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REFERÊNCIA

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Forensic psychiatric systems of the world
Sistemas de psiquiatria forense no mundo

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Abstract

Objective: *The study aims to approach forensic psychiatry within different contexts. It endeavors to show how this specific psychiatry science area is influenced by legal and cultural aspects.* Method: *The bibliography reviewed had in view understanding the different ways of how to deal with law within the psychiatric sphere, from a cultural point of view.* Results: *there is a great heterogeneity, of different nature (legal, political, cultural, and religious) that enrich, but at the same time makes difficult, a debate about this issue.* Conclusions: *there are two great obstacles to achieve a good knowledge about the practice of forensic psychiatry all over the world. The first one is represented by a heterogeneity that makes difficult its description in a comprehensible way. The second is the lack of knowledge of the cultural diverse realities. These difficulties should be a stimulus for newer studies of this characteristic. Only in this way it becomes possible to gradually increase the comprehension of this issue.*

Descriptors: *Forensic psychiatry; Mental health; Comparative study; International law; Culture*

Resumo

Objetivo: *Este estudo visa a uma abordagem da psiquiatria forense dentro de diferentes contextos, no sentido de mostrar como essa ciência é influenciada por aspectos legais e culturais.* Método: *Foi feita uma revisão bibliográfica com o objetivo de apreender formas culturalmente diferentes de se lidar com a lei dentro do campo médico-psiquiátrico.* Resultados: *Existe uma enorme gama de fatores, de diversas naturezas (legal, política, cultural, religiosa), que enriquece e, simultaneamente, dificulta um debate sobre o tema.* Conclusões: *Existem dois grandes obstáculos para se adquirir um conhecimento sobre a prática, em todo o mundo, da psiquiatria forense. O primeiro diz respeito a uma heterogeneidade que dificulta sua descrição de forma clara, e o segundo se refere ao próprio desconhecimento de realidades culturalmente muito diferentes. Por outro lado, essas mesmas dificuldades devem representar um estímulo para novos estudos dessa natureza, objetivando a alcançar, pouco a pouco, uma maior compreensão da matéria.*

Descritores: *Psiquiatria legal; Saúde mental; Estudo comparativo; Direito internacional; Cultura*

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Introduction

Forensic psychiatric is the specific area of identification, discussion, and guidance regarding issues related to the interface between mental health and law.[1] Therefore, in order to approach forensic psychiatric worldwide, it is fundamental to examine different legislations that rule the behavior of different cultures.

According to Poitras and Bertolote, inter-relating with individuals with mental disorders gives rise to two types of concerns that seem to form the basis for the early development of norms in the field of mental health. The first involves the patients affected by mental disorders, and the second concerns their relatives, neighbors, and friends, as well as society at large.[2]

Regarding the patients, the concern is focused on their vulnerability in dealing with society in the decision-making process, as well as on the risk that they will adopt behavior that might affect their health, safety, or capacity to manage their assets. As a consequence, legal measures for the protection of individuals with mental disorders have been created. Such measures include the partial removal of their rights, which are transferred to another person by court decision in a process known as judicial interdiction. Due to the seriousness, importance, and repercussions of such interdiction, it is the ethical obligation of the physician to ensure that this conclusion is in fact based on consistent clinical evidence and is as accurate as possible.[3]

Regarding the second concern, it addresses the individuals who interact with psychiatric patients. In a significant number of cases, actions or omissions by individuals with mental disorders may affect others to the point of jeopardizing their health and safety. This concern has justified legislators to adopt measures that allow the authorities to limit the autonomy of individuals with mental disorders, who may put the health and safety of others in danger. For example, compulsory confinement, by court order, can be carried out even against the will of the patient.

According to Bertolote et al., the various legal traditions in the world can be grouped into families, such as common law, Roman-Germanic law, Islamic law, Socialist law, Jewish law, and Hindu law.[4] Only the principal ones will be covered in this study.

