The Case for Progress in Forensic Psychiatry

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Steven Pinker, in his book *Enlightenment Now: The Case for Progress in Science and Humanity*,[1] argues that scientific rationality and liberal humanism have led to significant progress in most areas of our lives. The most obviously improved area is health, which has seen a widespread increase in life expectancy due to advances in medicine, including tools to treat infectious diseases, heart disease, and cancers. Similarly, there have been drastic reductions in infant mortality due to better maternal care, pediatric medicine, vaccinations, and antibiotics. There has been parallel growth in wealth and prosperity, starting in industrialized nations, which is gradually and dramatically spreading to developing nations. The rising tide of prosperity has decreased inequality, Pinker argues convincingly, and has led to increased opportunities for education, benefiting most people in the world with very few countries excepted. He points out that our values are rooted in emotion, personal experience, and expectation. As a result of this, many people in society feel that they have been passed by regarding these advantages, resulting in the rise of populism, Brexit, and a population who see scientific progress as anathema to social values.

In 1969, Dr. Jonas Rappeport invited a group of 10 forensic directors to meet in a Miami hotel, and it was at this meeting that the American Academy of Psychiatry and the Law (AAPL) was conceived.[2] As AAPL celebrates the 50th anniversary of this event, it is timely to consider the state of forensic psychiatry today. In this editorial, I argue that forensic psychiatry has demonstrated significant progress in a number of areas. These areas include more and better training in forensic psychiatry, accreditation of a growing number of programs, increased and standardized continuing medical education (CME), increased application of measurement-based forensic psychiatry, increased use of technology, increased contribution to correctional psychiatry, and an increase in equity of our members, all of which can only strengthen and continue to strengthen the field.

In forensic psychiatry, we have tended not to look inward and not to dwell on the state of the specialty as we know it today. There are few articles on the future of forensic psychiatry. In 2000, Professor John Gunn drew attention to troubling statistics, suggesting that the prevalence of mental illness in jails and prisons increases as the number of mental health beds decreases.[3] This is a complicated matter and is debated in the literature,[4] and it is beyond the scope of this article. It is pertinent to note that the provision of quality psychiatric care in jails and prisons is very much a concern today and is addressed later in this editorial. In Canada, the Goudge Report[5] severely criticized forensic pathology, leading to significant changes in the field. Parallel to some of these changes, the United States created board examinations for forensic psychiatry in an effort to define the specific characteristics that make forensic psychiatry a specialty and to direct training in such a way that culminates in specialized examinations.[6] Canada followed this lead in 2012, creating a subspecialty under the Royal College of Physicians and Surgeons of

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Canada. This made forensic psychiatry a freestanding specialty under the College, characterized by a subspecialty committee tasked with creating training requirements and an examination committee to evaluate candidates who fulfill these training requirements. As a result, we created formal fellowship programs, known in Canada as postgraduate year six programs (PGY-6). These programs are based on the training requirements spelled out by the subspecialty committee, which include didactic teaching as well as actual experiences of assessing evaluees, writing reports, and participating in teams treating and managing mentally disordered offenders.

Over the last two years, the Royal College of Physicians and Surgeons of Canada has focused its attention and resources on creating a different type of training that is believed to be an improvement over the previous Socratic method of training. This new method, known as Competency by Design, has become popular in medical training the world over and includes designating essential activities, known as entrustable professional activities, which a trainee must master before moving on to the next stage of his or her training. Such activities include interviewing skills, assessment skills, report writing, and testifying in court, as well as a comprehensive list of forensic activities. These might include an assessment of competence or fitness to stand trial, including the process of explaining any limits of confidentiality, performing an evaluation, writing a report, and testifying (which might be in a mock trial format). Each trainee must perform these designated activities successfully in front of a supervisor, who provides structured feedback. These entrustable professional activities become progressively and accumulatively more complex, addressing the whole range of activities of a practicing forensic psychiatrist, until, at the end of the training period, the trainee is judged to be a competent forensic psychiatrist. The emphasis on directly observing the trainee's experiences and structuring the feedback forces mentors to become better supervisors and teachers. I would also argue that this process makes us, as forensic psychiatric trainers, repeatedly examine the constituents of our work and, as a result, makes us better forensic psychiatrists, even as we strive to improve the experiences of our learners.

