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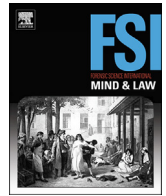
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## Forensic Psychiatry

## Mental health and the criminal justice system in France: A narrative review

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## ABSTRACT

The treatment of people diagnosed with mental disorders who committed crimes differ greatly in countries around the world because of the long histories of criminal justice and psychiatry specific to each country. As a result, it is often difficult to grasp the specificities of each system. The main objective of this paper is to provide a narrative review of the interactions between the French mental health and judicial systems. Subsequently, we will discuss how the concept of forensic psychiatry does not yet exist in France and how it can be applied.

## 1. Introduction

The treatment of people diagnosed with mental disorders who committed crimes differ greatly in countries around the world because of the long histories of criminal justice and psychiatry specific to each country. A brief historical introduction is crucial to understand the relationship between the mental health care and judicial systems in France.

Criminal responsibility has been a core principle of French criminal law since the early nineteenth century. Enshrined in article 64 of the “penal code” (*code pénal*, 1810, French criminal law), this principle established a fundamental dichotomy between psychiatric hospitals and prisons: “There is no crime or offense when the defendant was in a state of insanity at the time of offense, or when he was constrained by a force he could not resist.” Article 24 of the “insane persons act” (*loi sur les aliénés*, 1838) stated the same concept: “Insane persons may in no case be detained with convicted or accused persons or deposited in a prison.” Despite debates and sporadic experiments throughout the nineteenth and twentieth centuries (Renneville, 2003; Guignard, 2010), this dichotomy still underpins French criminal law.

In the 1930s, many European countries created facilities dedicated to forensic psychiatry. For example, in Germany, a “forensic psychiatric

hospital” for executing the so-called “*Massregelvollzug*” (psychiatric treatment under security conditions) was created as part of a so-called “second track” (*zweite Spur*) which encompassed different “rehabilitation and safety measures” as opposed to the first track of “penal sanctions” (Lancelevée, 2018, pp. 77–87). In Belgium, the social defense act (*Loi de défense sociale*) introduced a placement of people deemed “insane offenders” in specific wards, with the aim of “treatment” and “protecting society” (Cartuyvels et al., 2010). Similar facilities emerged in Switzerland, Austria, Norway, the Netherlands and even in Italy with “psychiatric judiciary hospitals” (*Ospedale Psichiatrico Giudiziario*) (Salize et al., 2007). Although the concepts of “social defense” and “dangerousness” clearly spread among French judicial reformers, no facility for people diagnosed with mental health conditions who committed crimes was created at that time in France (Kaluszynski and Mucchielli, 1994; Protais, 2014). This mission remained in the purview of community psychiatric hospitals.

After World War II, a reform movement substantially changed the organization of jails and prisons in France, providing detainees with social services for rehabilitation purposes. In this context, officials created “psychiatric examination services” in some prisons (the first ones were created in 1927 in Loos-lès-Lille and in 1936 in La Santé (Paris), La Petite Roquette (Paris) and Fresnes). These services sought to establish

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psychiatric evaluations for people in prison under the supervision of a psychiatrist on behalf of the Ministry of Justice. The “penal procedure code” (*Code de procédure pénale*, 1958, article D.398) introduced the possibility of placing temporarily incarcerated individuals whose “state of mental alienation is deemed incompatible with incarceration” in community psychiatric hospitals.

In the 1960s and 1970s, anti-psychiatry movements arose in France and across Europe and their criticisms resonated in prison contexts as people cautioned against “rebuilding the asylum in prison” (Farges). The challenge for psychiatrists was thus to provide care to incarcerated people without participating in their judicial supervision. In this context, the law changed in 1985, and stated that psychiatric care in prisons had to be provided by mental-health workers employed by community psychiatric hospitals, under the authority of the Ministry of Health. This landmark step stabilized the French mental health care system in prisons, reproducing the historical dichotomy between the mental health and criminal justice systems inside the walls of prisons.

