Editorial
The role of forensic psychiatry in mental health systems in Europe

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ABSTRACT

Background Forensic psychiatry at first glance seems to differ from one country to another due to different historical developments, different legal systems and different mental health systems. In spite of that, forensic psychiatry has several goals shared across countries, principally:

- assurance of treatment for severely mentally ill people who become delinquent;
- giving evidence to courts in cases when the offender’s mental responsibility is in question;
- working effectively at the interface of the law and psychiatry, and, in so doing, working well with other clinical and non-clinical professionals in the field;
- preventing relapse of offenders with mental disorder.

In order to achieve these goals, special knowledge and skills must be developed, especially in assessment and management of violence and sexual deviance and of the risk of these behaviours, incorporating techniques developed in neighbouring disciplines.

One of the greatest challenges in the development of forensic psychiatry lies in its relationship with general psychiatry. It is arguable that the specialization of psychiatry into sub-specialties has lead to loss of some skills in general psychiatry and to a ‘forensicification’ of people who would previously have been treated as general psychiatry patients.

Aims In partnership, however, general and forensic psychiatrists could potentially achieve more than either group on its own: They could better

- prevent people with mental illness from becoming offenders
- prevent people with mental illness from becoming victims of crime
- intervene in the vicious circle from victim to perpetrator
- assess young people at risk for antisocial behaviour and protect them from becoming criminals
Clinical research on these topics is just beginning and this article argues for a close integration of forensic psychiatry into the wider mental health system and for a more intensive exchange of knowledge and skills from forensic psychiatry to general psychiatry and vice versa. Copyright © 2009 John Wiley & Sons, Ltd.

Introduction

Forensic psychiatry is a small specialty within psychiatry, and is regarded with scepticism and ambivalence by many psychiatrists and many officials in psychiatric associations. Forensic psychiatry, however, attracts more public attention than most medical disciplines and it is no wonder that the public often confounds forensic psychiatrists and their clientele with general psychiatrists and their clientele. In 1999, in The Frankfurter Rundschau, a rather intellectual and progressive newspaper in Germany, the word ‘psychiatry’ referred to forensic psychiatry more than half of the time it was mentioned (Ehmig, 2003). The forensic psychiatrist is not publicly known for his research but for the famous criminals he has examined for the court. One highly publicized event has more influence on publicity and on politics than research and statistics and anti-stigma campaigns (see also Monahan, 1996). Many psychiatrists are afraid that public perception of psychiatry as a whole is contaminated by this.

Similarly, forensic psychiatry has difficulties finding public or private funding. Commercial companies do not want to be associated with criminality. For good reason, they are afraid of liability charges, e.g. if a perpetrator acted violently in spite of his treatment with anti-aggressive drugs. Even public funding for forensic psychiatry is not popular. In 1993, Reiss and Roth compared research monies expended in the USA per potential life lost due to various causes; for cancer it was $794, for AIDS it was $697, for cardiovascular diseases $441, but for violence it was just $31. This funding differential probably was then and still is similar in other developed countries. Also, research money is more often granted to short lived projects. In Germany, the federal research fund (Deutsche Forschungsgemeinschaft, DFG) restricts most grants to two periods of two years. This time is too short for many research projects in forensic psychiatry where the average hospitalization of forensic patients lasts around six years.

Neither the ambivalence of general psychiatry towards forensic psychiatry, nor the reluctance of major influence groups to associate with forensic psychiatry, are restricted to Europe. In the USA, Appelbaum (1997), an ex-president of the American Psychiatric Association (APA), even proposed completely different ethical codes for general and forensic psychiatrists, stating:

The forensic psychiatrist is not a medical doctor but a finder of truth. The basis of his ethical standards is not autonomy, non-maleficence or beneficence, but only truth (p. 445).
In the past, several gaps between forensic and general psychiatry have developed and there are good reasons for bridging some of them. The following questions have to be answered:

- What is the position of forensic psychiatry in Europe?
- What is the role of forensic psychiatry in the broad spectrum of psychiatric specialties?
- How can forensic psychiatry contribute to knowledge and practice throughout psychiatry?