Legal traditions

1. Common law

Common law is a legal tradition essentially characterized by the fact that it is based on previous rulings and not on a set of *a priori* principles. As a result, a previous ruling can be considered a legal precedent to be used as a defense argument, a legal principle in a new trial. This legal tradition originated in the United Kingdom and is applied in various countries, principally in those that were English colonies, such as the United States, Canada, India, and Pakistan. It has evolved into different legal groups in the countries in which it was adopted. However, such is their inter-relationship that it is not unusual for some judges from some of these countries to resort to principles and legal precedents from other nations that have also adopted common law.[4]

Specifically regarding mental health, the legal instruments tend to be thoroughly detailed and cover several possible situations, with the objective of avoiding confusions or ambiguities in their interpretation.

2. Roman-Germanic tradition

Also called civil law, Roman-Germanic law is considered a continuation of Roman law and is, similarly to the common law, an influential tradition. However, contrary to common law, it is characterized by the codification of legal principles. Originating in ancient Rome, its principal contemporary development took place in France and Germany in the 18th and 19th centuries.

In France, the codification of laws at the beginning of the 19th century had the objective of systematizing the laws, so that they would be understood by all the citizens. Germany, in turn, adopted the civil code in 1900, in order to structure legal concepts. In addition to Continental Europe, where most jurisdictions were influenced by the Roman-Germanic family, its influence can be found on other continents, such as America (mainly in Latin America), Africa, the Near East, and Asia.

3. Islamic law

Principally found in countries of the Middle East, Africa, and Asia, Islamic law is taken from sacred writings, such as the Koran, which focuses essentially on duties and gives secondary importance to rights. Over the years, theologians and jurists of Islamic law developed a set of interpretation texts regarding the rules of this law, which conferred upon it high credibility and great authority.

In principal, this legal tradition rules only the relationships among Muslim individuals. These, in turn, believe that religion cannot be separated from the political and social life because religion is the basis of all actions taken.[5] The followers of any other type of faith are subject to different rules, even within the same country. For example, in the northern part of Nigeria, there is a significant number of Muslims in the population. Consequently, both the English common law and the Islamic law are adopted in that region.[6] However, in the southern part, only the English common law is used. Different lines of thought have been developed based on various aspects of the Islamic law and in total agreement with its basic principles. Due to the variety of traditions and societies involved, the sets of laws are quite different in the various countries ruled by the Islamic law.

4. Other traditions

A socialist legal tradition is the legal system developed in the former Union of Soviet Socialist Republics (USSR). In countries that are autonomous today but were part of the Soviet Union in the past, as well as in countries that were influenced by the USSR, the legal systems are, to varying degrees, reminiscent of this legal tradition. The principles of this legal tradition are aimed at the creation of a communist society based on fraternity. Therefore, it is the collective interest, rather than the private interest of the individuals, that guides the legalization process.

There are various other important legal families, such as those developed in China, India, Japan, and Israel, as well as in African States.[7] However, it is important to mention that many societies do not consider the law as it is understood in the western world. This may be the case of countries without formal legal instruments and that presumably carry out informal arrangements. However, the precise knowledge about these informal systems is quite difficult and complex.

Legislation and mental health

Forensic psychiatric is a psychiatric specialty yet to be recognized in many countries.[8] However, catamnestic studies

have given this specialty a good reputation,[9] due to its success and competence, measured by the rate of criminal recidivism.

Of all fields of medicine, mental health care is probably the most dependent on - and affected by - the law, which reinforces the need for greater integration between the psychiatric and legal approaches to a specific human behavior or a specific mental condition.[10] For decades and until recently, the objectives of the legal instruments that rule the field of mental health have remained as tools that have only allowed a reaction from society regarding disturbing or unusual behavior from individuals with mental disorders. The legal instruments were principally used as a source of power for the removal of individuals with mental disorders from life in society, and for their involuntary confinement in psychiatric hospitals.