In the 1990s and 2000s, two major changes occurred that brought further integration between the mental-health and justice systems. Firstly, in 1994, reformers changed the criminal law by implementing “diminished criminal responsibility.” This new development blurred the clear-cut distinction between full and a lack of criminal responsibility. With this change, a person can be sentenced to imprisonment even if s/he was diagnosed as mentally ill at the time of the offense, which has been accompanied by a decrease in the number of people declared “irresponsible,” whereas the incarceration of people whose responsibility is considered “diminished” has increased (Protais, 2016). Secondly, psychiatric care during probation expanded in 1998 with the creation of a new court-ordered treatment (see 3.9. *Court-ordered treatment*). Initially limited to people convicted of sex offenses, this measure later extended more broadly to serious, non-sexual crimes and offenses in the 2000s.

The main objective of this paper is to narratively review the interactions between the French mental health and criminal justice

systems. We will also discuss how the concept of forensic psychiatry can be applied in France where it does not exist as such today.

## 2. Methods

Studies for this narrative review were included based on a literature search in two electronic databases (*MEDLINE* and *Cairn*) for articles published through January 2020. The literature search was performed by using the following keywords: forensic psychiatry, France, criminal law, responsibility, insanity defense, competency to stand trial, prison, jail. The article titles and abstracts of studies identified by the searches were screened. Only articles written in English or French were considered. Legislative acts were extracted from *Légifrance* which is the official website of the French government for the publication of legislation, regulations, and legal information.

## 3. Results

Fig. 1 provides an overview of the interactions between the mental health and judicial systems in France. It focuses on the criminal justice system in relation to individuals diagnosed with mental health disorders who committed crimes. Items appearing in blue are managed by the Ministry of Justice while items appearing in yellow are managed by the Ministry of Health. The following sections (3.1 to 3.10) refer to numbers 1 to 10 respectively in Fig. 1.

### 3.1. Trial

Criminal responsibility is a key-concept in the criminal sanctions of people diagnosed with mental health disorders. Three categories of criminal responsibility exist in the criminal law: (i) lack of criminal responsibility (“A person who was suffering, at the time of the offense, from a psychic or neuropsychic disorder that abolished his/her ability to control his/her actions”), (ii) diminished criminal responsibility (“A person who was

