library Press

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eISSN 2561-5645

# International Journal of Risk and Recovery

Volume 1, Number 1, January 2018

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## EDITORIAL

# Balancing risk and recovery

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*Gary Chaimowitz is a Professor of Psychiatry at McMaster University and the Head of the Forensic Psychiatry Program at St. Joseph's Healthcare Hamilton. Among many roles, Professor Chaimowitz has been granted Forensic Psychiatry Founder Status. He is one of the creators the Hamilton Anatomical Risk Management (HARM) and the Aggressive Incident Scale (AIS). Professor Chaimowitz is the Editor in Chief of the International Journal of Risk and Recovery.*

It is into a crowded world of journals that the first issue of the International Journal of Risk and Recovery arrives. Although there are forensic psychiatry journals that talk to a variety of issues, this journal will not only address key forensic psychiatry issues but we will strive to make the articles pertinent and applicable to forensic psychiatry clinicians. In doing so, we are acutely aware that an important aspect of forensic psychiatry that needs to be thoughtfully addressed with discussion, debate and research is the area of risk. However it is finding the fine balance between risk management and recovery promotion that is both delicate and critical to our work. Hence, finding and maintaining the balance between risk and recovery should be one of our key goals in forensic psychiatry [1].

Viewed from an international perspective, the area of forensic mental health can encompass a multitude of clinical, academic, and service delivery domains. One such domain is that of risk assessment, prediction, and management. It is thus an expectation that forensic mental health clinicians have the ability to assess, predict, manage, and mitigate risk [2]. In fact, this has been a fertile area for research over the last several decades as its application in the clinical space is both

immediate and practical, and the consequence of faulty risk management can have severe repercussions.

Correspondingly, an area that has bedeviled researchers has been getting forensic mental health clinicians to actually incorporate the scientifically validated risk tools into their practice. However, from a forensic mental health clinician's perspective, too often risk tools appear too impractical to be implemented at the bedside. The divide between researchers whose tools have evidence to support their usage, and clinicians who do not have the time or inclination to use them, still remains unacceptably wide. A large area of research dealing with implementation has sprung up to try to understand how to bridge the gap between what academia produces and what the service delivery sector actually uses [3].

Notwithstanding that, several significant advances have been made over the past decades to bridge these gaps. Increasingly evidence-based practice has become the norm in the clinical sector, with structured professional judgment tools now essentially integrated into clinical practice. However, as risk assessment, prediction, management, and mitigation have become standard practice in forensic mental health, and slowly so in the civil mental health services, something else appears to have been lost.

As the title of this journal suggests, forensic mental health practice requires finding a fine balance between risk management and fostering recovery [1]. All too often, risk management can become the dominant view and the clinical setting begins to approximate a correctional environment. Consequently, patients' needs and their rehabilitation can be lost when risk management is the only lens applied. Fortunately, in many

jurisdictions, the designated forensic facility is mandated by law to provide opportunities for rehabilitation of forensic patients. This is important as finely written vision and mission statements may obscure what happens on the frontline, specifically with the obligation to care for and assist the consumers of healthcare services in their recovery. This plays out specifically where stigma looms large, namely in mental health, and even more so in the forensic mental health domain, where the patients may be doubly or even triply stigmatized. This may seem unintentional, but there has been a perception over the years of a loss of understanding or even an acceptance of forensic mental health patients as people, rather than offenders or perpetrators.

The social contract that has created forensic mental health systems demands not only the detention and risk management of our patients, but also the rehabilitation of those self-same patients. The question then becomes how do we promote recovery in the forensic mental health system. On the face of it, recovery in its purest form may seem incompatible with a forensic system, where choice is subservient to risk management, and coercion implicit in the law, statutes, and regulations that govern patients.

If we are truly going to make a difference, fostering an environment of positive change can ultimately impact patients' mental health, reduce recidivism, protect the public, and make for a healthier and safer society.

Although much effort is put into prescribing the correct medication for the patient, ensuring medication adherence, monitoring for substance abuse, and arranging for substance abuse programs should be standard operating procedures in any mental health service. In fact, in all services that deliver mental health care, completing accurate mental state examinations of patients, ensuring safe environments, and engaging in structured professional judgment processes should be a basic expectation.

However it is the ability to understand the forensic mental health patient as a person

that appears still to be lacking. Of course, no organization or clinician would freely admit to this but many thoughtful clinicians can speak to this issue. Although increasingly more staff are now able to talk with some confidence about what would be considered evidence-based risk factors for violence, few of the staff actually get to know the patients as people [4]. Understanding our patients' strivings, goals, life experiences, and what would make for a healthier and meaningful life, gets lost in the multitude of mental status examinations, checklists, tools, protocols, and programs. Determining what our patients' goals are and so as to assist them in moving forward to living a meaningful life remains still one of our biggest challenges. Something that seems superfluous when compared to risk management is in fact probably the core factor that will provide access to assisting patients in changing, changing the very things that have driven them to enter the forensic psychiatry system [5]. This is then true risk mitigation.

Incorporating recovery principles into forensic mental health practices at the clinical, research, and educational levels must be our next initiative [6]. Some would argue that we already have sufficient structured professional judgment tools to manage risk of violence. In fact, with the use of analytics, those tools are probably close to where we want them to be. Fortunately, proponents of recovery and rehabilitation in the forensic mental health area are speaking out, research is growing, and various models such as the Good Lives Model are being examined for incorporation into a forensic psychiatry domain [7].

This journal intends to provide a forum for healthy discussion, debate, and innovation in the area of forensic mental health services by focusing on the delicate balance of risk management and recovery promotion. Its articles and commentaries will be accessible to both the academic world and to the clinical sector. We want to close the divide. We invite further discussion of this important topic and other related topics as we look at the balance

between risk and recovery in forensic mental health services.

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## ORIGINAL ARTICLE

# Point Prevalence of Adults with Intellectual Developmental Disorder in Forensic Psychiatric Inpatient Services in Ontario, Canada

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*A significant minority of people with Intellectual Developmental Disorder (IDD) may come into contact with the criminal justice system as a result of criminal behaviours. Many of these individuals, who are deemed Unfit to stand trial or Not Criminally Responsible (NCR), are transferred to forensic psychiatric facilities. Although the perception is that the prevalence of individuals with IDD in forensic facilities is increasing, the exact number was unclear, prompting us to conduct a provisional survey of forensic facilities across the province of Ontario to determine (i) point prevalence of IDD and (ii) the characteristics of such individuals. Detainees with IDD were identified in forensic mental health facilities across the Province of Ontario and information was collected regarding their demographics, characteristics of their index offence, and length of stay. We calculated a point prevalence (December 2012) of 19% and identified that individuals with IDD stayed, on average, longer in forensic psychiatric facilities than their non-IDD peers. We argue that there is a need for a working group to address forensic care pathways for adults with IDD.*

## Key words

*Intellectual Developmental Disorder (IDD), forensic care, prevalence, care pathways*

## Introduction

The recognition that individuals with intellectual developmental disorder (IDD) may come into contact with the criminal justice system for alleged offences has a long history, originating in the eugenics movement in the early part of the last century [1] and continuing with a program

that excluded such individuals from society, most notably by placing them in long stay institutions. Fortunately, in response to Government driven national frame-works of care that emerged 40 years or so ago, these institutions have since closed in many countries, and a more objective research agenda has emerged. A body of research does indicate that individuals with lower IQs, including those with IDD (defined below), are overrepresented in the criminal justice system although the exact prevalence is far from clear, with significant variation in estimates ranging between 2% and 40% [2]. This discrepancy between studies is the result of different methodological confounds, including diagnostic practice, definitions, criminal justice policy, and pathways of care. A more reasonable estimate probably sits somewhere between 2% and 12.5% of all convicted offenders detained in prison [3,4]. Consequently, although the numbers are unlikely to be very large in population terms, a pressing concern is with the provision of services for such individuals.

The argument for a specialist service for this population is based on their unique clinical profiles and treatment needs [5,6]. The availability of specialist services for this population, both inpatient and community based, varies significantly. In Canada, in the absence of a Government driven National Framework of care for such individuals, services are geographically inconsistent, and driven more by local expertise and interest rather than a top-down approach that is ideally warranted. Within existing intellectual disability services, there is generally a limited capacity to provide the rehabilitation needs of patients who come

into contact with the criminal justice system. As well, following the closure of long stay institutions, such services are now largely community based with limited access to inpatient care.

In the absence of specialist services or a clear pathway of care, navigating the criminal justice system for such individuals is fraught with uncertainty. In many cases, such individuals will come to the attention of general forensic services and consequently end up under their care with little in the way of specialist IDD service input. There are significant problems associated with this. One particular issue that arises is the charging of IDD patients, who by virtue of their IDD will be permanently unfit to stand trial [6], and, in essence, their IDD will “imprison” them in the forensic psychiatry system for an indeterminate time without ever being convicted for the offence charged against them.

The purpose of the current study was to evaluate the forensic needs of individuals with IDD in Canada, starting at the Provincial level. Most fundamentally, we were interested in identifying the prevalence of individuals with IDD detained in forensic psychiatry services across the province of Ontario, and their characteristics in terms of (i) demographics, (ii) the nature of their offences and (iii) average length of stay.

## Methods

In 2011 we secured funding from the Ministry of Health in Ontario to undertake a retrospective chart review study examining the prevalence of IDD in forensic units across the Province. We obtained Research Ethics Board approval from each of the ten forensic psychiatric facilities in Ontario (Table 1). Each facility offers secure and longer-term rehabilitative inpatient treatment and accepts male and female referrals from the criminal justice system. Each facility also has beds for short-term court ordered assessment and treatment services; however patients receiving these time limited assessment services were excluded from our sample.

We asked each psychiatrist responsible for inpatient beds in each unit to identify individuals under their care between the months of January and December 2012 who had an existing diagnosis of IDD (or synonymously, ‘mental retardation’ or ‘intellectual disability’), or who, in their opinion, may fulfill the following criteria: (1) an IQ less than 70 and (2) a documented diagnosis of IDD. For each individual identified, the case notes were reviewed by one of the authors (IF), using a data collection pro-forma.

### *Diagnosis*

For each individual identified, information was sought in their clinical records that would confirm a diagnosis of IDD. In current DSM-5 [7] and recent DSM-IV [8] classification systems, IDD (or ‘mental retardation’ in DSM-IV) is defined according to the presence of a significant limitation of cognitive functioning, defined as a recorded IQ of less than 70, associated impairment in adaptive skills, and onset before the age of 18 years. Cases were designated ‘definite IDD’ if evidence of an IQ of less than 70 with associated impairment of adaptive function as evidenced by performance on standardized assessments was available. Further, cases were identified as ‘probable IDD’ if there was evidence in the medical records of a recorded diagnosis, by a psychologist or psychiatrist, of Mental Retardation (MR) or Intellectual Disability (DSM-5, and its terminology IDD was not yet available in 2012).

### *Demographics*

Information was collected pertaining to demographic characteristics of the detainees with IDD, including gender and age distributions, ethnicity, employment status, and housing circumstances at the time of arrest.

### *Index Offenses*

Information pertaining to the index offense was obtained principally from Ontario Review Board (ORB) reports. Each index offense was categorized as violent or non-violent according to the Cormier-Lang system [9] and coded according to the categories in the Criminal Code of



Canada. Index offenses such as: parole and mandatory supervision violations; breach of probation, recognizance, or bail; failure to appear; escapes and unlawfully at large are not captured in the Cormier-Lang system and hence these index offenses were presented as a separate “breaches/violations” category. For each index offense against a person, we collected information pertaining to the victim.