Our licensing bodies and professional organizations have increasingly placed emphasis on CME and lifelong learning. Organizations such as AAPL, the Canadian Academy of Psychiatry and the Law, and the Royal College of Psychiatrists, Faculty of Forensic Psychiatry, offer courses, workshops, and conferences with a goal of making CME available to their members. Whether members are mandated to attend these conferences or attendance is optional, it is my experience that most of us are eager to attend and learn from our peers, as well as to benefit from the discussions and networking that are implicit in these conferences. The concept of lifelong learning likely increases the standard of forensic psychiatry in general.

One of the recent movements in psychiatry that reflects the scientific basis of psychiatry is a movement toward measurement-based care. This is a development of evidence-based psychiatry, which provides a scientific approach to our thinking. Measurement-based care is the systematic evaluation of patient symptoms before or during an encounter to inform behavioral health treatment.[7] In forensic psychiatry, we have considerable experience in using measurement for assessment, and this easily translates into measurement-based treatment.[8] We can trace this movement back to the development and use of actuarial tools for the prediction of violence and sexual offenses.[9] These tools were designed to add an evidence base to the prediction of sexual and violent offenses and originally included such instruments as the Sex Offender Risk Appraisal Guide (SORAG), Violence Risk Appraisal Guide (VRAG), and Static 99/2002-R. The Hare Psychopathy Checklist (PCL-R)[10] is a psychological test that has been found to be reliable and valid in measuring psychopathy. It has been applied to the prediction of recidivism and proven to be moderately effective.

A second generation of prediction has provided us with structured professional judgment instruments, such as the Historical Clinical Risk Management-20 (HCR-20), the Referral Screening Verification Process (RSVP), and various other tools. These have included both static and dynamic variables and, therefore, respond to changes in evaluees and their situation. They have also been proven to be moderately good predictors of recidivism. They invite us to consider all of the evidence-based variables in our prediction equation, as well as to delineate specific areas to target management and intervention. The Dundrum toolkit[11] is a structured professional judgment instrument that is specifically designed for managing the mentally abnormal offender. This in-

strument enhances decision-making in areas such as level of security and directs and delineates areas for treatment and intervention that are relevant to the individual. This test is subject to change as the individual progresses through treatment and provides a framework for cascading the individual from maximum security to the various levels of security, to outpatient care and eventual discharge. Another way of looking at measurement is through a strengths-based approach, a representative of which is the Structured Assessment of Protective Factors (SAPROF).[12] This focuses on the strengths of the individual and directs the treatment team to enhance these strengths to avoid recidivism and achieve a variety of goals.

Other instruments, such as those that measure competency or fitness to stand trial, are available but have not reached general acceptance to the extent that they are used in everyday practice. Similarly, instruments that may measure criminal responsibility, such as the Rogers Criminal Responsibility Assessment Scales (R-CRAS),[13] are not in routine clinical use, partly because jurisdictions and standards for criminal responsibility vary. It is likely that we will develop and adapt these ground-breaking instruments to improve our ability to assess these psycholegal standards in the future. Measurement-based forensic psychiatry offers us an opportunity to complement the essential features of any medical interaction, which still demands relationship-building, compassion, and the instillation of hope in individuals.[14] I would hope that these basic ingredients will not be lost in the flurry of excitement about measurement.

Medicine, in general, has benefited to a significant degree from technological innovation. The evolution from x-rays to computed tomography scans to magnetic resonance imaging (MRI), and now functional MRIs and positron emission tomography (PET) scans, has great potential to provide a more scientific basis to forensic psychiatry. At this stage, the application of these technologies to forensic psychiatry must still be considered in its early stages. There may be a time in the future when we can diagnose schizophrenia, neurocognitive disorders, and psychopathy using these tools. Recent research that aims to identify and understand the biological correlates of violence and aggression within particular populations using PET, MRI, and genetics to elucidate biomarkers within psychiatric populations (including those with borderline personality disorder, antisocial personality disorder, psychopathy, schizophrenia, and first-episode psychosis with conduct disorder) is already underway.[15] These lines of research promise a paradigm shift in our understanding of mental illness and its effects and may lead to improved screening and more effective and precise diagnosis and treatments for patients at risk of aggressive or violent behavior.