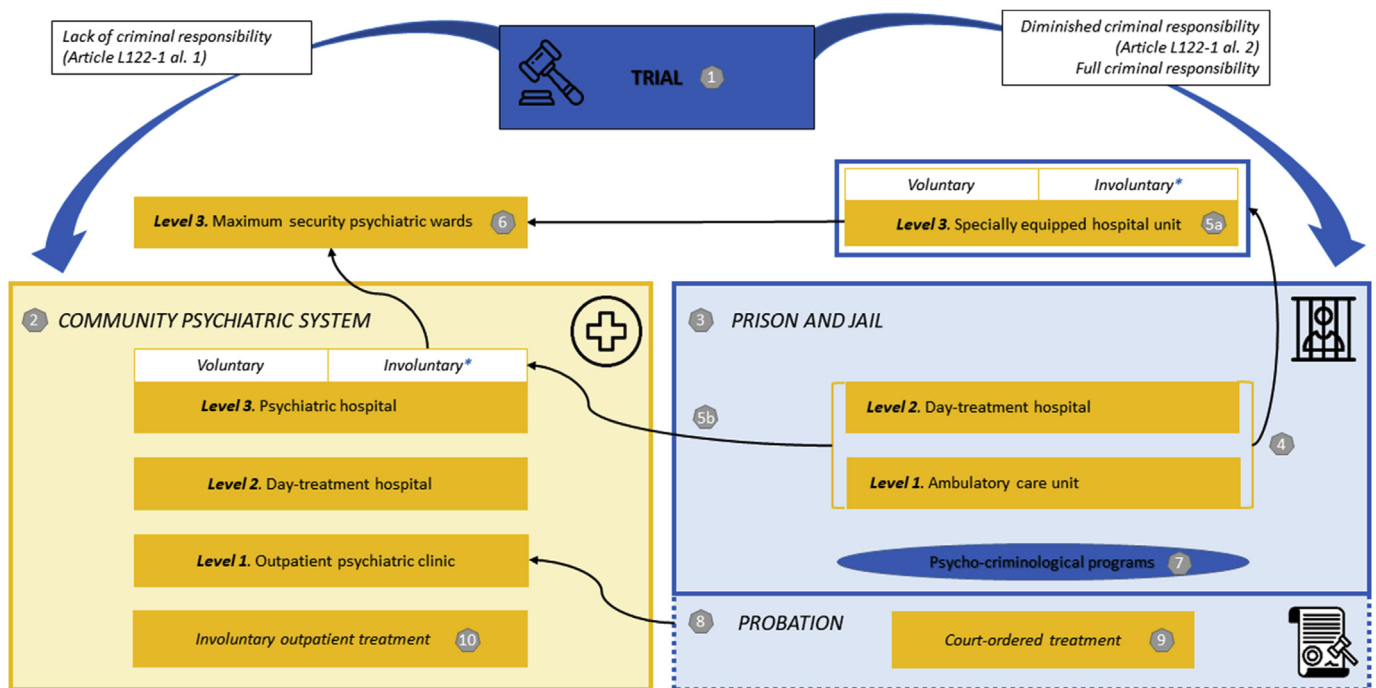


Fig. 1. An overview of the interactions between the mental health system and the criminal justice system in France. Numbers 1 to 10 refer to sections 3.1 to 3.10 respectively in the text. Items appearing in blue are managed by the Ministry of Justice while items appearing in yellow are managed by the Ministry of Health. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

suffering, at the time of the offense, from a psychic or neuropsychic disorder that impaired his/her ability to control his/her actions”) and finally (iii) full criminal responsibility.

France is a Romano-Germanic legal country that adopted a non-adversarial procedure for psychiatric assessment in criminal law (Combalbert et al., 2014). The judge can decide to ask for an independent expert who acts as a technician assisting the judge in his/her area of expertise (Guivarch et al., 2017). For all crimes, a psychiatrist expert must make an assessment before the trial. The expert who makes the assessment must provide proof of qualification and professional experience (Décret n°2004-1463 December 23rd 2004), but the law does not specify the criteria. For criminal cases (Cour d'assises: “criminal court” with a popular jury board), the law requires written and oral expert reports. Only written reports are required for any other offense (Tribunal correctionnel: “correctional court” with a professional jury board for offenses sentenced to a maximum of ten years of imprisonment). The assessment must include whether the committed offense was a direct result of a mental health disorder that abolished or altered the offender's discernment and/or ability to control his/her actions according to article 122-1 of the criminal law (see Box 1 for the complete list of questions usually asked to the psychiatric expert). No mental health disorder is explicitly included or excluded by the law. The French term “psychic or neuropsychic disorder” leaves the expert to consider any mental health or neurological disorder.

The judge or the court are not required to follow the expert assessment's recommendations. If an expert concludes a lack of criminal responsibility, the judge can declare the person not criminally responsible and thus not subject to a prison sentence (Law of February 25th 2008). The lack of criminal responsibility is registered in the criminal record. The judge can also impose security measures, such as prohibited access to victims or family members or restrictions on place of residence and/or travel, and order an involuntary hospitalization in a community psychiatric hospital according to a specific law (article L3213-1 of “Public Health Code” – which is called “Psychiatric care by decision of a State representative” (Soins psychiatriques sur décision d'un représentant de l'Etat, SPDRE)).