However, in the past two decades, there has been a substantial change in the pattern of legislation that regulates mental health issues. The origin of this change dates back from the 1970s and is of a global nature, reaching health care priorities as a whole. In the field of mental health, there was the development of a new model that focuses on five principal priorities: decentralization of authority; a shift from hospital-centered care to community care; active participation of the family and of the community; integration of general health care through increasing involvement of non-specialized health care workers; and, finally, the focus on prevention and health promotion. In 1990, this new model for mental health care was clearly recognized by the greatest international organizations in the declaration adopted in Caracas[11] at a conference organized by the Pan American Health Organization.

In addition, the right of every person with a mental disorder to live and work in the community, within the limits of their capacities, was specifically recognized by the United Nations General Assembly in a set of 25 principles adopted in 1991 and entitled “Principles for the protection of persons with mental illness and the improvement of mental health care.” These principles represent an important consensus of the nations, with significant importance in the structuring of international mental health norms. They can be grouped into three comprehensive categories: political, technical, and judicial.

Within this context, the legal instruments that rule mental health seem to be going through a transition phase, away from the reactive pattern, marked by hospitalization, toward a pro-active pattern, characterized by mental health care, integrated into the general health care system.

This reform has been welcome, since it presents innovative ideas.[3] However, it has also been the target of criticism, due to flaws in its implementation. According to Jager, it is well known that the emptying of psychiatric hospitals has resulted in the neglect and abandonment of many individuals with mental disorders.[8]

Arboleda-Flórez, who stressed the need for an integrated effort to replace the hospital-centered model, also called attention to the need for better information regarding the changes proposed by the reform.[12] According to the author, the closing of psychiatric hospitals is intimately related to the deinstitutionalization movement, as well as to changes in the legislation that address the legitimate rights of individuals with mental disorders.[13] However, this has repercussions for the area of forensics, due to an increase in demand, as well as to the risk of criminalizing psychiatric patients, who leave a hospital institution for a prison institution.[14]

Specific aspects of forensic psychiatric in different cultures

In their approach of similarities and differences in the different practices of forensic psychiatric in the world, Velinov and Marinov found a certain commonality: the ethical and professional difficulties in the daily practice, especially regarding conflicts of interest between the individual and the society. Another difficulty found by the forensic psychiatrists is the pressure of working in institutions of social control and having to solve all the problems of violent behavior of the patients.[15]

However, the same authors highlighted some differences as well. One is that, in many countries, forensic psychiatry is not recognized as a distinct specialty. Even where it is recognized, there are enormous variations as to the duration of the training, as well as in the composition of the curriculum. The differences in judicial practices are also noteworthy, since they do not allow for standardization in the practice of forensic psychiatry. Finally, there are enormous differences from one country to another or from one culture to another regarding the availability of forensic psychiatric services, as well as the kind of services rendered.

Some peculiarities of forensic psychiatry practiced in different regions and cultures are described below.

1. The American continent

The countries of Latin America adopt the Roman juridical tradition.[16] In the penal area, in contrast to the Anglo-Saxon model, they consider the cognitive and motivational aspects for the assessment of the penal responsibility.[1] Therefore, in the expert examination, not only is the capacity of understanding the unlawful nature of the act at the moment of its perpetration (cognition) assessed but also the decision-making capacity (volition) in accordance with this understanding, creating, beyond the possibilities of accountability or unaccountability, the condition of limited accountability.

However, even today, most of the expert assessments carried out in Latin America are performed by professionals who are not specialized in the area of forensic psychiatry.[15] However, continuous progress has been observed in the professional formation of new experts, since learning opportunities, both in theory and in practice, are increasing in this area of scientific knowledge.

Although Folino describes a real connection between the forensic psychiatric system and the public health system in the capital of Argentina,[17] this is not the case in Brazil, neither is it true of Latin America in general.[16] The existing relationship between the health and the legal systems is, in general, unsatisfactory, since both systems operate in an isolated and unintegrated way. The same unsatisfactory relationship is also found among the professionals working in the fields of psychiatry and the law, a relationship equally marked by the lack of greater integration. Although a process of psychiatric reform has also been initiated in Latin America, this movement has not reached the forensic sphere, and the prison population has not been invited to participate in it.

