

FACING THE INTERFACE: FORENSIC PSYCHIATRY AND THE LAW

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Abstract

As we know from history, in court cases experts used to be called in when the defendant showed symptoms of a psychiatric illness. This was necessary, as the law itself did not provide rules about how to define abnormality. Mental illness needed an explanation for it to fit into the framework of the criminal justice system. With the emancipation of the empirical psychology and progress in the examination of patients' brains with modern imaging techniques, a separation has developed between the naturalistic man-oriented view of offending, and empiricism, in which facts are true if they are measured with reproducible tests. This is the case with judicial rulings about responsibility for a crime, the presence of illness at the time of the offence and the risk of recidivism concerning the length of treatment of mentally ill offenders and their targets. These aspects in the debate between the court and expert witnesses are discussed separately. The conclusion is that the field of law has been extended into the field of empirical sciences for more objectivity, and that the influence of these sciences on juridical reality can play an auxiliary role only. It is therefore necessary that judges and lawyers be trained in the use of empirical data. Still, forensic reality requires an interpretation, in which the forensic psychiatrist has different loyalties to the relevant parties in the court proceedings. But he is above all a medical man with ethical restrictions.

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1 Introduction

Courts of law have always asked for the assistance of non-judicial experts. The presence of a medical expert, however, was not always accepted and in some cases laymen or clergymen were asked to give their opinion on the suspect's mental condition. In cases with a strong emphasis on the mental state of the suspect, it wasn't until the sixteenth century that doctors were asked to advise the court.¹

In the middle of the nineteenth century, neurology, the science of the mind at that time, had grown to be a medical specialisation. Law and medicine had both become professions requiring academic training. From that time on, courts turned to medical specialists for expert opinion, as they were the self-proclaimed experts in the field of those mental disturbances that led to antisocial behaviour and crime. Research in neurology then was empirical and used the possibilities of its time: a fully somatic origin of brain diseases was suspected, while neuroanatomy took place mainly by visual inspection or under a microscope. Emil Kraepelin (1856-1926) was the pioneer of neuro-psychiatric nosology (the taxonomy of diseases) at the end of the century. Before him, Wilhelm Griesinger (1817 – 1868) had already said that all mental diseases were diseases of the brain.

What claims can psychiatry make nowadays regarding its field of knowledge? With its origins in medicine, it has an empirical side, on which much emphasis is put. Technology has made it possible to use fMRI (functional magnetic resonance imaging) to make images of the brain when it is having symptoms like hallucinations or performing certain tasks. Genetics is making remarkable progress in showing the function or dysfunction of certain genes, with all the various consequences for the metabolism of nerve cells. Much more understanding has been reached with regard to the chemical substances in the brain called neurotransmitters. Not only have more specific anti-psychotic and anti-depressant drugs been developed, but the complexity of the brain has also been demonstrated by working with functional neural circuits connected by these neurotransmitters in bio-physiological research.

Psychiatry, however, although its origins lie in everyday practice and patient care, also has a psychological and philosophical side. It is concerned with the patient as a human being, with his or her individual vulnerability and dependence on rewarding relationships, the social context of disease, like living in a dangerous neighbourhood and the presence of alcohol and drugs, and man's limited ability to make choices, such as the cooperation with a treatment for his illness or the willingness to resume his work after an illness which has not totally disappeared. Psychiatry, like all practices in

¹ M. Prosono, 'History of forensic psychiatry' in R. Rosner (ed.), *Principles & Practice of Forensic Psychiatry* (London: Hodder Education 2003, 2nd ed.) 14 at 30.

medicine, is both the art of maintaining a good relationship with one's patients and creating a supportive network around him, and the science of using the right techniques and treatments for a certain disease, as has been worked out in 'evidence based medicine'.²

2 Forensic framework

In forensic psychiatry, when a doctor wants to treat mentally disordered offenders, he applies the same skills and medical ethics as used in regular psychiatry. But there is more: the context, which is no longer merely social, but juridical – another domain of rules and science. It has been reduced to special laws, for example mental health laws and criminal law, which means that others than the psychiatrist have their special expertise. The psychiatrist not only works within his own field of knowledge and the rules reigning in it, but is also restricted by rules from another field of knowledge in his primary concern: the relationship with his patient. So forensic psychiatry works within a three-partite model, which should be integrative: the legal-empirical-forensic model.³ This model has a legal background and uses juridical definitions, taken from law books, and jurisprudence, taken from court cases. To operate in this domain in court, the expert witness is required to have the necessary knowledge and experience.