## Results

In total, 124 detainees with possible IDD were identified across all units (Figure 1). Four were excluded due to limited documented information supporting the diagnosis, and two were excluded as they had an acquired brain injury post 18 years of age. Of the remaining 118 detainees, 29 (23.4%) had definite IDD according to DSM-5 criteria, whilst 89 (71.7%) had probable IDD based on documented evidence of an MR or IDD diagnosis, but with no available supporting evidence from more formal neuropsychological testing. For the purpose of our study, which was interested in casting the net wide for service planning reasons, we grouped the definite and probable categories together. During the one year period of retrospective case note analysis, there were 12 discharges and 14 admissions to inpatient care in 2012. In December 2012, there were 106 detainees remaining in forensic facilities with IDD.

## Point prevalence

Point prevalence of IDD was calculated based on total inpatient forensic beds across the Province, which was 588 in 2012. Using both figures for January and December 2012 and a median figure of 112 for total number of cases, results in a point prevalence estimate of 19%. Therefore, approximately 1 in 5 forensic inpatient beds across the Province of Ontario are occupied by an individual with an IDD.

## Demographics

The detainees with IDD (Table 2) comprised 99 males (84%) and 19 females (16%). All age groups were represented, although detainees with IDD were predominantly younger, with 79 individuals aged 35 years or less. Detainees were predominantly White (N=75, 64%), Black (N=17, 14%), and Aboriginal (N=16, 13.5%) with ethnicities forming the majority of the remainder. Most detainees with IDD were unemployed at the time of their index offence (N=112, 95%), with 89 (75%) on the Ontario Disability Plan. Living circumstances at the time of the index offence varied between detainees, with approximately equal proportions living in the family home (N=35, 30%) and in supported residential accommodation (N=31, 26%), and significant minorities living either on their own (N=17, 14.5%), as a hospital inpatient (N=17, 14.5%), or in temporary accommodation (N=18, 15%).

Table 1: Participating Forensic Centres

Centre	Location	Beds
Royal Ottawa Healthcare Group	Brockville, ON	56
Royal Ottawa Healthcare Group	Ottawa, ON	22
Providence Continuing Care	Kingston, ON	25
North Bay Regional Health Centre	North Bay, ON	42
Centre for Addiction and Mental Health	Toronto, ON	145
Waypoint Centre for Mental Health Care	Penetanguishene, ON	134
Ontario Shores for Mental Health Sciences	Whitby, ON	60
Thunder Bay Regional Health Centre	Thunder Bay, ON	12
St. Joseph's Healthcare Hamilton	Hamilton, ON	28
St. Joseph's Healthcare St. Thomas	St. Thomas, ON	64
Total		588

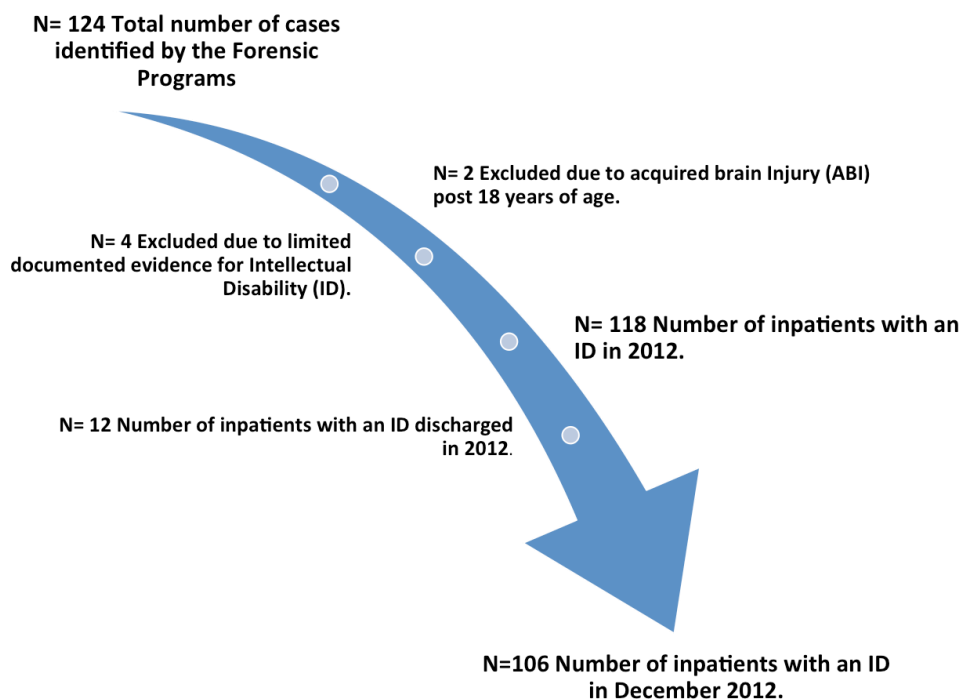


Figure 1: Identification of cases with IDD in secure forensic services in Ontario

*Offences*

A range of offences were coded using the Cormier Lang Index (Figure 2), with the most common categories being assault, uttering threats and breach and failure to comply offenses. In contrast, offences involving possession of illegal substances were low. When offences were further categorized into 'physical assault' (n=127), 'verbal assault' (n=75), 'sexual assault' (n=33) and 'non-interpersonal', 218 of 322 offences (67.7%) were interpersonal, including 152 (47.2%) that involved physical violence towards others (Figure 2). Further, when interpersonal offences were analyzed according to the alleged victims, 136 (62.4%) were against a known person.

*Length of Stay*

Length of stay information was obtained from the Ontario Forensic Bed Registry (Table 3). The data in this registry are entered by a designated individual at each forensic psychiatric facility. Much variation was seen in length of stay between the different forensic psychiatry facilities.

There was no pattern in terms of lengths of stay according to whether the detained person was NCR or Unfit. Detainees with IDD were more likely to be deemed NCR versus Unfit (two tailed Chi-squared p=0.001). When the figures were compared with those for the forensic population more generally, the average length of stay among detainees with IDD was notably longer, although we were unable to more formally generate figures for the effect size.

We also collected information pertaining to evidence of discharge planning during 2012. We reviewed ORB reports and looked for documentation indicating that the subject was on a wait list for community housing or whether there was documentation of service planning meetings with healthcare providers in the community. We found that 47% detainees with IDD had evidence of discharge planning documented in their ORB reports in 2012.

## Discussion

The aim of this study was twofold: first, to generate a prevalence figure for adults with IDD detained in forensic psychiatry inpatient beds across the Province of Ontario between January and December 2012 and second, to describe the characteristics of such individuals. Our results indicated a point prevalence of 19%, and, as such, we conclude that approximately 1 in 5 inpatient forensic beds are occupied by individuals with IDD at any one time. We also compiled information regarding the nature of offences and disposition, and observed that aggression characterized the majority of offenses, with 1 in 2 offences involving physical aggression, often towards caregivers.

The association between IDD and an Unfit decision likely represents the dilemma of those IDD persons charged who will never become fit to stand trial and who may become trapped within the forensic system [10,11]. This contrasts with the majority of those found Unfit whose psychotic disorder will respond to treatment, and will then exit the forensic system (unless then found NCR). This is consistent with the significantly longer stays among the IDD group than their non-IDD counterparts in our study. Whilst we are not able to identify the exact reason for this, a combination of inadequate care in the community and therapeutic failure seems likely, as discussed subsequently. Moreover, if such individuals are staying longer, we project that the prevalence figure will rise over subsequent years.

One in five beds is a significant proportion of inpatient forensic mental health beds, compounded by the oftentimes long length of stay. It is unclear how these figures compare to other Canadian Provinces, and difficult to compare directly with international figures. In Ontario, a previous study [12] drew data from 9 provincial psychiatric hospitals between 1998 and 2003 as part of a larger mental health planning study, and estimated the number of inpatients with IDD and forensic needs. In total, 74 such adults were identified, making up 12.8% of the forensic inpatient

population. Our own prevalence figure is therefore comparable to this.

Table 2: Summary of Demographics for cases with definite or probable IDD

Demographics	N=118 (%)
<b>Gender</b>	
Male	99 (84)
Female	19 (16)
<b>Age (years)</b>	
16-20 years	20 (17)
21-35 years	59 (50)
36-55 years	34 (29)
55+ years	5 (4)
<b>Evidence of IDD</b>	
1=IQ < 70	29 (23.4)
2=Diagnosis of IDD	89 (71.7)
<b>Ethnicity</b>	
White	75 (64)
Black	17 (14)
Chinese	3 (2.5)
South Asian	4 (3)
Arab/ West Asian	1 (1)
Aboriginal	16 (13.5)
No data	2 (2)
<b>Education</b>	
Not documented	62 (53)
up to grade 8	18 (15)
grade 9 to grade 13	38 (32)
<b>Employment</b>	
Unemployed	112 (95)
Supported Employment	3 (2.5)
Employed	2 (1.5)
No data	1 (1)
<b>Income Source</b>	
Self	5 (4)
Family	13 (11)
Ontario Disability Plan	89 (75)
Other Government Assistance	9 (8)
No Income	2 (2)
<b>Housing</b>	
Living alone	17 (14.5)
Living with Family	35 (30)
Group home	31 (26)
Hospital Inpatient	17 (14.5)
no permanent housing	18 (15)
<b>Grounds for detention</b>	
ORB-NCR	71 (60)
ORB-Unfit	33 (28)
Mental Health Act	8 (7)
Voluntary / Informal	6 (5)

In contrast to the dearth of available data concerning the prevalence of IDD in forensic mental health care, a number of studies have concluded that people with intellectual vulnerabilities are over-represented throughout the criminal justice system, and, as such, may require a specialist service to correctly rehabilitate them and reduce risk of further criminal behaviour. In order to achieve this, multi-agency strategic planning groups at a local level are required. These would allow for the partnership of professionals in intellectual disability services, forensic services and the criminal justice system with the eventual formation of community specialist forensic intellectual disability teams to provide care [13]. The first step towards achieving this goal is to form a Working Party comprised of commissioners and providers of forensic and IDD health and social care.

Importantly, whilst the doctrine of social inclusion dictates that individuals with IDD should be able to access the same services as their non-IDD counterparts, if there is no equity in outcome (i.e. if they are unable to benefit from the services

available that are designed to reduce risk), then the longer term result may simply be greater social exclusion. Aggressive and otherwise challenging behaviour among adults with IDD is often the result of the complex interaction between a variety of factors related to their IDD [14,15]. Whilst a psychiatric diagnosis may be an important component of this, other factors such as communication, wider cognitive vulnerabilities (including executive dysfunction, academic failure and difficulties with new learning), the oftentimes presence of Autism Spectrum Disorder or other neuro-developmental diagnoses (e.g. ADHD, Tourette's or tic disorders), medical comorbidity (for example epilepsy), and social vulnerability (poor employment opportunities, lack of a peer group) may each play a role in determining the final behavioural picture [15]. Consequently, the needs of this group may be quite different from the forensic psychiatry population more generally, and as such they may not directly benefit from the treatments on offer in such facilities.