In the United States, where common law is applied, there is a movement that aims at legislative alterations, including the debate regarding the inclusion or exclusion of the element of volition in relation to the forensic psychiatric assessment. Although a Model Penal Code was created in 1962 by the American Law Institute, it is not unanimously followed. Although the American state and federal laws are generally similar in structure, they vary significantly in definitions and probably in practice.[18] Therefore, there is no legal homogeneity, and, consequently, the forensic psychiatric assessment can vary substantially from region to region.

In comparing the North-American and the Brazilian cri-

minal systems, Taborda analyzes the similarities and differences between them. Regarding the points of convergence, the author calls attention to the fact that the Brazilian concept of unaccountability bears some resemblance to the Model Penal Code, since it combines the concept of an irresistible impulse (that affects the decision-making capacity of the examinee), created in 1834 in Ohio, with the M'Naghten rules of 1843, which focus the forensic psychiatric assessment on the cognitive condition of the examinee, although there is a difference between the American and the Brazilian concepts of the cognitive element.[19]

However, in contrast to what occurs in Brazil, where the defendant is passively defended by a lawyer, defendants in the United States participate actively in the trial. Consequently, the defendant needs to be mentally competent to stand trial, a condition known as "capacity to stand trial" or "fitness to stand trial". Since numerous defendants are not mentally competent to stand trial, they remain awaiting trial, indefinitely.

The same happens in Canada, since, according to Anglo-Saxon law, the assessment of the competence to stand trial is fundamental for an individual to plead guilty or innocent. The laws that rule the treatment of mental patients who have broken the law in the Canadian criminal judicial system were recently reformed. However, despite this reform (in 1992),[20] the changes observed in both clinical and judicial practice were minimal.

2. Europe

In European countries, there are a great number of individuals with mental disorders in the prison system. As an example, the prevalence rates of mental disorders, including personality disorders and disorders related to the use of chemical substances, in individuals not convicted of a crime as of 1996 were as follows: 64% in Denmark;[21] 62% in England;[22] 63% in England and Wales;[23] and 62% in Ireland.[24] However, not all such individuals actually require treatment. Regarding sentenced individuals, the data are different.[25]

Blauuw et al. carried out a study in 13 European countries, investigating mental disorders in prison systems. The following countries were included: England and Wales; Finland; France; Greece; Hungary; Ireland; Latvia; Malta; the Netherlands; Northern Ireland; Poland; Scotland; and the Ukraine. In the data collected, various studies were cited to show that the needs of many prisoners for attention and psychiatric treatment are not recognized, since the doctors of prison institutions tend to disregard the need to transfer patients with severe mental disorders to psychiatric hospitals, where they would receive more appropriate treatment.[25]

In contrast to the lack of professionals that is observed in other regions, such as on the African continent, all of the countries studied have psychiatrists, psychologists, and nurses with psychiatric training who are able to provide mental health treatment within the prison system. When these resources are not available within the system itself, some countries contract professionals from external sources. Countries such as Scotland, Northern Ireland, the Netherlands, France, England and Wales, due to the size of their prison institutions, have a great number of nurses with psychiatric training. Greece, the Netherlands and Scotland have a great number of psychiatrists, whereas Finland, Malta, Poland and Scotland have a great number of psychologists. Nevertheless, since the demand is enormous, the ratio of professionals to patients is unbalanced. None of the 13 countries have enough beds to accommodate the prisoner-patients who require specialized psychiatric treatment.