In the cases of a diminished or a full criminal responsibility, the courts can send people convicted of a crime to prison. If the judgment concludes that there is a “diminished criminal responsibility,” the court shall take this into account when determining the sentence. If the judge considers a prison sentence, he/she can reduce it by one-third or for a crime punishable by a sentence of life imprisonment reduce it to a 30-year maximum. The court may decide not to apply this sentence reduction, however.

### 3.2. Community psychiatric system

Each year, about two million people (including 424,000 who experienced at least one full-time hospitalization) benefit from psychiatric care in France (Agence technique de l'inf, 2019). Psychiatric care reforms

have led to the development of catchment area-based service provisions for the last 50 years. The “psychiatric sector” (*secteur psychiatrique*) is defined as a precise geographical catchment area for which a single, multidisciplinary team composed of physicians, psychologists, nurses, and social workers (Leguay and Boyer, 2012) takes responsibility for mental healthcare delivery. Today, there are approximately 830 sectors (initially each sector included about 70,000 inhabitants) which are organized in 3 levels of care: (i) outpatient psychiatric clinics (*centres médico-psychologiques*, CMP), (ii) day treatment hospitals, (iii) psychiatric hospitals in which patients can be admitted voluntarily or involuntarily. Even if each “sector” has an obligation to care for all people with psychiatric disorders in a given catchment area, all patients have the freedom to choose their psychiatrist (inside or outside the catchment area).

The procedure of involuntary hospitalization, which affected 82,000 people in 2018 (Agence technique de l'inf, 2019), has been amended a number of times since 1838, and the last amendment occurred in 2011 (Law of July 5th 2011). As of 2011, a “liberty and custody judge” (*juge des libertés et de la détention*, JLD) is appointed to guarantee the rights of hospitalized people and to prevent abusive hospitalizations (this control is indicated by the blue asterisk in Fig. 1). The court must hold a mandatory hearing before the 12th day of hospitalization. During this hearing, a lawyer assists the patient, and all the documents in the admission file (medical certificates, administrative documents) are examined. In ten percent of cases, the judge of liberty and custody ends the involuntary hospitalization against the opinion of the treating psychiatrist (Coldefy et al., 2017; Horn et al., 2018).

At the end of a trial, if the judge declares the person not criminally responsible, he/she is referred to the psychiatric hospital in charge of him/her, according to residency. In most cases, the psychiatric expert suggests an involuntary hospitalization if the person requires psychiatric care and endangers the safety of others and/or the public order (SPDRE, article L. 3213-1 Health Public Code). These individuals are then hospitalized with involuntarily hospitalized patients who did not commit offenses. The psychiatrist in charge decides the type of treatment and the duration of stay, leading to significant variations in the outcomes of these individuals. Before discharge, a psychiatric assessment by two independent psychiatric experts is required. If both psychiatrists agree on the discharge decision, the local state representative (*Préfet*) makes the final decision.

### 3.3. Prison and jail

With more than 70,000 people incarcerated under severely overcrowded conditions (including 21,000 in pre-trial detention), the situation of correctional institutions in France is extremely worrisome and a high prevalence of psychiatric disorders has been reported among people in French prisons (Duhamel et al., 2001; Prieto & Faure, 2004; Falissard et al., 2006a; Sarlon et al., 2012; Fovet et al., 2020a). The mental health care system in correctional institutions, created in 1985, includes three

#### Box 1

Standard list of the questions that psychiatric experts are generally asked by judges (1958)

1. Does the examination reveal mental or psychic abnormalities? When appropriate, give a description of the disorders they relate.
2. Is the offense related to this disorder?
3. Does the person present a danger for himself or others?
4. Is the person able to understand the penal sanction?
5. Can the person be treated or rehabilitated?
6. Did the person suffer from a psychic or neuropsychic disorder that prevented or impaired his/her discernment, prevented or impeded the control of his/her actions at the time of the offense?
7. Provide information about the appropriateness of a court-ordered treatment.
8. Provide any observation deemed useful to establish the truth (open question).

levels of care that correspond with the public mental health system (see 4 and 5a in Fig. 1) (Fovet & Thomas, 2017). These levels are the same for all incarcerated people, regardless of whether they are incarcerated in a jail or prison. The professional independence of caregivers from the judiciary system and medical confidentiality are fundamental values on which these correctional psychiatric care facilities have been built (Fovet et al., 2015).