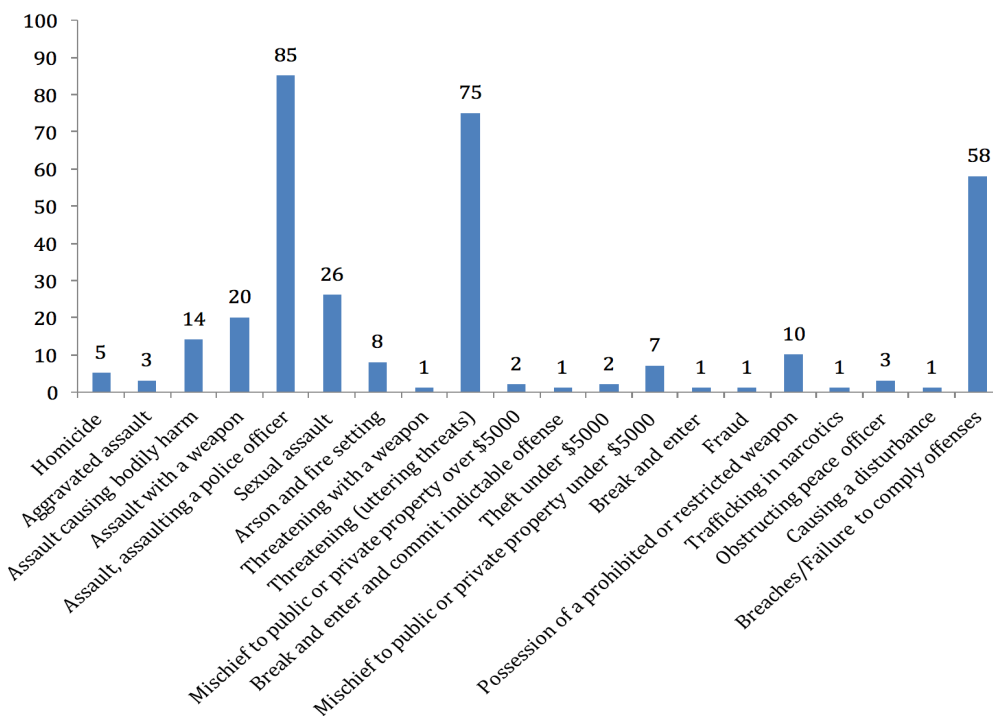


Figure 2: Index Offences categorized by Cormier-Lang scheme with number of detainees with IDD in each category

Table 3: Length of Stay (LOS) in days from Jan 1-Dec 31, 2012 - \*No range provided by Provincial Forensic Bed Registry

Intellectual Disability (ID) Study	Average LOS (range)
ID-ORB-NCR (N=74)	339.08 (range 5-365 days)
ID-ORB-Unfit (N=36)	325.64 (range 12-365 days)
ID-Involuntary MHA (N=8)	319.88 (range 107-365 days)
ID-Voluntary (N=6)	358 (range 323-365 days)
Provincial Forensic Bed Registry	Average LOS (*)
ORB-NCR (N=256)	141
ORB-Unfit (N=54)	140
MHA (N=17)	65
Voluntary (N=65)	154

This current study has a number of important limitations, tempering caution in the interpretation of our results. For example, we did not directly measure IQ, and relied on information recorded in patients' medical records. Moreover, a diagnosis of IDD is only truly correct in light of additional evidence concerning associated impairments of adaptive function, something we did not directly measure nor obtain corroborating information for. The cross-sectional nature of our data collection also did not allow us to fully realize pathways into and out of forensic services, nor to capture an individual's total length of stay.

## Conclusions

In conclusion, approximately 1 in 5 inpatient forensic beds are occupied by

individuals with IDD at any one time. Aggression characterizes the majority of offenses, with caregivers often the victims. Furthermore, such individuals are, on average, detained for longer periods than the forensic population as a whole. There are, therefore a number of good reasons for strategic discussion at the commissioning level to decide on the most effective type of service provision for the IDD population in forensic psychiatric facilities.

Conflict of Interest: none

Acknowledgments: The authors would like to thank all the forensic units in the Province of Ontario who took part in this study.

Funding: The authors thank the Ministry of Health in Ontario, Canada for funding this project

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## ORIGINAL ARTICLE

# The utility of treatment orders in the restoration of fitness to stand trial: a Canadian study

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*Involuntary treatment orders to restore fitness to stand trial under the Criminal Code of Canada provide an opportunity to explore variables associated with restoration. Charts were reviewed for 199 defendants assessed for fitness to stand trial in a catchment area of 2.3 million people over a three-year period. A treatment order was issued for 26 of these defendants that were admitted to a regional psychiatric program. All had a psychotic disorder, and 92% (n=24) were restored to fitness within the 60-day order period. No specific factors were associated with restoration. Unlike other studies, our study found that psychosis did not militate against restoration of fitness to stand trial.*

## Key words

*Treatment orders, fitness to stand trial, competence restoration, forensic psychiatry*

## Introduction

Fitness to stand trial (FST) is a complex psychiatric-legal construct that has been interpreted in different ways over time and among jurisdictions. In North America, the definition and evaluation of FST has been framed by the standard set in *Dusky v. United States* (1960) [1], in which the U.S. Supreme Court found that FST involved more than orientation in time and place and recollection of events. Rather, the *Dusky* test for FST indicates that the defendant can consult with his/her legal counsel and has a rational as well as factual understanding of proceedings [2]. Subsequent attempts to develop structured protocols and other aids to evaluate defendants have been only modestly

successful [3], because of difficulties in defining and conceptualizing “fitness to stand trial.” To address these, Bonnie proposed that fitness should be based on a theoretical foundation and reflect two dimensions: fitness to assist counsel and decisional fitness [3]. Fitness to assist counsel includes an understanding of charges, process, system and role of counsel; capacity to understand one’s situation as defendant; and ability to recognize and relate relevant factual information to counsel. Decisional fitness includes the ability to communicate preference about the defense, to understand relevant information, to appreciate the significance of that information, and to weigh the information to reach a decision.

The Criminal Code of Canada (Criminal Code), as amended in 1991, defines “unfit to stand trial” as unable on account of mental disorder to conduct a defense at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings (b) understand the possible consequences of the proceedings, or (c) communicate with counsel (Sec. 2, 1991) [4]. This is similar to the definition in *Dusky* [1] and reflects only the more operational aspects of Bonnie’s concept, lacking those that capture the defendant’s insight and judgement concerning his or her interests in the proceedings [3].

A subsequent case heard by the Ontario Court of Appeal, *Regina v Taylor* [5], further limited the test of fitness to stand trial [6]. The appeal court opined that the test is “one of limited cognitive capacity” to relate factual details of the offence to counsel. It

held that the accused is entitled to choose his or her own defense, which may not be what others would consider in his or her best interests. This decision has been criticized as lacking an understanding of the effects of mental illness on a defendant's motivation, insight, and volition [6].

Thus, in Canada and the United States, evaluation of FST involves ensuring that the defendant meets limited standards to understand proceedings and their consequences and to communicate with counsel. A wide variety of instruments have been developed in both countries to assist in court-ordered FST evaluations [2]. However, some authors have pointed out that these instruments can assess capacities relevant to fitness, but not fitness itself, as there is no recognized psychometric definition of fitness [7].

As FST remains the most common forensic evaluation requested by the courts [2,6], the role of forensic mental health experts has evolved from simply opining on a defendant's FST to using the Criminal Code to include a process for restoring fitness. Trying a defendant who is incompetent offends moral dignity and undermines the reliability of the criminal justice process, as well as impinges on the defendant's autonomy [3]. Conversely, it can be argued that restoration of fitness supports the dignity and reliability of the legal process and the autonomy of the defendant. Restoration also avoids lengthy hospitalization due to being unfit to stand trial [8], which may be longer than the potential sentence for the crime. As a result of this ethical dilemma, the U.S. Supreme Court ruled in *Jackson v. Indiana* [9] that an incompetent defendant may not be held more than a reasonable amount of time to determine whether fitness will be attainable [10]. Despite the benefits of and legal requirements for restoration of FST, there is limited research on its achievement.

In a large meta-analysis of studies of unfit to stand trial rates among defendants referred for evaluation, the base rate of unfit to stand trial was found to be 27.5% [2]. This meta-analysis and many other studies have looked at defendant characteristics associated with being unfit to stand trial, in

order to guide public policy [7] and to better target treatment. Among the characteristics identified are age group (among adolescents) [7]; visible minority, employment, and marital status [2]; and psychiatric and legal antecedents, including diagnosis of psychotic disorder, previous psychiatric hospitalization, and violent criminal charges versus non-violent charges [2].

Similarly, a few studies have looked at whether defendant characteristics affect the restoration of FST. The percentage of those treated who do not achieve restoration of fitness is remarkably similar from study to study, at 20%–25% [8,10,11,12]. Morris & DeYoung found that several factors decreased restoration potential such as: psychotic disorders, intellectual disability, and prior psychiatric hospitalization (which may be a clinical indicator of treatment resistance); diagnosis of personality disorders was associated with successful restoration of fitness [8]. Advokat et al. also found that most patients who did not have their fitness restored after treatment had a diagnosis of psychotic disorder, moderately severe symptoms, and initial low scores on a test of psycho-legal comprehension. However, variables such as employment status, type of offence, IQ and overall symptom severity did not differ between those whose fitness was restored and those who remained unfit to stand trial [10]. Colwell & Gianesini found that defendants deemed unfit and not restorable after treatment had higher rates of previous hospitalizations, incarcerations, and unfit to stand trial findings. In addition, defendants had lower IQ and more medications prescribed, as well as more diagnoses of borderline intellectual functioning, mental deficiency, and psychosis [11].

Many of these authors have also looked at time to restoration of fitness, as they have noted an association between greater length of stay (LOS) in hospital and decreased likelihood of restoration of fitness. For those restored to fitness, LOS averaged 7.7 months [10], and 98.9 days (3.3 months) [11], versus 27.5 months and 173.2 days (5.8 months), respectively, for those not restored. Other studies have also found this association between non-

restorability and LOS [12,13].

Another aspect that may affect outcomes in fitness restoration is whether treatment is voluntary or involuntary. There have been some studies of involuntary treatment, but it is unclear in this literature whether the patient is involuntarily committed but able to accept or refuse treatment, or is being treated involuntarily [14]. The United States and Canada have various mechanisms for mandated involuntary treatment of incompetent defendants in certain situations, both within a limited time period (120 days in the United States and 60 days in Canada). Evidence for these periods is only from the voluntary treatment literature, although patients treated involuntarily may differ substantially from those accepting treatment [14].

In the United States, involuntary treatment of incompetent defendants who pose a danger to themselves or others is mandated under the Penal Code. However, such treatment of “non-dangerous” incompetent defendants has been permitted only since the U.S. Supreme Court decision in *Sell v. United States* (2003) [15]. Under *Sell*, a judge can grant a request to involuntarily treat such defendants. Four criteria must be met to override a defendant’s refusal to accept treatment [14]: the individual is accused of a serious crime in which government interests are at stake; medication is substantially likely to render the defendant FST and substantially unlikely to have side effects that will interfere with the defendant’s ability to assist counsel; less intrusive treatments are unlikely to achieve the same results; and administering the drugs is medically appropriate. A study of all U.S. defendants treated under the *Sell* decision from June 2003 to December 2009 ( $n = 132$ ) found that 78.8% were restored to fitness [14], which is similar to outcomes for restoration of fitness of those voluntarily treated. No predictive relationships were found with type of charge, primary diagnosis, cognitive disorder or substance disorder, although there were slightly better outcomes for first-generation psychotic drugs versus second-generation, and older patients had a shorter LOS. LOS ranged widely, with some defendants restored in

less than one month and some requiring one year or more, and a median time of 120 days — exactly the period mandated.