In Sweden, the forensic psychiatric assessment system was reorganized in 1991, and new legislation was approved in 1992.[26] One of the objectives of the change was to reduce the number of criminals who were transferred to this system of forensic psychiatric treatment instead of going to prison.[27] In order to reach this objective, the medical-legal criteria for insanity were refined and became more rigorous. For individuals who have broken the law to receive forensic psychiatric treatment, they must present a severe mental disorder, such as a psychosis or one of certain types of personality disorders. However, this stricture was not adhered to, and the mean proportion of criminals who were declared insane (50%) did not decrease. This could be attributable to the fact that, although the number of cases in which personality disorder was used as a medico-legal justification for a plea of insanity dropped, the number of cases in which undefined psychosis was similarly used increased.

3. Africa

What might best characterize the African situation is the lack of professional resources.[28] Most professionals who act in the area of forensic psychiatry do not receive the proper education or appropriate training before beginning to work in this area. However, according to Njenga, the quantity of available information regarding the status of forensic psychiatry on the African continent is not sufficient to allow a homogeneous and uniform description.[29]

Nigeria presents a peculiarity that constitutes a forensic problem: most people look to witchdoctors for solutions to their physical and psychic problems. This may become a problem, since the testimony of these witchdoctors is not accepted in court. Another difficulty is the fact that the penal code is written completely in English, and 70% of the Nigerian population do not understand English.[6]

Most African psychiatric hospitals are located in "economic ghettos" of the cities, and the forensic facilities, in turn, are located in maximum security areas within these hospitals. Although located inside the hospitals, these units are, in practice, an extension of the prisons. In addition to the lack of appropriate facilities, most countries have, on average, one psychiatrist per one million inhabitants. Patients who need forensic care are in a worse situation, and they can practically face a life sentence. In South Africa, for example, according to Bateman, the number of psychiatrists has not increased in the past 30 years.[28]

On the African continent, human rights and dignity are not always taken into consideration when it comes to mental health care. The most severely ill patients receive only a few medical visits per month. Those who are not severely ill are not even re-examined. There is an almost total lack of doctors and medication.

There is no legislation on mental health in most African countries. Among those where there is legislation, some have out-of-date colonial versions that date from the time before they became independent countries. In various African regions, such as in Nigeria, suicide attempts are considered a crime. The African psychiatrist needs to try to explain to the legal professionals why someone attempts suicide and to convince them that the individual should go to a mental health facility rather than to prison. At the same time, psychiatrists threaten to report patient suicide attempts to the police if the patient does not agree to remain at the institution for treatment. Most of the legal systems in Africa, except for that of South Africa, treat homosexuality as a crime. In these societies, homosexuality is regarded as evidence of insanity or as a criminal act.

4. Oceania

Australia is a federation comprising six states and two territories. Its legal system is marked by great heterogeneity. The country, in principle, applies the legal tradition of common law. However, each of its eight states and territories has its own mental health legislation, criminal codes, correctional system, and public health system.[30] Three states (Queensland, South Australia, and Western Australia) have criminal codes. In the remaining states and territories, criminal law exists in the form of statutes.[31] Therefore, despite efforts to attain legal homogeneity, there are different forensic psychiatric systems. However, the federal government can exert relative influence over the states and territories.

The examples mentioned by Müllen et al. illustrate this reality quite well. In South Australia, the element of volition is taken into consideration in the forensic psychiatric assessment. However, the same does not happen in Victoria or in the Australian Capital Territory. However, curiously and inconsistently, even if you take volition into consideration in South Australia, personality disorders, even severe ones, are not considered conditions that hinder penal responsibility.[30]

The law in the Australian Capital Territory also does not approve the inclusion of severe personality disorder and even introduces a new term, "mental dysfunction", with remarkably broad limits. Victoria, in turn, avoids guidelines for the definition of mental impairment in its legislation, in which casuistry, which is a characteristic of common law, prevails. New South Wales did not accept the model code promulgated by a committee in 1995. Therefore, various reformulations were devised to address decreased responsibility. Simultaneously, other aspects of the previous legislation, which bears with a resemblance to the model proposed, were maintained.