The second, the empirical part of the model concerns the application and analysis of the juridical criteria in the psychiatric or psychological examination of the patient. A check should follow of the findings of the examination, by comparing them with the observations already made and the interpretations thereof. Preferably, the methods of the examination will be strictly empirically based, which means that for measurements validated methods from an independent theory or model are used as much as possible. These can be structured checklists for the main topics on which the arguments in the model are based, like drug use, changes in the level of consciousness and amnesia. The third, the forensic aspect concerns the specific characteristics of the examinee, patient and/or suspect, and the situation and circumstances of the offence, brought together in a hypothesis and its possible affirmation by the found facts. The forensic view implies the conclusion that the examinee does or does not fit the juridical context brought forward by the questions of the court on certain forensic psychiatric criteria founded on the real examination.

² H.J.C. van Marle, *Tussen wet en wetmatigheid. De forensische psychiatrie in sociaal perspectief*, Inaugural lecture (Deventer: Kluwer 2004).

³ R. Rogers and D.W. Shuman, *Fundamentals of Forensic Practice; Mental Health and Criminal Law* (New York: Springer 2005).

With this legal-empirical-forensic model and within its domain of ‘reasonable medical certainty’, psychiatry has the following contribution to make to the domain of law: a diagnosis with a specific context as criterion for conclusions about the possible relationship, such as offence (criminal law), competence (health law), capacity to work (insurance), and damages (liability in law). This diagnosis – not to be confused with a category in a diagnostic classification, such as the DSM-IV – leads to conclusions about responsibility, fitness to stand trial, competence for decision making, compensation for being not able to work and compensation for damage done. Medical knowledge then can assess ‘with medical certainty’ the development of a certain disorder and predict possible problems or risks which are the consequences of this disorder. With that, essential clues in behaviour can also be assessed and after that managed by a specific psychiatric treatment. Because of their experience in this field, forensic psychiatrists are often asked to participate in the drafting of new laws on the above-mentioned subjects.

The definition, then, of forensic psychiatry is the application of psychiatric examination, diagnosis and treatment within the realm of law, according to those criteria which need to be explained to legal experts before they are able to apply the rules of law, such as jurisprudence or risk for recidivism (dangerousness). There is an interface with the law, which means that forensic psychiatry and the law have something in common, concepts used in law, defined by law but to be filled in by forensic psychiatry. So forensic psychiatry has to know these definitions and their usage, and it has to translate them into psychiatric concepts which are suited for further psychiatric examination. Research within a forensic psychiatric population does not mean that this is forensic research. A forensic examination and research bear in mind certain juridical criteria, like risk, recidivism, responsibility and violent behaviour. In this view, forensic psychotherapy means that forensic patients with a juridical background and aim, which is to control the psychiatric disorder so that re-offending is prevented. From now on I will use the term forensic psychiatry in relation to criminal law, because in criminal law offences and the use of the criterion of responsibility are well-defined, in contrast to damage and liability law. Still, the analogy remains with forensic psychiatric activities in other domains of the law.

3 Theoretical model

This legal-empirical-forensic model needs a theory, a view on human behaviour, as it examines the interactions between a persons biological aspects like the functioning of his brain circuits, his psychological states and traits and the social context he lives in. A comprehensive model to combine these different levels of human functioning is the bio-psycho-social model of

Engel⁴ in which, depending on the latest development in psychiatry, the emphasis of the research can switch between these interdependent fields. It is questionable, however, if this often-mentioned model does indeed integrate the thinking and practice of these three levels, or that the word ‘model’ is used only to serve as window-dressing for pursuing efforts in one domain instead of all three together. With the modern demands for evidence-based medicine, research nowadays is on an empirical basis, and so is mainly epidemiological, psycho-biological and psychological assessment. The preferred tool for scientific empirical research is the randomised controlled trial (RCT), which, because it uses a control group, is different from the individual-based forensic psychiatric examination. A scientific comparison with a control person is not possible, as the examination with or without auxiliary empirical examinations, such as fMRI, tries to find an answer particular to one case only, within the context of that specific situation. That is why judges and psychiatrists feel comfortable with each other: They both focus on a specific and unique individual.