In Canada since 1985, under the Criminal Code (s.672.58, 1985) [16], courts have the power to order involuntary medication treatment for up to 60 days for defendants who are “unfit to stand trial” in order to restore fitness. As with involuntary treatment under *Sell*, several conditions must be satisfied: a forensic psychiatrist must provide an opinion that psychotropic medication would make a defendant fit to stand trial, the defendant will likely become fit within 60 days, and the risk of harm of taking medication is not disproportionate to the benefit anticipated for the defendant. The psychiatrist needs to specify the type of treatment, which involves medication and cannot include electroconvulsive therapy or psychosurgery. Importantly, the psychiatrist must state that, in the absence of the treatment order, the defendant will remain unfit to stand trial.

This study aims to understand whether the rates of restoration of FST, as a result of judicial treatment orders in Canada, is consistent with the findings of Cochrane et al (2013) for involuntary treatment under *Sell* in the United States [15]. Further, we will explore the association of defendant characteristics with restoration of FST in our study sample. Finally, this study aims to verify whether the 60 day time frame is sufficient for restoration of FST, since this time frame is not based on research evidence.

## Methods

A chart review was conducted of all defendants on treatment orders over a three year period at a Forensic Psychiatry Program (FPP) in Ontario, where the standard for fitness to stand trial follows the *Regina v Taylor* decision [5]. The study was conducted in one of the ten FPP in Ontario that provides assessments of fitness to stand trial for defendants in detention centres within a catchment area of 2.3 million. The FPP is a secure facility with inpatient beds designated for defendants requiring inpatient hospitalization for forensic psychiatry assessments, including judicial treatment orders.

In the Canadian legal system, defendants are presumed fit to stand trial. However, if there are concerns about a particular defendant, the issue of fitness to stand trial can be raised by lawyers representing the defense or the Crown (prosecution), or by the court. When this issue is raised, an assessment is requested and is normally conducted by a forensic psychiatrist. It may be conducted in a jail or prison, in a hospital, or in a specialized clinic. If the psychiatrist finds that the defendant is unfit to stand trial, the court then holds a fitness to stand trial hearing during which it hears evidence concerning the defendant's fitness to stand trial from the psychiatrist and any counter-arguments before a decision is made by the court. In cases where there is concern that the defendant will refuse medication (because of prior refusal or continuing untreated psychosis), the Crown may seek a treatment order to render the accused fit to stand trial within 60 days (see explanation in Introduction). In many cases defendants found unfit to stand trial have untreated psychosis and are likely to continue to refuse medication, a court order requiring involuntary medication provision is a useful tool to render the accused fit to stand trial in a relatively short period. To obtain a treatment order, the Crown makes an application for treatment disposition; a hearing is held at which the psychiatrist opines (per Criminal Code requirements) as to whether psychotropic medication would render the defendant fit to stand trial, and whether he/she would remain unfit without such treatment, as well as an opinion on harms and benefits of treatment. The psychiatrist's opinion and recommendation are submitted to the court, where the judge makes a decision and then may issue a treatment order.

Our FPP conducts the assessments of fitness to stand trial within the detention centre. Although there are several instruments available for this purpose, for efficiency, and given the very ill state of most defendants, the assessing psychiatrists use an interview method based on the current legal definition for fitness to stand trial and for involuntary medication in Section 2 of the Criminal Code, and as articulated in *Regina v Taylor*.

Once defendants receive a treatment order and are admitted to the FPP, medication is ordered. All defendants are provided an explanation for the purpose of the hospitalization and the requirement to start medication immediately under a judicial treatment order. The treatment order mandates that medications be provided in the least intrusive and least restrictive fashion. Thus, the least intrusive form of medication is offered first and, if the defendant refuses, treatment may be initiated in an injectable form. Once the defendant is hospitalized and treated, his or her fitness to stand trial is assessed regularly by nurses and a forensic psychiatrist. The opinions of the forensic psychiatrist who performed initial assessments of fitness to stand trial and regular assessments during treatment are recorded in the defendants' medical records.

When the assessing psychiatrist considers a defendant's FST to be restored, a complete FST assessment is completed and the defendant is referred back to the court. If this occurs before the conclusion of the 60-day period, the court is notified and the defendant may be brought back to court early. The forensic psychiatrist provides an opinion on fitness to stand trial upon the defendant's early return to court or, more often, to the court upon the conclusion of the treatment order.

Defendants admitted to the FPP between January 1, 2011, and December 31, 2013, under a judicial treatment order were entered into the study. As this study is retrospective, psychiatrists assessing these patients were not aware that their opinions would be used in this study, but some of the psychiatrists are authors and others have been made aware of the study.

A data collection form was developed and used to standardize data collection. Two co-authors reviewed defendants' medical records and documentation of the initial FST assessments that were carried out in the FST clinic. All data in the medical records that we hypothesized could affect restorability or LOS was collected, such as: age (continuous), gender (M/F), DSM-IV primary diagnosis [17], offences (all offen-



ces, scored according to the Cormier-Lang system of quantification of criminal history [18]), medication treatment (start date, oral versus injectable, drug class), and fitness restoration (LOS) were collected. All data collected and coded was reviewed against the medical records by a forensic psychiatrist.

## Results

### *Referrals for Judicial Treatment Orders*

Between January 1, 2011, and December 31, 2013, a total of 199 defendants were referred for fitness to stand trial assessments from our catchment area. Subsequently, 43 (22%) were found unfit to stand trial. Of those unfit to stand trial, 17 (40%) were not subsequently admitted to our facility under judicial treatment orders for the following reasons: 10 (59%) were found FST when re-assessed in court at a later date, 3 (18%) were assessed as unlikely to become fit by both the psychiatrist and court, 2 (12%) were admitted for a further 30-day inpatient fitness assessment, the outcomes of which are not available and due to violence risk concerns, 2 (12%) were admitted to a maximum secure forensic facility in Ontario under a judicial treatment order.

Of those defendants unlikely to become fit, one had a diagnosis of severe mental retardation and two had cognitive impairments that would not benefit from psychotropic medication. These defendants were not admitted to a forensic facility under a judicial treatment order, but rather were placed in a hospital or long-term care facility that was more appropriate to their needs. Finally, 26 (60%) of those unfit to stand trial were hospitalized under a 60-day judicial treatment order and entered into the study. See Figure 1.

### *Gender and Diagnosis*

Eighty-five percent of the sample was male, with mean age 35.0 years (range 19–54 years; SD 10.46). Eighty-eight percent (n=23) of the sample had a DSM-IV [17] diagnostic category of Schizophrenia and other psychotic disorders, with one defendant each having a primary diagnosis of bipolar affective disorder, dementia, and traumatic brain injury. However, all

defendants had a primary or secondary diagnosis of Schizophrenia and other psychotic disorders, and two had a secondary diagnosis of intellectual disability.

### *Offences*

A total of 100 offences were committed by the 26 defendants admitted under a judicial treatment order. Offences for each defendant were categorized as violent or non-violent, using the Cormier-Lang system for quantifying criminal history [18]: 32 of the offences were violent, and 29 of the offences were considered non-violent. While the Cormier-Lang system does not categorize offences such as breaches or failure to comply, these made up 39 of the offences. By defendant, the most serious offence for each defendant was violent in 58% (n=15) of defendants, non-violent in 23% (n=6) and consisted of a breach or failure in 19% (n=5).

### *Medications*

Psychotropic medication was started on the day of admission to the FPP for 92% (n=24) of defendants and on the second day of admission for the remaining 8% (n=2). All defendants had some form of psychosis and were given antipsychotics. During the 60-day judicial treatment order, 27% (n=7) of the sample received oral antipsychotic medication only and 73% (n=19) received a combination of oral and injectable antipsychotic medication. Other medications used in addition to antipsychotic medication during the 60-day judicial treatment order were mood stabilizers in 31% of patients (n=8), benzodiazepines in 88% of patients (n=23) and antidepressants in 12% of patients (n=3).

### *Fitness Restoration*

All defendants' fitness to stand trial was eventually restored (Figure 1). While 92% (n=24) of defendants were found fit to stand trial by the end of the order period (60 days), 8% (n=2) were not. Both defendants found unfit to stand trial after 60 days agreed to continue with treatment and eventually one was deemed FST at 69 days and the other at 95 days. For defendants whose fitness was restored within the 60 day period, the mean number of days to

fitness restoration was 50 days (range 26–95 days; SD 13.9).

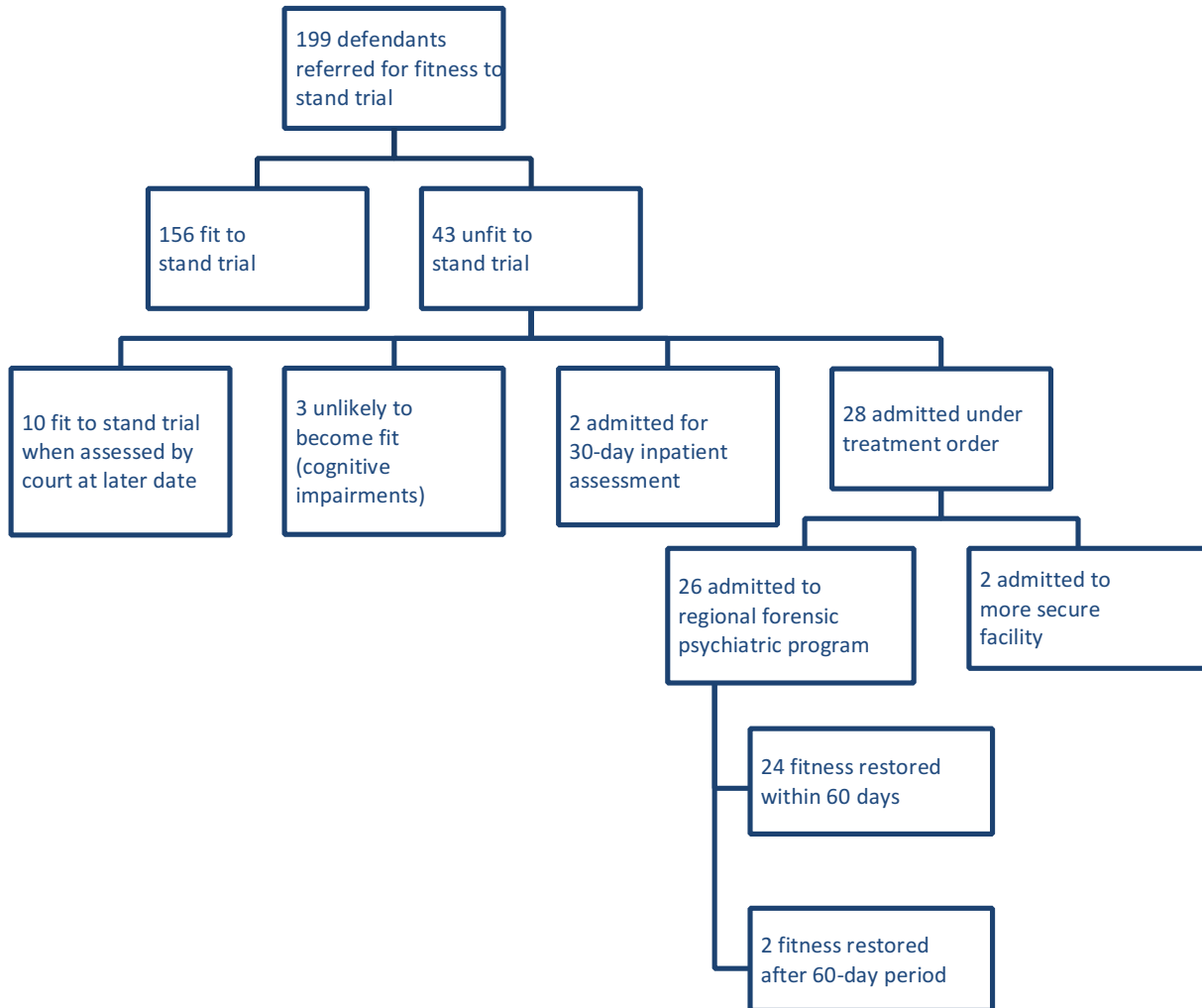


Figure 1: Disposition of defendants referred for assessment of fitness to stand trial in the catchment area of the regional forensic psychiatric program during the three-year study period.