Historical perspectives

In Western civilizations, philosophers and lawmakers have tended to preclude persons with severe mental disorders from punishment for a crime using various arguments. Aristotle (English translation 1962) thought that confusion over the reality of a situation, caused, for example, by delusions, could provide a moral excuse for an unlawful act, if the person acted because of those delusions and without criminal intent. Roman law did not punish the severely mentally ill. Romans believed that the mentally ill were punished enough by their fate, so that men should not add to their miserable situation (*furiosum fatis infelicitas excusat, satis furore ipso punitur*). During antiquity and the Middle Ages, neither Anglo-Saxon nor Continental European courts considered mental illness to be a reason not to punish. It was not until the Age of Enlightenment that Græco-Roman ideas won new support through Catholic Canon Law and, from there, was transmitted throughout European jurisdictions. In the nineteenth century, utilitarians reasoned that it was not useful to punish the mentally ill, because they did not have the faculty to learn from punishment and to change their behaviour.

The first proponent for the involvement of the medical profession in decision on responsibility for crime and liability for punishment was himself a doctor and an advisor to the Roman Catholic court, Paolo Zacchia (1584–1659). The following centuries brought debate about such a role for doctors. Many philosophers and jurists were opposed to it. The model of an insanity defence was established in England as late as 1843 with the McNaughten rule, but, although medical evidence is sought, the decision is for the Court (O’Reilly-Fleming, 1992).

In fact, a number of famous psychiatrists then pushed themselves into the field of punishment, criminology and crime prevention. Pinel is known to have gone through Paris dungeons to select those whom he thought to be mentally ill in order to separate them from the ordinary criminals. Lombroso (1894) tried to
identify the repetitive criminal, and developed similar theories based on the then popular idea of degeneration for the manifestation of criminality and of mental disorders, theories greatly endorsed by his contemporaries (Bleuler, 1896). Even Kraepelin (1880) tried to intervene in the legal system. He pleaded for the abolition of a guilt-dependent punishment and for preventive measures, which should rely on psychiatric advice. In 1968, Halleck listed a number of American psychiatrists, who

through unselfish motives have committed themselves to helping a portion of society that is ordinarily abused and neglected (p. 186),

but he also warned:

In 1884 as today psychiatric involvement in legalistic rather than scientific decisions often resulted in confusion and ineptness (p. 189).

In many countries, leading psychiatrists saw the teaching of forensic psychiatry and assessment of mentally ill offenders as among the most difficult tasks in their work.

In historical reviews, it appears that the origins of forensic psychiatry lay in the scientific interest of psychiatrists, many of them clinicians, and in their humanistic ideals. Forensic psychiatry was not developed to help the executioner, but to protect those people with mental illness who could not tell right from wrong from being measured with the same legal measures as their sane peers. This appears to be a general consensus across Europe and is an influential position in the International Courts at The Hague.

Forensic psychiatry in Europe

Several publications describe the different legal and administrative procedures applied to the question of responsibility of offenders, the disposal of dangerous offenders with mental disorders and of involuntary treatment of the mentally ill in the different countries of Europe (Dreßing and Salize, 2005; Gordon and Linqvist, 2007; Kallert et al., 2007). These authors all note the marked variation across European Union (EU)-member states and the constant reform of laws. Most countries in Europe embrace Roman Law, with an inquisitorial process; a common law approach is applied only in England and Wales, in Ireland and partially in Scotland and in Sweden, with an adversarial process. Whereas Germany and Austria developed concepts out of ideas about the way the mentally ill should be treated by the law, in the UK law was developed initially through specific cases.

Some countries have developed training and specialization of forensic psychiatry, while other countries have not. In part this follows from national
treatment philosophies. While most countries have provisions for offenders with diminished responsibility, some countries, like Austria, Belgium and Denmark, have a dichotomous concept. While most northern European countries have special forensic hospitals and services, France and Italy and some other countries in southern Europe do not have such institutions or services. Although psychiatrists have to know, understand and react to these different conditions, the differences are not consequent on specific psychiatric competence, nor guided by it.