For the court, the purpose of the forensic psychiatric assessment is to inform the judges about the person and personality of the suspect with regard to the offence he has been charged with.⁵ As each case is different in its psychiatric diagnosis, criminal context and the manner in which the offence was committed, different scientific models can be applied to a case. Depending on the background of the forensic psychiatrist and the clarification which has been sought to make the case understandable and open to judgement by others, he can choose a model with the best fit. Like regular psychiatry, forensic psychiatry is a multidisciplinary specialisation, based on its broad bio-psycho-social model. These models for investigation, explanation and conclusions should be based on available scientific knowledge and the ‘state of the art’ of the forensic psychiatric field.

In the United States, agreed-upon criteria are used to judge the scientific level of the forensic report, the so-called Daubert criteria (from the 1993 court case *Daubert v. Merrell Dow Pharmaceutical, Inc.*) for scientific evidence. These are:

1. Falsifiability should be shown by the fact whether it can be and has been tested.
2. The theory or technique has been subjected to peer-review and publication.

⁴ G.L. Engel, ‘The clinical application of the biopsychosocial model’ (1980) 137 *American Journal of Psychiatry* 534 at 544.

⁵ H.J.C. van Marle, ‘Het strafrechtelijk psychiatrisch gedragskundigenonderzoek’ in B.C.M. Raes and F.A.M. Bakker (eds.), *De psychiatrie in het Nederlands recht* (Deventer: Kluwer 2007, 5th ed.) 113 at 136.

3. The known or potential rate of error of the technique and procedures can be established.
4. The theory or technique has general acceptance in the relevant scientific community.

Especially in the dialogue between courts and psychiatrists, tests with a numerical conclusion seem important, but behind such a clear answer lies the validity of these tests and the reliability and experience of the expert with these tests. Also, there are no rules whether or not to use tests in forensic psychiatry, only on a scientific level. But these tests, with the exclusion of risk-assessment scales for recidivism, are not able to give an answer to juridical questions like responsibility or competence, as these concepts are juridical and philosophical by nature. Conclusions from tests and other empirical measurements like medical diagnostics are far from exact, considering their internal correlations and certainty of their prediction. Until now, a chance of more than 80 per cent never has been demonstrated. Nor can the rate of error in psychiatric technique be shown, as it is a verbal medical examination, reproducible only by the same or another psychiatrist in the same way and with the same patient. For forensic psychiatry, the hallmarks of expertise are peer-review, publication and general acceptance in the relevant scientific community.

There is not just one expert: forensic expertise can only be tested by the court by asking another psychiatrist or psychologist for a second opinion. In criminal court sessions with a great impact on the life of the suspect (prison sentence or detained under a hospital order) the expert should be interrogated by the court and not be a decision-making member of it. Psychiatry, and therefore forensic psychiatry, working from their bio-psycho-social framework, will not succeed in meeting these Daubert criteria fully; certainly not in Europe, where due to the philosophical background the emphasis is more on 'man as a whole'. So next to giving responsibility for the quality of the scientific level of the conclusions in the report itself, each case assessment has to be acknowledged by expert colleagues (the peers) in the form of guidelines by the responsible professional organisations about the quality of the report.⁶ These guidelines prescribe the contents, the required validity of the connections between subjective accounts, objective symptomatology, decrease of mental functioning; they also dictate the criteria for the court, such as responsibility for the offence, fitness to stand trial, the mental capacity for decision making, and the ability to resume work and further social functioning. They also include warnings on unverifiable data, like unconscious motives, or unwarranted conclusions, drawn for example from childhood. The guidelines reflect the current state of (forensic)

⁶ R. Weinstock, G.B. Leong and J.A. Silva, 'Ethical Guidelines', in R. Rosner (ed.), *Principles & Practice of Forensic Psychiatry*, above n. 1, 56 at 72.

psychiatry and are subject to regular renewal by special representative committees.

Giving advice about the link between the mentally disordered offender and the crime he has committed is the essential activity and primary idea in forensic psychiatry, as this link justifies the presence of forensic psychiatrists in court in a certain case. Only once the connection between offence and disorder has been demonstrated (step 1) can the level of responsibility for this offence be assessed (step 2). As a third step, it is possible to advice about the treatment necessary in this case to reduce the risk of re-offending. There are three theoretical behavioural models to be used for forensic fact finding. Firstly, we have the ideographic model, in which psychiatric diagnostics and assessment of impairment in functioning are at the centre and are judged in their relationship to the offence. This is plain psychiatric diagnosis based on the story of the examinee and the actuarial reports. Secondly, there is the cognitive-behavioural model, with its contingencies and learned behaviour as a result of both psycho-biological factors and contextual reinforcement. It has been tested in empirical research for its efficacy in treatment and supported by laboratory models, and uses essential psychological reasoning. Finally: the phenomenological model comes to the fore, with its emphasis on understanding and clarification of the offence in terms of meaning and motives. It has the advantage of producing a carefully painted picture of the examinee, but the disadvantage is the irreproducible, highly personal nature of the 'facts', which are based on opinion rather than verification. An example of this kind of examination is the psychoanalytical one, which is for that reason not used anymore. But in its impressionistic way it resembles the stories told in court and with them a deepening of insight seems possible with regard to the question: How could this have happened? It is appealing, but not verifiable.