**Discussion**

One of the aims of the study was to determine whether the rates of restoration of FST as a result of judicial treatment orders in Canada was consistent with the findings of the Cochrane et al. (2013) study whose findings showed that involuntary treatment resulted in restoration of FST in 78.8% of defendants retrospectively reviewed in the United States [14]. In our study, 92% (n=24) of defendants were restored to fitness within a 60-day timeframe with the remaining 8% (n=2) restored at 69 and 95

days after admission to the FPP for involuntary treatment. One strength of this study, as with the Cochrane et al. (2013) study is that it represents the entire population in the catchment area, not a sample.

If all defendants found unfit to stand trial before and during involuntary treatment are considered, high rates of restoration of fitness continue to hold. Three defendants were considered unlikely to become FST

with psychotropic medication as a result of cognitive impairment or severe mental retardation in the absence of psychosis. One of the predictors of fitness restoration found in other studies is the degree of cognitive impairment [11]. However, two of the defendants restored to fitness in this study had some degree of intellectual disability in addition to psychosis. For 10 of the defendants who were found unfit, fitness to stand trial was found to be restored when re-assessed the day of their court proceedings. One factor that may have accounted for this was that these defendants voluntarily started psychotropic medication while detained and awaiting their fitness hearing. Information was not available on the outcome for the two patients admitted for a further 30-day inpatient assessment or the two referred to a more secure facility. Thus, of 43 defendants, 36 had fitness restored, for a restoration rate of 84%, which is still higher than the findings of other studies [8,10,11,12]. The outcome was unknown for four defendants.

The high rate of restoration of FST was not related to triage of defendants before issuing the treatment order. However, it may have been related to a concerted effort within the FPP to treat and educate defendants. All of the defendants admitted to the FPP under a judicial treatment order had refused medication when it was offered at the detention centre. However, their assessment by the forensic psychiatrist showed they would benefit from psychotropic medication. Upon admission, defendants were provided with an explanation of the purpose of the judicial treatment order and offered options to receive medication orally or by injection. Most started medication upon admission, although two defendants started medication the following day. There is no indication clinically or from the data that indicates this brief delay affected outcomes. Therefore, all defendants admitted under a judicial treatment order to

the FPP received continuous psychotropic medication.

A judicial treatment order only mandates psychotropic medication. However, as standard practice in the FPP, defendants also are educated about courtroom proceedings. This combination may help restore fitness over medication alone, but this study did not compare medication alone with medication plus education. As well, it should be noted that medication alone may have restored fitness for 10 defendants at the detention centre.

The high rate of restoration may also be partially explained by the relatively low standard for fitness, the limited cognitive capacity test, that prevails in Canada under the *Regina v Taylor* [5] decision. This was the standard used in assessments in the FPP. A standard with added criteria, such as the Dusky [1] criteria, might have resulted in fewer defendants achieving FST.

A statistical analysis of patient or medication characteristics that may be associated with fitness to stand trial was not conducted because of the small number of defendants and the fact that all were eventually restored to fitness. However, some observations indicated that the sample was fairly homogeneous, with almost all having a diagnosis of psychotic disorder and 85% being male. These characteristics may suggest some risk factors for the status of unfit to stand trial. Yet all were successfully restored to fitness. Previous studies have shown psychotic disorder as a risk factor mitigating against restorability [2,8,10,11], although the study did not indicate this.

As there was no comparison group, conclusions could not be reached about the relative effectiveness of treatment orders. However, the study confirmed the findings of Cochrane et al [14], and demonstrated that fitness to stand trial within 60 days is achievable utilizing a judicial treatment order as available in Canada.

## Conclusion

This was a retrospective study at a single regional forensic psychiatric program. Clearly, much more research is needed in order to determine factors affecting restorability and time to restoration of fitness to stand trial in the setting of involuntary medication treatment. Future research should involve multiple programs as well as comparisons of voluntary with involuntary treatment, and of different standards for fitness.

Such research would support decisions to continue to use judicial treatment orders in Canadian jurisdictions, where there has been some reluctance to use these orders due to ethical concerns about involuntary treatment. These concerns must be weighed against the value of restoring not only the defendant's fitness to stand trial but also his or her autonomy, and allowing justice to be served in a timely manner. This study provides support for imbedding similar provisions in to the Criminal Code in other jurisdictions.

The Canadian judicial treatment order provides a unique opportunity to treat a defendant with a mental illness quickly and decrease pre-trial detention. This study lends support for the Criminal Code measure in Canada and involuntary treatment measures in other jurisdictions.

Conflict of Interest: none

Ethical Approval: This study received approval from the local research ethics board before starting data collection.

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## ORIGINAL ARTICLE

# The next generation of risk assessment and management: Introducing the eHARM

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*Big data and analytics are rapidly changing healthcare and enabling a degree of measurement and quality improvement not previously seen. For a variety of reasons, including the limited number of quality indicators in mental healthcare, these technological advances have not yet been introduced in the area of psychiatry. The use of technology to measure, monitor, and assess risk in this area would have a significant impact for key stakeholders, including patients, care providers, and the community. The field of analytics offers an opportunity to increase our understanding of psychiatric populations, target effective programs and interventions, and direct more personalized care at a critical intersection of risk assessment: risk management. The electronic Hamilton Anatomy of Risk Management (eHARM) aims to harness the capabilities afforded by data analytics to enhance the assessment, monitoring, and management of risk within psychiatry at the clinical interface.*

## Key words

*Violence risk assessment, violence risk management, data analytics, eHARM, AIS*

## Introduction

Healthcare organizations are increasingly seeking ways to modernize their operations to improve patient care, increase productivity, promote cost-efficiency, and streamline everyday practices. This phenomenon is evident through the adoption of electronic health records and health information technologies designed to generate and store data in more accessible electronic formats. Electronic health records aim to organize an overwhelming growth of valuable clinical data, but due to a lack of

built-in analytical software, the data is often underutilized [1]. This highlights the need for tools that go beyond merely storing the data to using it to inform clinical decisions, particularly at a time of increased pressure for evidence-based, patient-centered practice [2,3]. Proposed solutions to these challenges include small data analytics, big data analytics, and visual analytics [1,4,5]. Data analytics refers to the systematic use of data through applied analytical disciplines to drive fact-based decision-making for measurement, management, planning, and learning [6]. Similarly, visual analytics refers to the combination of analytical techniques with visual interfaces [7]. These approaches provide outputs in the form of graphical analyses or concise summaries, thereby offering a vast array of uses in healthcare.

## *Integrating data analytics and psychiatry*

Real-time depictions of changes in patient status, treatment, and response over time have the potential to revolutionize clinical decision-making. By accessing a visual of a patient's status over time, clinicians can pinpoint times of decompensation or improvement and better identify the factors that may have led to the changes. Moreover, by combining this data with graphs depicting medication dose, or treatment status over time, clinicians can better understand that individual's treatment responses, therefore allowing for more individualized care.

On a larger scale, the use of data analytics may increase the knowledge and understanding of trajectories of specific illnesses by providing large quantities of data for patients with similarly presenting concerns. This information could then be used to inform best practices by identifying

the most effective treatment options for a particular presentation, for instance. In turn, this data can inform administrative decisions about resource allocation.

As a result, data analytics can inform treatment and care at all organizational levels, increasing the effectiveness and timeliness of care, and promoting a shift towards more proactive treatments [1]. Moreover, the better use of large sectors of data has the potential to improve drug discovery, diagnostics, and resource allocation, thus enabling data-driven decisions at lower costs [8,9].

While data analytics programs have been utilized in healthcare to inform predictive risk assessments, clinical decision-making, in-home health monitoring, finances, and resource allocation [9], such tools have yet to be used in the field of psychiatry. One potential reason for this is a lack of direct indicators within psychiatry which can act as measures of progress over time. Nonetheless, the growth of data analytics within psychiatry would provide unparalleled opportunities for exploration, hypothesis generation, and risk prediction at the clinical, administrative, and research levels [10].

One key consideration within the area of psychiatry is risk, including one's risk to them self and to others. In fact, the risk of harm to others is a primary criterion for certification in mental health legislation for all Canadian jurisdictions [11]. In Canada, an individual's status within the forensic psychiatric system is dependent on their identified risk to others, and the onus is on the designated hospital to determine whether an individual represents a significant risk to the safety of the public [13]. Risk is also a key consideration within general psychiatry, where psychiatrists are typically required to assess risk as frequently as forensic psychiatrists [14]. As a result, risk assessments are necessary in all areas of psychiatry, including emergency, inpatient, and forensic psychiatry [12]. Numerous risk assessment tools have been developed in an effort to assist clinicians in the prediction, assessment, and management of risk. Examples include the

Hamilton Anatomy of Risk Management (HARM) [15], Violence Risk Appraisal Guide (VRAG) [16], Historical Clinical Risk Management-20 (HCR-20) [17], and Classification of Violence RISK (COVR) [18]. Such tools provide a unique platform for introducing data analytics to psychiatry due to the wide variety of dynamic recordable indicators measured on a regular basis.

#### *The eHARM: an analytics-based tool*

The Hamilton Anatomy of Risk Management (HARM) [15] is a structured professional judgement (SPJ) tool developed for use in a variety of inpatient and outpatient psychiatric settings. The HARM has been adapted for forensic, general, community, correctional, and youth psychiatric settings. Designed for use in a multidisciplinary team setting, the HARM guides assessors to formulate opinions regarding risk of violence and guides discussions of risk and risk management through three stages: past, present, and future. Stage one consists of historical risk factors such as major mental illness, substance use, cognitive deficits, and criminal history. Stage two consists of empirically-supported and dynamic risk factors and protective factors. Risk factors are recorded based on their presence, status ("managed," "monitor," "needs improvement"), and change from the previous report ("better," "worse," "same"). Finally, stage three consists of final risk estimates, which includes an individual's clinical likelihood of violence and escape risk. Teams score these estimates based on a 5-point scale for two time frames: "immediate future" (days) and "short term" (weeks). An additional consideration regarding the clinical likelihood of violence is the presence of professional support including inpatient and community supports. Specifically, clinicians are asked to consider whether an individual's likelihood of violence would change in the absence of professional support. As a result, there are a total of four estimates of the likelihood of violence.