### 3.4. Mental health care for incarcerated people: levels 1 and 2

Mental health care workers provide two primary levels of care inside correctional facilities. The first level corresponds to ambulatory care units and is present in each of the 188 French correctional facilities. The resources allocated to these facilities vary considerably from one institution to another, however, and a severe shortage of mental health professionals exists in many prisons, limiting people's access to primary mental health care (Davidson, 2015). Only 26 out of France's 188 correctional facilities benefit from the second level of care: day treatment hospitals (*services medico-psychologiques regionaux*, SMPRs). These hospitals include nurses, psychiatrists, and psychologists during working hours as well as day hospital beds inside the prison. Psychiatrists working in prisons can refer people to these centres, but admission can only be voluntary. In 2016, 1465 inmates were admitted to SMPRs (Fovet et al., 2020b).

### 3.5. Mental health care for incarcerated people: levels 3

The third level includes full-time hospitalization for incarcerated people. This level has undergone the most significant change in the past few years. Before recent changes in the law, people could only be involuntarily hospitalized (Fovet et al., 2018). This hospitalization (shown by 5b in Fig. 1) occurred in community psychiatric hospitals, which sometimes led to the inappropriate use of isolation and mechanical restraint (most of the time to limit the risk of escape in the absence of security guards). In 2002, new facilities called "specially equipped hospital units" (*unités hospitalières spécialement aménagées*, UHSAs) were created as shown by 5a in Fig. 1. The nine UHSAs (full-time inpatient psychiatric wards exclusively for people in the correctional system), established in the 2010s, offer a total capacity of 440 beds. They belong to the public health system and are generally located in community psychiatric hospitals, but the prison administration ensures the security of the unit, manages entries and exits, coordinates the transfers of patients, and intervenes when major security issues arise (see [supplementary material](#) for some pictures). In contrast to community psychiatric hospitals, where incarcerated people can only be involuntarily hospitalized, people can be hospitalized in a UHSA either with their consent (written consent is mandatory) or against their will (a medical report is mandatory). In both cases, a psychiatrist working in the correctional facility must request the hospitalization (see 3.4. *Mental health care for inmates: levels 1 and 2*). For involuntary hospitalization, the medical report, which the liberty and custody judge controls, should state that the person suffers from a psychiatric illness and may endanger himself/herself or the safety of others. Overall, in 2016, 3334 incarcerated people were hospitalized either in a UHSA (approximately 50% involuntarily) or in a community psychiatric hospital (or both) (Fovet et al., 2020b).

### 3.6. Maximum security psychiatric wards

The so-called "units for difficult patients" (*unités pour malades difficiles*, UMDs) are maximum-security psychiatric wards located in community psychiatric hospitals (these total 10 interregional UMDs with 620 beds for men, 36 beds for women) (Raymond et al., 2015). Fully managed by the public health system, UMDs are designed for the involuntary hospitalization of patients, detained or not, who "endanger the safety of others and for whom the necessary care, supervision and safety measures can only be carried out in a specific unit". Only a minority of people admitted to

the UMDs come from prison, and most of them are referred by community psychiatry hospitals (in 2016, only 97 inmates were hospitalized in UMDs) (Fovet et al., 2020b). After a stay in the UMD, the person returns to his or her initial inpatient psychiatric facility. This discharge is only possible after a positive assessment from the "medical follow-up commission" (*commission du suivi médical*) which is comprised of three psychiatrists who are not working in the UMD and a physician representing the "regional health agency" (*agence régionale de santé*, ARS). This commission examines the medical record of each person admitted to the unit at least every 6 months.