Other types of technology might include the use of ankle or wrist bracelets for forensic patients.[16] We have seen a rise in monitors no more obtrusive than a wristwatch that can monitor the distances we have traveled, our heartbeat, and the amount of exercise we have done. It is likely that these can be used to provide a less obtrusive kind of supervision to our patients. For instance, if a patient goes on a pass with the specific task of going to a store to buy an article, the monitor can demonstrate that the patient went directly to the store to buy the article and returned safely to the hospital. In this way, there can be a more specific application of passes whereby the patient designs a series of progressive passes for specific purposes, in association with the clinical team, and achieves various milestones toward a specific goal. The bracelets can be linked simply with apps that record the data, demonstrating the progress of the patient over the course of time. This would involve patients in their own treatment planning, in concert with the treatment team, and allow them to monitor and appreciate their progress toward treatment goals. It may also be possible for the patient to become aware, through the use of these instruments, of physiological signs of anxiety and arousal, and then use emotional-regulation techniques that would decrease their risk of inappropriate actions at these times.

Due consideration of informed consent and human rights would require some debate before we see these technologies in general use.[17] The technology exists for us to consider the use of artificial intelligence in the delivery of cognitive therapy. This is a field that may have particular applications in forensic psychiatry, especially in correctional psychiatry, where barriers to face-to-face treatment are particularly apposite.[18]

In the area of equity, the last 20 years have seen significant changes in forensic psychiatry, which reflect changes in most areas of society. Traditionally, the medical profession has lacked diversity, and fo-

rensic psychiatry has been no exception.[19] In fact, the leadership of AAPL has committed to increasing diversity among its members and has initiated a number of strategies to affect this. Without diminishing the seriousness of the situation, it is my observation that forensic psychiatry has become an increasingly popular subspecialty among women and various minority groups. At the University of Toronto, we have trained 22 PGY-6 (fellows) since forensic psychiatry became a subspecialty in Canada. Out of these 22, nine have been female and eight from a visible minority. One study showed that 58.1 percent of graduates in forensic psychiatry graduated from medical schools accredited by the Liaison Committee on Medical Education, which is higher than in other psychiatric subspecialties.[20] In addition, 65 percent of trainees were of white, non-Hispanic ethnicity, not significantly higher than 61 percent of the general population,[21] but this is a significantly higher figure than in other psychiatric subspecialties. Further, 53.2 percent were female, which is again lower than in other psychiatric subspecialties, except addiction psychiatry, but still noteworthy.[20] Taken together, this admixture reflects the diverse society that we increasingly enjoy. It demonstrates that forensic psychiatry is becoming accessible and popular among diverse groups, and there is no reason to think that this trend will not continue.

Noting Gunn's timely reminder regarding the large numbers of individuals with mental illness in corrections, forensic psychiatry has heeded his warning.[3] During my AAPL presidency, I argued that correctional psychiatrists should be forensic psychiatrists.[22] As a follow-up to this, during his presidency, Dr. Michael Norko initiated a drive to welcome correctional psychiatrists to AAPL and to convince them to make AAPL their home. It is my impression that this has been successful, and correctional psychiatrists are making an increasingly meaningful contribution to the organization. For instance, the AAPL correctional psychiatry committee recently produced a resource document for prescribing in correctional settings.[23] I predict that, as correctional psychiatrists come to feel more at home in AAPL and similar organizations, this will increase the standard as well as the consistency of care in correctional psychiatry. In addition, as fellows and trainees will have more exposure to correctional psychiatrists, they may feel more comfortable entering this field, thereby increasing recruitment in a field that has traditionally been neglected.

Conclusions

In this article, I have posited that we have made significant gains in a number of areas in forensic psychiatry. These areas include training, CME, measurement, technology, and perhaps equity. We have also made steps to increase the standard of forensic psychiatry in correctional psychiatry, rising to the challenge made by Gunn. This unequivocal progress could be argued to have begun with the conception of AAPL. Other significant milestones have included the creation of a subspecialty, which has facilitated the delineation of the competencies of the field, which in turn has led to better training and an examination system that ensures that all trainees begin, at the very least, as competent forensic psychiatrists.

Pinker makes the point that "it's the idea of the progress that sticks most firmly in the craw. Even people who think it is a fine idea and theory to use knowledge to improve well-being insist it will never work in practice" (Ref. 1, p 35). There are those in forensic psychiatry who also refuse to accept that we have made progress; Mullen[24] suggested that the adoption of measurement tools, as well as the increased bureaucratic machine that has become inherent in our growth, have adversely affected our core principles.

It is appropriate to remind ourselves that, although we have made progress, we should not forget the basic principles that made us want to be clinicians. Norko[14] reminds us whence we came and of the nature of vocation in medicine and forensic psychiatry. He emphasizes the attitudes and activities in forensic practice that form pathways to truth, presence, empathy, compassion, and centering. This is an important reminder that, no matter the progress we make in the field, we should not lose the sense of compassion that made us physicians.

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