Also embedded within the HARM is the Aggressive Incidents Scale (AIS) [15], which is a 9-point scale designed to record

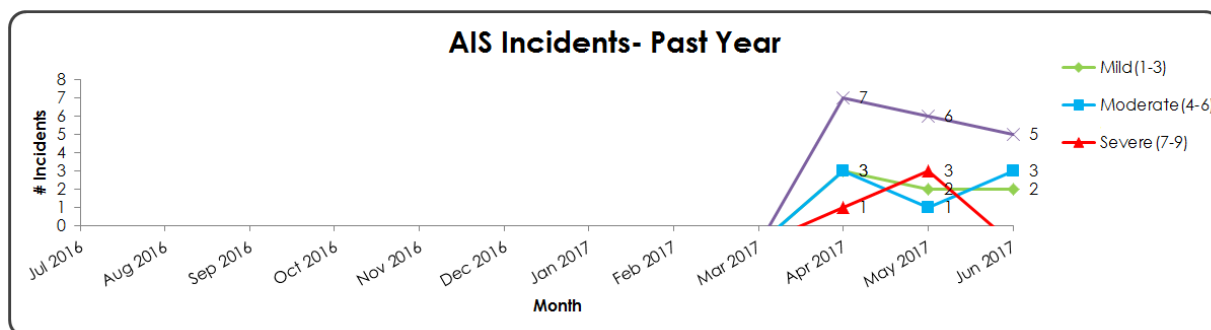
varying acts of aggression easily and consistently. The HARM also guides the assessors to develop and record a personalized risk management plan, based on an individual’s past and current risk. This may include specific treatment plans, interventions, and medications designed to reduce risk and improve outcomes. Combined, the AIS and the HARM have been indicated to improve the clinical documentation of dynamic risk factors and outcomes, communication of aggressive incidents, and discussions of risk and relevant risk factors [15,19]. Moreover, the AIS demonstrates excellent reliability as a measure of inpatient aggression [19], while the HARM demonstrates promising predictive validity for inpatient aggression, and has shown good reliability with the HCR-20 [20]. The HARM is completed on a weekly to monthly basis, making it a hub for rich, longitudinal data.

Combining the HARM tool with data analytics allows the ability to visually identify in a quick and efficient manner any fluctuations in risk, which then informs the current and future risk assessments. The result is the Electronic Hamilton Anatomy of Risk Management (eHARM); an electronic, Excel-based tool that transformed the original HARM risk assessment process using data analytics. The eHARM has introduced the potential for individual, patient-level analytics, as well as group-level analytics for descriptive observation of an entire unit or program at a time, and the collection of real-world, electronic data for further use. The tool is comprised of two components that work in conjunction: The Patient Tool and the Patient Aggregator.

The Patient Tool is the function most often used to complete risk assessments, access past assessments, and view individual-level analytics. This tool contains the HARM form, which has been modernized to include drop-down menus, required fields, and embedded definitions. These features improve the documentation of aggression and risk-related data, ensure reliability and consistency of documentation, and also streamline the risk assessment process for teams who may have limited time for large group discussions.

As well, the functionality adds a level of innovation and widespread applicability not seen before within psychiatric risk assessment. In addition to the user-friendly electronic form, the Patient Tool contains individual patient analytics, which collect and graph data as a team completes their regular assessments. These analytics allow users to view individual performance trends in AIS scores, risk factors, and risk ratings over time, thus providing automatic, graphic depictions of an individual’s progress (Figure 1). Users can refer to the analytics during an assessment as a way to track decompensation or improvement and inform the assessment process. These analytics may also allow teams to better distinguish antecedents to specific incidents or behaviours, and then use this information to inform future treatment or interventions.

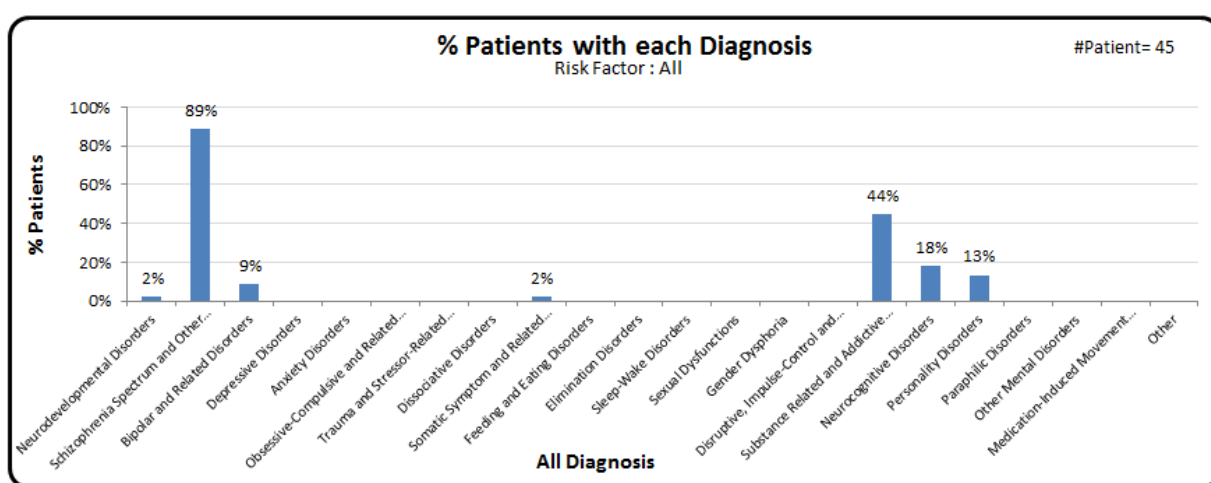
Figure 1: Patient-level analytics depicting aggressive incidents over one year for one patient



The second component of the eHARM is the Patient Aggregator, which introduces additional unique capabilities. Specifically, it allows users to upload multiple individual HARM files in order to view trends across groups of patients. Users may select any number of patient files, by physician, unit, or program as a whole. Upon uploading the files, the Patient Aggregator automatically generates a number of descriptive analytics of group trends in diagnosis, risk factors, and treatment

(Figure 2). This includes the percentage of patients for each diagnosis, the percentage of patients referred to each program or intervention, and more. In addition, the Aggregator allows users to download imported data, including a de-identified database of each existing eHARM report for each patient selected. As a result, users can access an accurate, real-time, longitudinal database that contains historical, treatment, risk, and outcome data for further analysis.

Figure 2: Group-level analytics depicting diagnoses for a group of n=45 patients



## Conclusion

The usefulness of the eHARM Tool and Patient Aggregator is self-evident; within moments, users can generate a program overview for an entire hospital, service, or unit, or answer a specific research question. The research possibilities are vast, but include examining the efficacy of specific medications, programs, and interventions, exploring trajectories for specific groups of patients, and even assessing the validity of the eHARM tool itself. In addition, the eHARM database contains data regarding risk management and transition planning, and patients' responses to specific programs or interventions. Using this data, users can easily identify which programs have the highest number of referrals, greatest involvement, longest waitlists, and least

engagement to inform program planning and resource allocation. Moreover, decision-makers may cross-reference this with data on dynamic risk factors, aggressive incidents or risk ratings to determine where a need exists for a given program or unit.

In addition to aggregated data, a closer look at longitudinal data from an individual patient can demonstrate the eHARM's applicability for program evaluation. Specifically, users may graph AIS scores, risk ratings, and performance on a specific risk factor before and after a new program is introduced, to determine the program's effectiveness. This data may allow clinical staff to better target effective as well as ineffective programs, resulting in more timely, individualized and efficacious care.

These benefits are aligned with the immense need within healthcare to increase cost-efficiency, improve prediction of health trends, and implement more efficacious practices [8-9].

The eHARM offers extensive opportunity across many domains within psychiatry and a solution to the need for better management and use of electronic clinical data. The database derived from the eHARM is generated at the clinical interface, removing any need for data collection or data entry and the potential for errors occurring during these steps, and increases the ecological validity of future studies. With numerous time and data points, the eHARM database has the potential to inform risk management, research, service planning, quality improvement, and introduces unprecedented opportunity to improve violence risk assessment in psychiatry.

Conflict of Interest: none

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## ORIGINAL ARTICLE

# Réflexion sur le recours à la visioconférence pour la réalisation de l'expertise psychiatrique en France

## *Benefits and limitations of implementing videoconferencing for forensic psychiatry assessment in France*

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*La télémédecine est une technique qui a fait ses preuves dans de nombreux domaines. La psychiatrie légale française pourrait s'inspirer de ce succès afin d'améliorer la pratique de l'expertise psychiatrique. Dans cet article, nous nous attachons à analyser les bénéfices et les limites de la visioconférence dans la réalisation des expertises psychiatriques. Cette technique pourrait permettre de palier certaines des difficultés que rencontre cette discipline en France.*

*Telemedicine has been successfully used for many years in North America for the purpose of conducting forensic assessments. France, however, has not yet implemented this potentially useful tool. French forensic psychiatry could get inspired by this success in order to improve the practice of court ordered psychiatric assessments. In this article, we address the benefits and limitations of videoconferencing in the field of forensic psychiatry. Using these new means of telecommunications could help solve some of the issues encountered in France.*

### Mots clés

Psychiatrie légale, expertise psychiatrique, télémédecine, visioconférence, amélioration des pratiques

### Key words

*Forensic Psychiatry, forensic assessment, telemedicine, video-conferencing, quality improvement*

## Introduction

La pratique de l'expertise psychiatrique en France est sujette à de nombreuses critiques qui sont régulièrement recensées par les professionnels rayonnant autour de

cette discipline (professionnels de la santé et du droit) et les médias [1,2]. Parmi ces critiques, le manque d'expert, et de fait la difficulté à faire appel dans un délai raisonnable à un praticien compétent dans ce domaine, sont mis en avant notamment par les magistrats. Différentes solutions semblent être recherchées ci-et-là afin de remédier à ce problème. Pour augmenter le nombre d'experts, plusieurs solutions pourraient être envisagées, telles que 1/ créer des vocations, 2/ renforcer la formation à l'expertise psychiatrique, 3/ avoir recours à des psychiatres non-experts pratiquant l'expertise, 4/ avoir des psychiatres dont au moins une partie de leur activité serait spécifiquement dédiée à l'expertise, 5/ créer des unités d'expertise psychiatrique pour obtenir un regard pluriel sur le dossier...

Il est difficile de savoir si de tels changements pourraient induire un réel accroissement du nombre de praticiens dans ce domaine et répondre ainsi dans les délais impartis aux besoins de la Justice qui sont croissants. Il est indéniable que l'expertise psychiatrique apporte des informations techniques permettant d'orienter les magistrats dans leurs décisions. Ces derniers peuvent, de leur propre chef, décider de la réalisation d'une expertise lorsque certains éléments du dossier les y incitent. Cependant ils sont parfois mains liées, puisque le Code de Procédure Pénale impose la réalisation d'une expertise psychiatrique dans un certain nombre de situation, et notamment lors de faits de nature sexuelle ou lors de l'évaluation du risque de dangerosité (par exemple article 706-47-1 du Code de Procédure Pénale) [3]. Ce n'est donc pas du côté de la Justice que l'on peut trouver une solution quant à la charge de travail

donnée aux experts psychiatres, et c'est bien à la psychiatrie légale de proposer des modifications.