### 3.7. "Psycho-criminological" programs

In addition to the mental health care services managed by the Ministry of Health (see 4 in Fig. 1), the prison administration has developed "psycho-criminological" expertise over the last few decades and the Ministry of Justice runs a myriad of "psycho-criminological" programs in correctional facilities. Four "national evaluation centres" (*centres nationaux d'évaluation* in Réau, Fresnes, Lille-Sequedin and Aix-Luynes) are dedicated to a 6-week "psycho-criminological" evaluation for people with long prison sentences in order to determine their "potential dangerousness", the necessity of specific security measures, and to assign them to a correctional facility "adapted to their personality". A 4-month evaluation is also organized in particular wards (*quartiers d'évaluation de la radicalisation*) for people identified as "radicalized," (i.e. violent extremists) who may eventually be incarcerated in high-security wards providing a counter-radicalisation program (*quartier de prise en charge de la radicalisation*) (Chantraine et al., 2018; Herzog-Evans et al., 2019). Twenty-two prisons which mainly house people convicted of sexual offenses have developed specific treatment programs. Furthermore, each "long-term correctional facility" (*établissement pour peine*, prisons housing approximately 30% of the incarcerated persons) since 2000 has established a "sentence management program" (*parcours d'exécution de peine*), which aims to help people with long prison sentences manage their time in prison and eventually prepare their release by setting annual goals under the supervision of a psychologist. Since 2007, "programs for the prevention of recidivism" (*programmes de prévention de la récidive*) are set up in many prisons for specific groups (individuals with convictions for domestic abuse, sexual offenses, etc.). These focus groups are moderated by "prison counselors" (*conseillers pénitentiaires d'insertion et de probation*) and coordinated by psychologists. Finally, a "security detention unit" (*Centre socio-médico-judiciaire de de sûreté*) opened in 2008 for people who have served their sentence but are deemed "very high risk of reoffending" by a multidisciplinary commission. This unit consists of 10 studios of about 205 sq. ft (19 sq. m) each, equipped with a bathroom and a kitchen (CGLPL, 2013). The procedure is strictly regulated but several human rights control organizations are calling for its abolition.

### 3.8. Probation

In France as in other Western countries, the number of people on probation has dramatically increased over the last several decades. In June 2019, there were 162,034 people on probation (probationary suspension, community service, residence ban, civic training, etc.) or placed under a "safety measure" (*mesure de sécurité* – such as electronic monitoring or judicial supervision). Among these probationers, approximately 7000 were submitted to a "socio-judicial supervision", i.e. monitoring measures determined by the sentencing court for a period of time and designed to prevent recidivism. Among those measures is "court-ordered care" (*injonction de soins*), which changed the relationship between psychiatry and justice.

### 3.9. Court-ordered treatment

This court-ordered care was implemented in 1998. Initially implemented for people convicted of sex offenses (but gradually extended to

other serious non-sexual crimes or offenses (Orsat et al., 2015; Bernard et al., 2019; Tesson et al., 2012)), this legal measure sought to reduce the risk of recidivism through medical follow up (Halleguen and Baratta, 2014). “Court-ordered care” mainly consists of psychiatric or psychological care after people have served their prison sentence. The judge can order this measure at time of sentencing or after sentencing but only if a previous psychiatric expert indicated that it is relevant. The judge also decides the duration of the measure (from several months to ten years, depending on the judge and the severity of the offense). In contrast, the psychiatrist or psychologist decides the care program in cooperation with the convicted person with the help of the medical coordinator, if necessary. This arrangement is monitored by a sentencing judge, a social worker, a psychiatrist chosen by the judge from a list of accredited psychiatrists (i.e. “medical coordinator”, *médecin coordonnateur*), and occasionally a psychologist. No previous training is required. The medical coordinator is the connection between the treating psychiatrist, psychologist, and the judge: he/she has to report every year for the duration of probation about the relevance of the care program and the compliance of the offender. Established in 2006, “resource centres for professional caregivers working with sexual offenders” (*Centres Ressources pour les Intervenant auprès des Auteurs de Violences Sexuelles, CRIAVS*) are regional structures aimed at improving the prevention, understanding and management of sexual violence on the basis of ethical and practical considerations (Bertsch et al., 2017).