Several initiatives have been undertaken to learn and understand the different traditions and practices across Europe, especially through the forensic section of the European Association of Psychiatrists (EAP) and the Gent Group. The latter consists of about 40 forensic psychiatrists from different EU member states, whose main interest is to improve and harmonize teaching and training in forensic psychiatry through developing knowledge of theory and practice in each other’s jurisdictions (Gunn and Nedopil, 2005). In spite of the many differences, the group achieved a common definition of forensic psychiatry:

Forensic psychiatry is a specialty of medicine, based on a detailed knowledge of relevant legal issues, criminal and civil justice systems. Its purpose is the care and treatment of mentally disordered offenders and others requiring similar services, including risk assessment and management, and the prevention of future victimization.

The role of forensic psychiatry within psychiatry

This definition indicates that forensic psychiatrists are professionals who cross the border from empirical medical science into the courtroom and may act on behalf of courts or administrations when they treat their patients, but still the patient is at the core of what they do. They are interpreters of medical and psychological findings into language which judges, prosecutors, defence lawyers and administrators and, in common law jurisdictions the ‘common man’, can understand and to which they can apply their rules. They also examine and look for the findings they have to interpret to the courts. They are advisors. There is a risk that their role could become more shaped by the legal framework than by their medical professional ethics, but, if they did, psychiatrists would very soon lose respect in courts and be regarded as their servants, not advisors (Gunn, 1982). To avoid a merely serving role, forensic psychiatry has to do two things:

(1) It has to stay within the larger field of psychiatry and to adhere to the basic ethical principles of medicine.

(2) It has to keep up its own profile of research, relevant both to courts and to psychiatry.
If specialization in forensic work means a branch of psychiatry having its own code of conduct, its own professional association and entirely separate teaching, training and scientific schedules, as some authors seem to want (Appelbaum, 1997; Strasburger et al., 1997) there would be serious drawbacks for general and forensic psychiatrists as well as patients, the courts and wider society. Not enough of the research about mentally disordered offenders is done by forensic psychiatrists, and far too little by general psychiatrists; psychologists and sociologists tend to hold the field. Could this also lead to clinical work being left to professionals other than psychiatrists, and psychiatric patients who come into conflict with the law only diagnosed, legally assessed, treated and maybe disposed of by forensic professionals who are not constrained by the scientific, professional, and ethical standards of psychiatry?

Psychiatrists may need the help of police and others within the criminal justice system in order to cope with some patients. So, they act within a forensic context, even if they are not primarily concerned with criminality. Five to 10% of all patients come into contact with the criminal justice system (Taylor and Schanda, 2000; Soyka et al., 2004). As it is now, forensic psychiatry often sits at the end of the line and waits for the poor fellow who drops into its basket, after he or she has been through a number of institutions and finally has nowhere else to go. Almost 80% of patients in secure units after having committed a crime have been in general psychiatry hospitals, and almost half of forensic patients have been in a prison (Hodgins et al., 2006). The number of forensic psychiatric beds has increased in many European countries as the number of general psychiatric beds has decreased (Priebe et al., 2005). The length of hospitalizations in general psychiatry has decreased, with diversion of some chronic and/or difficult patients to other institutions. Are general psychiatrists losing their skills in dangerousness assessment or long-term management? Maybe insurance companies or social welfare have a role in this, but it would be unethical and psychiatry would lose its credentials in society if it claimed to treat mentally disordered patients but left the job to somebody else as soon as the mental disorder caused a criminal act.

Psychiatric patients have a much higher risk of becoming victims of crime, a risk which exceeds their risk of reoffending. Teplin (2005) compared the victimization of the severely mentally ill to the US National Crime Victimization Survey and found that the former were between 13 and 22 times more often victims than the general population. Consider the vicious circle between victimization and offending and extend this circle to psychotic patients, Hiday and her group (Hiday, 1997, 2006; Hiday et al., 2001) showed that in many cases of violent behaviour by psychotic patients, rather than a direct link to the psychotic symptoms, the resultant bizarre behaviour of the patients brought them into tense situations with others which led to violence both by those patients and against them. Using data from the US American MacArthur risk assessment study, conducted with general psychiatric patients, she calculated odds ratios for
violence by the severely mentally ill and found that only young age, substance abuse and being a victim of violence significantly increased the risk of these patients themselves being violent. General psychiatry will always need the skills, which are preserved and improved in forensic psychiatry, to help to prevent patients from becoming violent offenders.