Trouver des solutions n'est pas chose aisée, puisque cela requiert des modifications substantielles, dont les décisions parfois tardent à être prises, comme par exemple la mise en place d'un Diplôme d'Etude Spécialisé Complémentaire de psychiatrie légale [4] ; pourtant les difficultés sont actuelles et il devient impératif d'y remédier. Il y a plusieurs années, un projet de loi avait émis l'idée que les internes en psychiatrie pourraient réaliser certains types d'expertise psychiatrique [5]; l'idée principale était que ces médecins en formation permettraient de couvrir le manque d'expert et de participer d'une certaine manière à la création de vocation. Notre opinion, partagée par d'autres, est que cette « solution de fortune » dévalorisait la pratique de l'expertise psychiatrique, méconnaissait les risques médico-légaux associés à la pratique de l'expertise et ne s'attachait pas à régler les problèmes de fond. Ce projet avait la volonté de tenter de trouver une solution pour remédier au moins partiellement au problème.

Répondre à la demande de la Justice de façon appropriée est une problématique multifactorielle. Des solutions doivent donc être proposées pour tenter de régler chacune des difficultés évoquées (qualité de l'analyse médico-légale, réponse des missions dans le temps imparti, revalorisation de la discipline ...). Cet article n'a pas pour objectif de prendre en considération tous les problèmes liés à la pratique de l'expertise psychiatrique, mais de s'attacher à un problème en particulier qui est de répondre aux demandes des magistrats dans un délai raisonnable. Il nous semble qu'une des solutions pour permettre l'accroissement du nombre d'expertises réalisées pourrait être l'utilisation de la visioconférence.

### **Le recours à la visioconférence pour la réalisation de l'expertise psychiatrique**

La réflexion liée à l'usage de la visioconférence est née de l'observation de cette pratique au Canada. L'étendue du territoire canadien a, de fait, obligé les promoteurs de la santé à innover en termes d'accès aux

soins. La pratique de la psychiatrie légale par visioconférence au Canada est courante et l'expertise psychiatrique y a également trouvé sa place. Il ne s'agit pas d'une pratique qui s'est substituée à l'expertise en face à face, mais plutôt d'une méthode qui est venue compléter la pratique courante afin de faciliter les procédures judiciaires. De nombreuses études nord-américaines ont démontré l'impact positif d'une telle technique sur la relation de soin, qu'il s'agisse de la psychiatrie générale, pénitentiaire ou expertale [6-10]. Ces études insistent particulièrement sur la fiabilité des données recueillies, la satisfaction des cliniciens et des patients, ainsi que sur la réduction du coût financier.

Les méthodes sécurisées de communication à distance se sont démultipliées et généralisées, et la France en bénéficie. Désormais, les structures judiciaires, policières, pénitentiaires et sanitaires françaises disposent de telles méthodes ; de plus leur accessibilité est possible dans le domaine privé. Notre réflexion n'a pas pour but de comparer les pratiques canadienne et française en matière de visioconférence en expertise psychiatrique, puisque la France n'a pas généralisé cette méthode. La suite de ce propos va, par contre, s'attacher à comprendre d'un point de vue théorique, quels sont les bénéfices et les limites de l'utilisation d'un système de visioconférence lors de la réalisation d'une expertise psychiatrique. Les bénéfices de l'utilisation de la visioconférence semblent être d'ordre technique, alors que les limites à son utilisation semblent plus être de l'ordre du registre inter-individuel. Nous verrons également en quoi la France pourrait bénéficier du recours à un tel système.

### *Les bénéfices du recours à la visioconférence*

Les bénéfices liés à l'utilisation de la visioconférence sont essentiellement liés à l'optimisation du temps passé, au cadre dans lequel la mission est réalisée et à la minimisation des risques pour l'ensemble des professionnels intervenants au cours d'une mission.

Il est indéniable que l'utilisation de la visioconférence permet de sauver un temps

précieux, notamment lorsque les ressources humaines sont limitées, comme le précisent certains articles [11,12]. Certes un certain nombre d'expertise peut être réalisé en consultation à l'hôpital ou en cabinet, mais lorsqu'il s'agit d'une personne détenue, le temps de trajet, le temps passé au portail de sécurité, le temps de trouver un local adapté ... sont autant de facteurs limitant leur réalisation. Choisir la visioconférence permet à l'expert de ne plus se déplacer et de planifier son expertise comme toute autre consultation au cabinet. Quant aux magistrats, ils peuvent alors choisir de nommer l'expert de leur choix sans avoir à se poser la question de la faisabilité due à la distance. L'expertise par visioconférence peut être alors programmée de façon plus rapide, puisque l'on soustrait le temps passé au déplacement, ce qui permet une plus grande latitude d'action pour l'expert.

De même les expertises réalisées en détention ont souvent lieu dans des locaux exigus et sans esthétisme. Les locaux mis à disposition pour la visioconférence en détention ou au tribunal sont généralement de meilleure qualité et diminue cette « chape de plomb » imposée par les quatre murs de la salle exiguë de détention. Un entretien psychiatrique doit pouvoir être réalisé en toute circonstance, mais il est favorable de pouvoir proposer une atmosphère neutre et détendue afin de limiter, autant que possible, les résistances du mis en examen, détenu ou non.

Dans certaines situations, notamment en cas de personnes présentant un comportement violent ou inapproprié, l'usage de la visioconférence permet de minimiser le risque pour l'expert, pour les officiers chargés de veiller au bon déroulement de l'entretien ou au transport du détenu. De plus, cela limite la stigmatisation du détenu qui n'a pas à être transporté dans les lieux publics, escorté et menotté ; quant à l'expert, il n'a pas à craindre l'impact d'une telle escorte sur sa patientèle. L'autre point que l'on pourrait citer même si impactant indirectement l'expert (puisque ce dernier généralement se déplace en détention) concerne la réforme des extractions des centres de détention qui est désormais à la charge de l'administration pénitentiaire, qui n'a malheureusement pas toujours les

moyens matériels pour les exécuter [13].

L'impact financier de la mise en place du système de visioconférence en expertise est favorable et non négligeable, et se place tant du côté de l'expert que de la Justice. Il permet à l'expert de réaliser plus d'expertises et de limiter le temps passé à certaines formalités qui sont imputées de son temps clinique. Cela permet également à la Justice d'économiser ses ressources, comme de monopoliser des escortes pendant plusieurs heures, ou bien de disposer de ces ressources de façon plus optimale.

#### *Les limites du recours à la visioconférence*

L'entretien en psychiatrie est un art qu'il faut savoir maîtriser ; recueillir les informations adéquates ne s'apparente pas à faire passer un questionnaire de réponses « fermées ». Savoir contourner les mécanismes de défense intrapsychiques du sujet est primordial ; c'est en cela que certains pourraient voir des limites à la réalisation des missions par visioconférence. L'écran qui sépare les individus en visioconférence pourrait donc impacter la qualité de l'entretien. Il est évident que le face à face permet de communiquer un certain nombre d'éléments cliniques non verbaux, qui font partie de la séméiologie. Cette problématique liée à la distance « physique et psychique » créée par l'écran ne semble pas être insurmontable et dépend de l'installation du système de communication. Plusieurs études ont démontré que la qualité de l'échange relationnel n'était pas impactée par la visioconférence [9-11].

L'installation du système, permettant à la caméra de viser le regard et le visage de l'interlocuteur, est primordiale pour pouvoir apprécier ces éléments non verbaux. De même, le fait que la caméra ne soit pas simplement ciblée sur le visage, mais puisse prendre en considération le buste et d'une façon générale tout élément visible au-dessus du niveau de la table (une table ou bureau séparant généralement expert et expertisé en face à face) permet d'apprécier l'ensemble du discours corporel, autorisant alors l'obtention des informations relatives à une attitude défensive ou à une agitation psychomotrice entre autres. L'expert a donc visuellement accès à tous les éléments dont il aurait accès en face à face.

De même la qualité auditive du système entre en compte. Le climat de confiance mis en place au cours des opérations d'expertise joue un rôle dans la qualité des données recueillies. Une difficulté d'écoute induit un climat de tension qui peut être préjudiciable dans un tel contexte. De plus, le fait qu'expert et mis en examen ne partagent pas la même langue natale, induisant la présence d'un accent ou de fautes dans la structure grammaticale (ce qui est chose courante au Canada étant donné l'importance de la population immigrante) peut avoir un impact sur la compréhension particulièrement lorsque le système audio n'est pas de bonne qualité.

Les éléments cités ci-dessus n'ont pas seulement un rôle dans la qualité des informations cliniques relevées, mais également dans la connexion émotionnelle que deux individus peuvent avoir lorsqu'ils communiquent. Comme nous l'avons brièvement cité, la mise en confiance diminuant les résistances du sujet à répondre aux questions posées dans un cadre judiciaire est favorisée par la mise en place d'un climat de confiance ; cette confiance permet donc un échange d'émotions réciproques. Le respect et l'absence de jugement au cours de l'expertise sont donc nécessaires. Cependant, la relation virtuelle a parfois tendance à produire un sentiment de liberté qui peut amener à prêter moins attention à ses propres comportements ; il est donc nécessaire de maintenir le même degré d'attention sur sa propre attitude, comme cela est le cas en face à face. De même l'utilisation de la visioconférence ne doit pas être ressentie par le mis en examen comme un manque de considération du fait de ne pas prendre le temps du déplacement ; expliquer les raisons qui ont poussé à utiliser la visioconférence, plutôt que le face-à-face, est important.

Ainsi, bien que des critiques puissent être formulées, il nous semble que les limites exposées peuvent être résolues. Les études sur le sujet insistent notamment sur la satisfaction des participants et la fiabilité du recueil des données, la confidentialité des échanges, ainsi que le gain en termes de coût [10,14-16]. Il s'agit à l'expert de prendre le temps avec le sujet et de faire cet effort d'instaurer ce climat de confiance

même à distance. Les limites relatées existent déjà parfois, même lors d'entretiens en face-à-face ; ainsi, même si la visioconférence peut facilement répondre à ces limites, elle n'est certainement pas à leur origine. Par contre, il est légitime de penser que les cliniciens qui n'instaurent pas de climat de confiance en face à face, ne l'instaureront pas en communiquant via une caméra.

#### *Applicabilité de la visioconférence dans l'expertise psychiatrique française*

A partir de la réflexion menée précédemment, nous avons mis en évidence les conséquences potentielles de la visioconférence dans ses aspects techniques et organisationnels. Nous nous sommes également interrogés au sujet de l'impact relationnel que cette méthode pourrait engendrer. Comme nous l'avons exprimé plus haut, la visioconférence est d'ores et déjà utilisée, avec succès, dans certains pays. Notre opinion est qu'une telle technique ne peut être préjudiciable à la pratique de l'expertise psychiatrique en France. Comparativement aux pays qui utilisent la visioconférence, la France ne possède pas de dispositif procédural particulièrement différent, qui ferait d'elle une entité à part entière où la réflexion sur l'utilisation d'une telle méthode devrait être menée différemment. Il nous semble au contraire qu'il s'agirait d'un atout majeur permettant de palier certaines des difficultés actuelles rencontrées dans l'interface entre la Psychiatrie et la Justice.