### 3.10. Involuntary outpatient treatment

Since 2011 in France, a “mandatory ambulatory care program” (*programme de soins ambulatoires*) can be set up at the end of a full-time involuntary psychiatric hospitalization (Pastour et al., 2020). This kind of program can only be decided by the treating psychiatrist (it is not court-ordered). This mandatory ambulatory care program after discharge is usual and there is no minimum or maximum duration of mandatory ambulatory care after the person's discharge from the hospital. If the person does not comply with ambulatory care, he/she may be readmitted to hospital. In 2015 nearly 37,000 people were undergoing “mandatory ambulatory care” with significant geographical and institutional disparities. This type of program can apply to people for whom the courts determined lack of criminal responsibility at the time of his/her discharge from involuntary hospitalization.

## 4. Discussion

The above sections laid out an overview of the relationships between psychiatry and criminal justice in France. Fig. 1 highlighted the general principles connecting mental health and criminal justice – particularly in correctional settings. As a complement to this overview, below we discuss some of the major challenges faced by the French judicial system in relation to incarcerated people diagnosed with mental health disorders.

### 4.1. Prison as the ultimate asylum?

Several studies conducted in France have reported very high rates of mental health diagnoses among the prison population (Falissard et al., 2006a; Fovet et al., 2020a). The most significant study (Falissard et al., 2006b) was conducted in 2004 on a sample of 799 incarcerated men and indicated that 35% of the people interviewed showed at least one severe mental health disorder. Prevalence rates of schizophrenia, major depressive disorder, generalized anxiety and drug dependence were 6.2%, 24%, 17.7%, and 14.6% respectively. A study conducted on people recently admitted to remand prisons in the North of France identified very high rates of mental health diagnoses (Fovet et al., 2020a) which could be explained by several factors.

In the last quarter of the twentieth century, there has been a significant decrease in the number of people declared “not criminally

responsible” whereas the incarceration of people whose responsibility is considered “diminished” has increased (Protais, 2016). Moreover, the policy of deinstitutionalization has made the least socially integrated patients more likely to fall into a vicious circle of petty crime and prison stays. This situation is worsened by accelerated trial procedures such as “immediate trial” (*comparution immédiate*) without any psychiatric expertise. A study of hospital and prison statistics showed an inverse correlation between hospitalization and incarceration rates (Raoult and Harcourt, 2014) which, even if debated (Winkler et al., 2016), could suggest that prisons have absorbed many of the custodial functions that psychiatric hospitals once served (Bhugra, 2020; Rubinow, 2014). In addition, due to the drastic reduction in the number of beds in community psychiatric hospitals and a shortage of staff and resources, the duration of stay of the people with more severe mental health disorders has dramatically decreased. This tendency has been associated to early discharge of people deemed insufficiently improved who might commit offenses in relation to their mental health diagnosis.

Furthermore, the dismal conditions of detention are suspected of perpetuating the poor mental health status of detainees and limiting their reintegration into society (Fovet et al., 2019). Correctional facilities remain insufficiently equipped for mental-health care. Difficulties in recruiting caregivers are significant due to poor working conditions which often hamper the efficiency of health units. Paradoxically, improving access to mental health care in prison (particularly with new psychiatric facilities such as UHSA) strengthens the notion that prison is a suitable place for people with serious psychiatric disorders. For example, it is not uncommon for French judges to refer a person to a particular prison with an efficient mental health care unit (Guibet-Lafaye et al., 2016) in order to combine penal sanction and psychiatric care. It is noteworthy that even when the court declares non-responsibility, the person is still often incarcerated pre-trial, which can last up to two years. This situation is very challenging for the incarcerated people as well as the mental health and prison workers.