Finally, although the Australian states apparently recognize the effort of the federal government to stimulate legal uniformity in the forensic psychiatric field, in practice, each jurisdiction behaves its own way. Similarly, forensic mental health services are the responsibility of the state governments, and the federal government only defends the strategies of action that it deems important. The forensic psychiatric services are both of a public nature (especially the criminal cases) and of a private nature (essentially the civil cases).

Patients diagnosed with primary personality disorder or substance abuse in Australia do not legally fit in the group of individuals that benefit from the forensic psychiatry services. However, there is a lot of pressure, from the courts or from other institutions, for the forensic services to accept those patients with severe personality disorders, who are living among the criminal population and are causing problems related to self-inflicted wounds or seriously irresponsible behavior.[31]

In Australia, individuals convicted of sexual assault do not typically benefit from mental health services. The predominant point of view is that the sexual offense *per se* does not require psychiatric treatment. It would be correct to say "would not require", since practice reveals the opposite. In practice, the forensic mental health services do provide therapy for individuals convicted of sexual assault. This might be due to the fact that the treatment programs for this clientele are performed by professionals who do not belong to the health services, but directly from the prison in which these criminals are confined.

In New Zealand, the Mental Health Act was reformed in 1992. This legislative reform provided a rapid forensic psychiatric development, even though New Zealand had no specific forensic legislation prior to that time. It was possible to clearly perceive the great repercussions of this reform on clinical practice, both in the civil and in the penal sphere.

The principal changes, compared with the previous version, according to Brinded, were as follows: a stricter and more specific definition of what mental disorder is; explicit recognition of cultural identity and greater importance being placed on the well-being of the patient; the establishment of a legal structure to determine community treatments that would make it possible for the patient to be treated at home or within the community; the creation of procedures that might make it possible to review and appeal of decisions on the legal conditions and status of a patient; and, finally, the specification of the rights of the patients subject to compulsory assessment and treatment, as well as the provision of investigation of and reparation for any violation of these rights.[32]

5. Asia

Most Arabic countries do not have specific mental health legislation, which is in a phase of development in Islamic countries. This, however, does not prevent forensic psychiatry from having its place. The capacity to stand trial and the insanity defense are taken into consideration. Since there is no crime if there is no criminal intent, *mens rea* is well accepted and is necessary for a person to be considered guilty. In Islamic law, insanity is determined by the court based on the psychiatric evaluation.[33]

Under the Islamic law, the fact that a person poses a risk to others is not necessarily an important criterion for involuntary confinement. This is because the emphasis is not on the protection of liberty but on providing mental health care.[5] However, there is no single satisfactory description of the mental health services, because there are more than 50 Islamic states. By western standards, such treatment resources are scarce in the Islamic states.

An interesting peculiarity is that Islam defends the professional confidentiality of the physician (not the expert) to such an extent that some authorities even defend perjury by physicians who are pressured by the court to break their confidentiality oath, stating that such an act protects them from being punished by Allah.[34] Another peculiarity is that only Muslim psychiatrists can issue an opinion about a Muslim patient during the trial.[5]

In Japan, it is well known that the overwhelming concern is for the great stigma under which individuals with mental disorders and their families live. The evidence of this is, among other things, the considerably limited access to housing and employment for such patients.[35] Consequently, there is much criticism regarding the denial of human rights to psychiatric patients in Japan.[36]

Japanese legislation addressing mental health issues clearly tends toward the institutionalization of the patient[37] rather than toward greater involvement with their treatment. However, the 1987 revision of the Mental Health Law promoted measures to protect forensic patients, although not in a satisfactory way. The greatest changes might come about because many Japanese psychiatric patients have been gathering together in associations and becoming more visible in the media, fighting for their rights.