#### **Conclusion**

L'utilisation de la visioconférence en expertise psychiatrique semble être une solution intéressante, pour palier, au moins en partie, les difficultés rencontrées par experts et magistrats dans cette discipline. Décider de recourir à la visioconférence peut avoir un impact non négligeable sur le délai de la procédure judiciaire. Il faut cependant que chacune des personnes intervenant dans la mission (expert, magistrat, mis en examen/détenu, avocat) soit à l'aise avec une telle procédure, afin de ne pas induire des difficultés de forme et de fond. Il nous semble qu'avoir recours à une telle technique ne doit pas être imposée, mais qu'elle doit être laissée au libre choix des



parties lorsque cela s'avère pertinent. De même la décision d'interrompre une expertise par visioconférence doit être laissée au mis en examen, sans être considérée comme un refus de participer à la mission.

La psychiatrie légale française doit être en mesure de trouver sa place au sein de ces nouvelles technologies. Néanmoins, nous partageons l'opinion que l'entretien face-à-face doit être considéré comme la méthode

à utiliser de principe. La visioconférence est une solution annexe qui doit être envisagée au cas par cas et demeurer une décision commune. Il est sans doute probable que l'évolution technologique permette d'améliorer encore la qualité de la visioconférence dans le futur. L'utilisation de la 3D et de la réalité virtuelle pourrait y jouer un rôle pertinent.

Conflit d'intérêt: aucun

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## LETTER TO THE EDITOR

# La HARM et l'AIS comme échelles standardisées du risque en psychiatrie légale : intérêts et limites à leur application en France

## ***HARM and AIS as risk assessment tools in forensic psychiatry: benefits and limitations of their use in France***

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*Cher Editeur,*

L'évaluation du risque en psychiatrie légale a subi des modifications majeures au cours des trente dernières années. Les pratiques ont évolué dans le temps, suivant les avancés de la recherche dans ce domaine. On rapporte trois générations d'évaluation du risque. La première génération est le jugement clinique non structuré. Il a été démontré que cette méthode n'était pas plus fiable que le hasard et par conséquent ne doit plus être utilisée [1]. La seconde génération a consisté dans le développement des méthodes actuarielles, ou autrement dit statistiques. Ces méthodes consistent à prendre en considération les facteurs historiques, c'est à dire statiques, afin d'évaluer un risque de récidive. Les échelles actuarielles permettent de comparer le profil d'un individu donné à un groupe d'individus présentant les mêmes caractéristiques sociodémographiques et cliniques, et dont le taux de récidive est connu [1,2]. La troisième génération d'évaluation du risque a consisté en l'apparition d'échelles de jugement clinique structuré, qui prennent en considération les facteurs dynamiques, en sus des facteurs statiques. Il s'agit alors de prendre en compte tout élément clinique pertinent susceptible de changement au cours du temps, et ainsi avoir une gestion active du risque [1,2]. Une dichotomie a même été établie entre facteurs dynamiques stables (qui peuvent se

modifier mais de façon lente) et facteurs dynamiques aigus (qui peuvent se modifier de façon rapide) [3].

L'échelle Hamilton Anatomy of Risk Management (HARM) a été créée dans la lignée des échelles de troisième génération pour favoriser une évaluation rapide et pratique du risque. Il s'agit d'un outil créé pour une évaluation en équipe, permettant ainsi une discussion plurielle autour du risque posé par le patient. L'échelle Aggressive Incidents Scale (AIS) est complémentaire de la HARM dans le sens où elle identifie les comportements déviants et guide le clinicien dans l'évaluation du risque ([www.ais-harm.com](http://www.ais-harm.com)) [4].

### **Les échelles HARM et AIS**

La HARM a été développée afin de réunir les deux problématiques principales dans la prise en charge des patients en psychiatrie légale que sont l'évaluation et la prise en charge du risque. Cette échelle présente de multiples avantages. Il s'agit d'un outil *standardisé*, basé sur les données de la littérature scientifique; *qualitatif*, aucun score numérique n'est calculé, mais le résultat donne une appréciation de l'évolution dans le temps des facteurs de risque; *pluridisciplinaire*, chaque membre de l'équipe a l'opportunité d'exprimer son opinion; *efficient*, quelques minutes suffisent pour compléter l'échelle (voire plus dépendamment de la discussion suscitée par la situation clinique). Du fait de sa facilité d'utilisation, cette échelle peut être utilisée de façon quotidienne, hebdomadaire, mensuelle, ou lorsqu'un

incident particulier survient.

La AIS a été développée afin de répertorier les comportements déviants des patients, en prenant en considération deux aspects : *la gravité du comportement*, scorée sur une échelle de 0 à 9; et *l'intervention nécessaire* apportée par le soignant afin de faire cesser le comportement inapproprié (intervention verbale, physique...).

Il est ainsi possible de visualiser l'impact immédiat de la prise en charge de certains facteurs de risque. Par exemple, l'augmentation du traitement neuroleptique amenant une diminution des symptômes psychotiques et de l'irritabilité associée peut conduire à une diminution du nombre d'incidents côtés par l'AIS. Ces outils incitent également à s'intéresser à chaque facteur de risque comme valeur indépendante dans la prise en charge, même si une même intervention thérapeutique peut avoir, au final, un impact sur plusieurs facteurs de risque.

De plus la HARM a subi plusieurs développements récents. Les facteurs de risque et le visuel de l'échelle ont été adaptés pour une utilisation en psychiatrie générale, pédopsychiatrie et psychiatrie correctionnelle. Une autre transformation, majeure, l'a fait basculer d'une version papier à une version électronique : la e-HARM permet désormais un enregistrement instantané des données. Elle permet la création de graphiques qui donnent une image de l'évolution des facteurs de risques et des incidents dans le temps. Grâce à cette avancée technologique, l'ensemble des données d'un même patient peut être agrégé afin de procéder à des tableaux de corrélations et ainsi avoir une analyse plus fine de la prise en charge du patient. L'ensemble des données d'un même service, regroupant l'ensemble des patients, peuvent également être agrégés pour permettre une analyse des pratiques au sein du service et améliorer la prise en charge de façon globale.

### **Intérêts et limites de l'utilisation de ces échelles en France**

L'utilisation d'échelles d'évaluation du risque en psychiatrie légale, en France, est

une évolution récente, mais non systématique. Comme le soulignent Vanderstukken & Lacambre, ces outils sont «souvent décriés comme étant limitatifs et stigmatisant» [5]. Néanmoins l'absence d'utilisation d'échelles standardisées induit un pourcentage d'erreur non négligeable, notamment du fait de la surestimation du risque [1,5]. Il est fort à penser que l'évolution récente des pratiques et l'influence de la recherche scientifique dans ce domaine va conduire à la généralisation de l'utilisation de ces échelles dans la pratique.

Il faut également ajouter que l'utilisation d'échelles standardisées ne doit pas se limiter à la psychiatrie légale. La pratique de la psychiatrie générale, lorsqu'il existe un risque de passage à l'acte hétéro ou auto-agressif, voire une problématique médico-légale plus large, doit prendre en considération un outil de référence. L'utilisation des échelles HARM et AIS pourraient répondre à ce besoin en pratique clinique, tout en prenant en considération les limites et intérêts d'un tel outil en France.

#### *Les limites à leur utilisation*

La problématique posée par l'utilisation de telles échelles en France est multiple. Comme nous l'avons exposé, la culture de la psychiatrie française n'implique pas l'utilisation courante d'échelles d'évaluation du risque. Leur utilisation dans des domaines particuliers comme la psychiatrie légale ne s'est pas encore généralisée. Aussi il est probable qu'une utilisation systématique dans une pratique plus généraliste prenne encore plus de temps. Ensuite, les échelles sont développées par des professionnels possédant une expertise particulière. Il est donc souvent considéré que seuls ces mêmes praticiens sont en mesure – et ont l'utilité – de manier de tels outils. De plus ces échelles sont généralement développées dans des unités dédiées à la prise en charge de patients à problématique médico-légale, permettant une application uniforme pour chaque patient du service. Les unités d'hospitalisation mixte en France, en raison de la pluralité des diagnostics et des modes d'hospitalisation (libre ou sous contrainte),

imposeraient de faire un choix dans l'utilisation ou non des échelles pour un patient donné. Il est entendu que bien que la notion de dangerosité et son évaluation sont rencontrées par tout clinicien, celles-ci ne s'appliquent pas à chaque patient. Structurer la pratique de l'évaluation standardisée est une nécessité pour permettre une utilisation optimale de l'outil. Il semble ainsi qu'un changement de mœurs est nécessaire, l'approche de la dangerosité en psychiatrie doit progressivement évoluer vers des méthodes d'évaluation qui ont prouvé leur validité.

#### *Les intérêts à leur utilisation*

Les échelles HARM et AIS permettent une évaluation clinique objective du risque et de son évolution dans le temps. Elles permettent également une évaluation rapide qui s'intègre dans la discussion clinique, sans nécessiter une analyse séparée potentiellement chronophage. L'existence d'un arbre décisionnel guidant l'utilisation ou non de l'échelle, permet de discriminer les patients présentant une dangerosité (actuelle ou historique) ou non et ainsi permet d'orienter l'utilisation de ces outils pour les patients nécessitant une évaluation standardisée du risque. L'adaptation des facteurs de risques de la HARM en fonction du contexte de prise en charge (général, médico-légal, patient mineur, suivi ambulatoire) permet une utilisation adéquate de l'outil pour le clinicien. De plus, même si ces échelles ont été développées dans un contexte de passage à l'acte à l'égard d'autrui, les facteurs de risques sont transposables aux comportements auto-agressifs et peuvent donc guider la prise en charge des patients présentant des conduites suicidaires. Enfin, la documentation issue de l'évaluation standardisée peut prendre valeur légale, puisqu'elle reflète une opinion objective et pluridisciplinaire. Ainsi cette documentation peut supporter les certificats établis au cours des hospitalisations sous contraintes et de fait soutenir la décision de prolongation ou de levée de la contrainte. L'évaluation répétée du risque grâce aux échelles standardisés permet également une visualisation

graphique de l'évolution des facteurs de risques et des comportements inappropriés, ce qui peut s'avérer être une aide dans la compréhension dynamique de l'évolution clinique, notamment pour les non-cliniciens.

#### **Conclusion**

Il nous semble que les intérêts liés à l'utilisation d'outils d'évaluation standardisée en France, tels que la HARM et l'AIS, sont majeurs. Les limites exposées ci-dessus ne semblent pas être un frein prééminent à l'instauration d'une telle pratique. Il est évident qu'il existe un réel intérêt à leur intégration dans les pratiques courantes au sein de structures telles que les UHSA, les SMPR et les UMD, puisque par essence une problématique médico-légale et/ou de violence existe. Les services de psychiatrie de secteur, à vocation plus généraliste, possèdent les mêmes problématiques médico-légales de façon récurrente ; l'utilisation des échelles HARM et AIS peuvent donc être un atout supplémentaire dans la prise en charge de certains patients désignés.

Ces deux échelles ont évolué au fil du temps afin de répondre de façon plus adéquate à la demande des cliniciens et aux exigences de la Société (gestion du risque et réhabilitation thérapeutique). La HARM pourrait d'ailleurs être considérée comme la 4e génération d'évaluation du risque, en raison de son caractère pluridisciplinaire. La e-HARM quant à elle serait une échelle de 5e génération, une évaluation dite analytique.

Conflit d'intérêt: aucun

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