The contributions of forensic psychiatry to the knowledge and practice of psychiatry

Besides the integration of forensic psychiatry with general psychiatry and its adherence to core medical professional standards, development of its own scientific profile is another important step to prevent being used only as service providers for courts or from being misused for the purpose of others. Forensic psychiatry has to answer questions that are relevant both to the courts and to psychiatry. Research in the field has grown and become more international within the last 20 years (Hodgins, 2002; Nedopil, 2004, 2005), but so much more needs to be done. Topics which are important regardless of nationality or specific legislation include:

- violence by people with mental illness, and its management;
- risk assessment and risk management;
- impulsivity and impulse control;
- personality disorders and their role in violence;
- assessment, treatment and management of patients with paraphilias; and
- types, causes and risks of stalking.

Each of these topics fills books, and there is insufficient space to explore the extent to which answers are adequate, and where new research is most urgent. In the context of the contributions of forensic psychiatry to the mental health systems, data from the Munich Prediction Study (Stadtland et al., 2005; Nedopil and Stadtland, 2006; Kröner et al., 2007) deserve mention. In this project 262 offenders who were assessed for criminal responsibility were followed for an average of five years. Initial examination included a risk assessment and the application of many assessment instruments but did not influence management. Thirty-six individuals reoffended violently. Contrary to expectation arising from the population based studies of the 1990s that schizophrenia would be a risk factor for violent reoffences, only a small number of these patients reoffended violently. The relative risk of schizophrenic patients compared to the whole sample was only 0.33. This can probably be attributed to the fact that for these schizophrenic offenders reoffending was prevented by psychiatric treatment; in diagnostic groups with less established treatments or individuals without mental disorder this was less achievable. The forensic psychiatry contribution is endorsed
in a large international study by (Erb et al., 2001; Lincoln et al., 2005; Hodgins et al., 2007), in which schizophrenic patients released from forensic institutions were compared to those released from other psychiatric institutions. Although the patients did not differ in many clinical or forensic aspects, those released from forensic hospitals were less likely to act violently or come into contact with police than their general psychiatric peers.

Risk assessment has been a major research topic. It remains important to translate its findings into practice, but new research priorities have to emerge in forensic psychiatry. The future lies in large interdisciplinary networks of neuroscience, clinical psychiatry, child and adolescent psychiatry and epidemiology (Taylor et al., 2009). Mental health professionals should be worried about the enormous increase of patients in forensic psychiatry and devote some research capacity to the goal of preventing people from becoming forensic patients, focusing on early detection of indicators of increased risk of violence. Topics might include:

- the vicious circle between victimization and offending and the development of methods to intervene;
- the antecedents of offending in general psychiatry patients;
- elaboration of understanding of interactive pathways between genetic predisposition to disorder and environmental pathways; and
- the assessment, management and treatment of sex offenders.

Research development could have a unifying force:

- general psychiatrists would gain more effective intervention methods and so disrupt the vicious circle between victimization and offending and retain more patients;
- young scientists would be inspired to come into the field from all of psychiatry;
- enhancement of the evidence base for treatment and its demonstrable effectiveness would reassure the judiciary and the wider public alike; and
- for politicians and administrators, implementation of research results would increase public safety and reduce costs in a very sensitive field of public concern.

**Conclusion**

Although details in the practice of forensic psychiatry differ across European borders, general principles are shared. This is an additional strength in a field often under ethical challenges. The other key safeguards are retention of a strong relationship with general psychiatrists, firm adherence to medical ethics and
development of research. Forensic psychiatry is not a field with much commercial interest and there are risks of compromise in accepting government money, but it is a thrilling and growing field central to public interest, and clinical unity can only be an advantage here too.

Acknowledgements

This article is an abbreviated manuscript of a presentation at a presidential symposium of the EAP congress 2008 in Nizza. The author would like to thank Professor John Gunn for comments and corrections.

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