In India, forensic psychiatric law could be referred to as nice in theory but deficient in practice. The 1987 Indian Mental Health Act was constructed over the course of decades and was a legitimate attempt to update humanitarian policies in psychiatry. Nevertheless, as Ganju states, the document is

still an ideological plan rather than a reality, due to a deficient mental health infrastructure.[38]

Finally, in Russia, in contrast to the worldwide movement toward psychiatric reform, the hospital-centered system has remained virtually the same. Actually, the number of hospital beds has begun to decrease, albeit due to financial difficulties,[39] and the current model of psychiatric treatment is basically the same as it was in the time of the USSR. The psychiatric expert can be held criminally responsible in Russia if he refuses to reach a conclusion in a given trial. Moreover, he cannot divulge the results of an investigation without previous judicial authorization.

Conclusion

There are basically two great obstacles to the acquisition of knowledge and the raising of consciousness regarding the forensic psychiatry situation worldwide. The first has to do with its immense heterogeneity, due to various factors (cultural, political, juridical, religious, etc.) Such heterogeneity, sometimes within the same country, makes it difficult to describe it clearly. The second obstacle is the lack of knowledge regarding many culturally different situations. For example, little has been written in English about the Islamic situation, which makes it difficult to gain access to information. Therefore, it is important to publish articles such as this, no matter how incomplete it might be, since such practice helps to collect, little by little, the elements that compose this complex and heterogeneous issue.