### 4.2. Out of prison, into the world

Access to mental healthcare has increased significantly in recent decades in French prisons (see above). Nevertheless, the continuity of care after release from prison remains fragile. Two main reasons explain these difficulties. First, it is difficult to assess the needs of people leaving prison because little data on psychiatric care in prison exists. It would be necessary to estimate, for example, the prevalence of people leaving prison who require psychiatric care and social supports (housing, financial assistance, etc.) prior to release. It would also be useful to measure the effects of incarceration on the evolution of mental-health status and social rehabilitation. Second, the strong dichotomy between mental health and judicial services complicates coordination between these systems. In some places, partnerships make it possible to prepare release plans; in others, care teams are not always informed of people's release. Furthermore, coordination between correctional and community health care services are not always optimal: medical centres and psychiatric outpatient facilities are often overloaded. Finally, mental health teams have had concerns about people leaving prison and blurring the lines between care and social control.

### 4.3. Towards the creation of forensic psychiatry in France?

Despite an early interest for people diagnosed with mental disorders who committed crimes in the nineteenth century, France remains one of the last European countries without formal recognition of forensic psychiatry. Criminology is not officially recognized as a scientific discipline by the ‘National Commission of Universities’ (*commission nationale des universités*) and the term “forensic” (which would be translated by “*médico-légal*” or very rarely by “*forensique*”), is not commonly used to designate a spectrum of activities ranging from expertise to the provision of mental-health care for victims or incarcerated people with mental

health disorders.

With regard to psychiatric expertise, registration on the list of psychiatric or psychological experts does not require specific qualifications and the expert activity is often not the main professional activity, meaning that no expert is committed full-time to this work. Hence, practices largely differ between experts, as some of them rely on standardized assessment scales while others use non-structured clinical assessments (Combalbert et al., 2011, 2014). The determination of non-responsibility widely differs among experts, as well (Guivarch et al., 2017, 2015). Moreover, despite the growing needs of the criminal justice system in this area, there is a shortage of psychiatric experts (Pélisse, 2012). During the 2000s, several public reports called on state authorities to better regulate the training of psychiatric and psychological experts (Guibert-Lafaye et al., 2016). The same difficulties apply for medical coordinators of court-ordered care.

Specific training for French mental health workers regarding people with mental health diagnoses who committed crimes is also scarce. Some universities have developed specific educational programs in forensic psychiatry and psycho-criminology, but these initiatives remain rare and are not included in the training for all psychiatric caregivers. In addition, some psychiatrists have recently created a professional network of forensic psychiatry (<https://www.afpbn.org/sections/section-psychiatrie-legale/>) to complement national associations of psychiatric experts (e.g. *Association Nationale des Psychiatres Experts Judiciaires*). Improving the mental health of prisoners and facilitating their rehabilitation after release through a better training of health and justice professionals is thus an urgent need in France.

## 5. Conclusion

In France, interactions between the mental health and judicial systems are complicated by the boundaries between these two systems, producing serious gaps in the psychiatric care of incarcerated people. This clear separation has the advantage of allowing absolute respect for medical confidentiality and independence of psychiatric care from judicial institutions. That distinction makes it possible to keep the interests of the patient as the primary objective of psychiatric care, bearing in mind that the clinician's role is not to implement policy against criminal acts, but to provide care. The high prevalence of people with severe psychiatric disorders in prisons today, however, raises concerns about the practice of psychiatric expertise and the lack of training for caregivers. We think that recognizing forensic psychiatry in the education of French psychiatrists is a key factor in improving these issues.

## Declaration of competing interest

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.fsml.2020.100028>.

## Authors' contributions

TF and CL participated in the conception and design of the study; TF and CL wrote the first draft of the manuscript. All authors participated in the writing and revision of the successive drafts of the manuscript and

approved the final version.

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