References

1. Abdalla-Filho E, Engelhardt W. A prática da psiquiatria forense na Inglaterra e no Brasil: uma breve comparação. *Rev Bras Psiquiatr*. 2003;25(4):245-8.
2. Poitras S, Bertolote JM. Mental health legislation: international trends. In: Henn F, Sartorius N, Helmchen H, Lauter H, ed. *Contemporary Psychiatry. Vol 1. Foundations of Psychiatry*. New York, NY: Springer; 2000.
3. Arboleda-Florez J. Forensic psychiatry: contemporary scope, challenges and controversies. *World Psychiatry.* 2006;5(2):87-91.
4. Bertolote JM, Taborda JG, Arboleda-Florez J, Torres F. The impact of legislation on mental health policy. In: Sartorius N, Gaebel W, Lopez Ibor JJ, Maj M, eds. *Psychiatry in Society*. West Sussex, UK: John Wiley & Sons; 2002.
5. Pridmore S, Pasha MI. Psychiatry and Islam. *Australas Psychiatry*. 2004;12(4):380-5.
6. Mafullul YM. Forensic psychiatry in Nigeria: the current status. *Am J Forensic Psychiatry*. 2003;24(4):45-64.
7. Gutheil TG. The history of forensic psychiatry. *J Am Acad Psychiatry Law*. 2005;33(2):259-62.
8. Jager AD. Forensic psychiatry: a developing subspecialty (commentary). *World Psychiatry*. 2006;5(2):92.
9. Konrad N. Forensic psychiatry in dubious ascent (commentary). *World Psychiatry*. 2006;5(2):93.
10. Sharma S, Sharma G. Exploring evolving concepts and challenges in forensic psychiatry. experience (commentary). *World Psychiatry*. 2006;5(2):97-8.
11. Pan American Health Organization (PAHO). Declaration of Caracas, 1990. *Inter Dig Health Legislation*. 1991;42(2):361-3.
12. Ontario Ministry of Health and Long-Term Care. *Assessment, treatment and community reintegration of the mentally disordered offender. Final Report. Forensic Mental Health Services, Expert Advisory Panel.* [cited 2006 Feb 5]; [Available at: http://www.health.gov.on.ca/english/providers/pub/mhitf/forensic_panel/final_report.pdf. 2002.
13. Arboleda-Florez J. On the evolution of mental health systems. *Curr Opin Psychiatry*. 2004;17:377-80.
14. Sestoft D. Crime and mental illness: it is time to take action (commentary). *World Psychiatry*. 2006;5(2):95.
15. Velinov VT, Marinov PM. Forensic psychiatric practice: worldwide similarities and differences (commentary). *World Psychiatry*. 2006;5(2):98-9.
16. Taborda JG. Forensic psychiatry today: a Latin America view (commentary). *World Psychiatry*. 2006;5(2):96.
17. Folino JO, Vazquez JM, Sarmiento D. Forensic psychiatric system in the Province of Buenos Aires. *Int J Law Psychiatry*. 2000;23(5-6): 567-77.
18. Bloom JD, Williams MH, Bigelow DA. The forensic psychiatric system in the United States. *Int J Law Psychiatry*. 2003;23(5-6):605-13.
19. Taborda JG. Os sistemas de justiça criminal brasileiro e anglo-saxão: uma comparação. In: Taborda JG, Chalub M, Abdalla-Filho E, eds. *Psiquiatria Forense*. Porto Alegre: Artmed; 2004.
20. Stuart H, Arboleda-Florez J, Crisanti AS. Impact of legal reforms on length of forensic assessments in Alberta, Canada. *Int J Law Psychiatry*. 2001;24(4-5):527-38.
21. Andersen HS, Sestoft D, Lillebaek T, Gabrielsen G, Kramp P. Prevalence of ICD-10 psychiatric morbidity in random samples of prisoners on remand. *Int J Law Psychiatry*. 1996;19(1):61-74.
22. Birmingham L, Mason D, Grubin D. Prevalence of mental disorder in remand prisoners: consecutive case study. *BMJ.* 1996;313(7071):1521-4.
23. Brooke D, Taylor C, Gunn J, Maden A. Point prevalence of mental disorder in unconvicted male prisoners in England and Wales. *BMJ.* 1996;313(7071):1524-7.
24. Smith C, O'Neill H, Tobin J, Walshe D, Dooley E. Mental disorders detected in an Irish prison sample. *CBMH.* 1996;6(2):177-83.
25. Blaauw E, Roesch R, Kerkhof A. Mental disorders in European prison systems. *Int J Law Psychiatry.* 2000;23(5-6):649-63.
26. Holmberg G. Forensic psychiatric research in the Nordic countries – current state, potentials and possibilities. *Nord J Psychiatry.* 1998;51(Suppl 39):15-32.
27. Grann M, Holmberg G. Follow-up of forensic psychiatric legislation and clinical practice in Sweden 1988 to 1995. *Intl J Law Psychiatry.* 1999;22(2):125-31.
28. Bateman C. The insanity of a criminal justice system. *S Afr Med J.* 2005;95(4):208, 210, 212.
29. Njenga FG. Forensic psychiatry: the African experience (commentary). *World Psychiatry*. 2006;5(2):97.
30. Mullen PE, Briggs S, Dalton T, Burt M. Forensic mental health services in Australia. *Int J Law Psychiatry.* 2000;23(5-6):433-52.
31. Jager AD. Forensic psychiatric services in Australia. *Intl J Law Psychiatry.* 2001;24(4-5):387-98.
32. Brinded PM. Forensic Psychiatry in New Zealand. *Int J Law Psychiatry.* 2000;23(5-6):453-65.
33. Murad I, Gordon H. Psychiatry and the Palestinian population. *Psychiatric Bull R Coll Psychiatr.* 2002;26:28-30.
34. Chaleby K. Issues in forensic psychiatry in Islamic jurisprudence. *Bull Am Acad Psychiatry Law.* 1996;25(1):117-24.
35. Kuno E, Asukai N. Efforts toward building a community-based mental health system in Japan. *Int J Law Psychiatry.* 2000;23(3-4):361-73.
36. Mandiberg J. The Japanese mental health system and law: social and structural impediments to reform. *Int J Law Psychiatry.* 1996;19(3-4):413-35.
37. Salzberg SM. Japan's new mental health law: more light shed on dark places? *Int J Law Psychiatry.* 1991;14(3):137-68.
38. Ganju V. The Mental Health System in India. *Int J Law Psychiatry.* 2000;23(3-4):393-402.
39. Ruchkin VV. The forensic psychiatric system of Russia. *Int J Law Psychiatry.* 2000;23(5-6):555-65.