4 Ethical demands

It is then the psychiatrist who examines the suspect or the forensic patient within a double framework: as a doctor and as a forensic specialist. Should he identify with a 'welfare paradigm', whereby he upholds the altruistic and beneficent tenets of medicine 'to do good for the patients'? Or should he be required to act within an opposite 'justice paradigm', in which he is expected to act and to uphold justice principles as applied in due legal process?⁷ In my opinion, the two paradigms do not exclude each other, as they are normal activities done by a psychiatrist from the essence of being a doctor. The

⁷ J.E. Arboleda-Florez,, 'The ethics of forensic psychiatry' (2006) 19 *Current Opinion in Psychiatry* 544 at 546.

Hippocratic oath, *primum non nocere*, primarily means: Do nothing that can harm your patient. It not only includes the use of different medical treatments (not harmless in early years and even still with regard to the treatment of cancer) but confidentiality as well. Medical confidentiality is based on the ethical rule that a patient has the right to visit a doctor without running the risk of his doctor breaching his confidentiality, so that the patient will no longer feel free to speak about his ailments. But from the year 1976 the rulings of the Supreme Court of California in the *Tarasoff* case spread all over the world: the duty doctors and psychologists have to protect the physical and psychic integrity of a third subject against assaults made by their patients. One can also question to what extent a mentally disordered offender is harmed when the psychiatrist, using his knowledge of the treatment, warns his patient not to continue his threatening behaviour, or reports to the probation officer or the police in extreme cases with a high risk of a new offence. Of course, contacting a colleague before that time has its advantages, but with a highly explosive patient there is not much time. But even then, the forensic expert will protect his patient from another trial and verdict, and perhaps from remorse about another victim.

So, in forensic psychotherapy and forensic assessment and examination, there are rules to this engagement, which are intended to lead to motivation for participation and informed consent. Informed consent is based upon sufficient information to make a choice and enough time to consider the alternatives which should also have been proposed by an impartial and trusted expert. In these rules, the different roles of the expert and doctor are described so as to reflect the different responsibilities and ethical stances. In my opinion, the forensic expert and the forensic therapist must be able to speak of their separate loyalties to their patient, explain them, and, with the patient's consent, apply them if necessary. Complete confidentiality is no longer ethical in forensic psychiatry, as we have the knowledge (to a certain extent) to predict when harm will come to others, as former behaviour is the best predictor for future behaviour. Having this knowledge means we also bear responsibility for the community in which we live. General psychiatry also has to reckon with the possibility of criminal acts by a patient for the first time; these colleagues, too, should be trained to use the instruments of risk assessment, as they might know from their practice where risk factors lie hidden in the history or tales of their patients.

But, to be explicit, a doctor remains a doctor, even when working for a third party, like a court. In his attitude towards the patient or examinee, he puts the well-being of his patient in first place by giving respect, whatever the circumstances, and by building up a relationship with a beginning, a middle and an end, after which the patient is left unharmed and informed. As such, the forensic physician can be seen as the patient's counsellor, who mediates between him and society. Forensic assessment for the courts is a

translation of the patient's *status mentalis* to the law, an explanation of the patient's inner status when he committed the offence, viewed from his mental state at the moment of examination. The question of the responsibility then is a reconstruction, with all the distortions that makes possible. This, however, is not an empirical question, but a juridical one. Fact-finding and assessment take place in the juridical domain and the answer should also be sought within that domain. The purpose of this translation is to provide building bricks for the conclusion in the verdict. This participation by interpretation is the interface between psychiatry and the law, the law and psychiatry: participation is not possible without knowing each other's rules and appreciating them.

5 Assessment

The relationship between the psychiatrist and the person undergoing assessment is different from that in a treatment situation. The difference needs to be made clear to persons being examined, in view of the fact that, based upon their previous experience with doctors, they will have the tendency to see no difference between the two and regard them as identical. Therefore, the meetings between the examiner and the examined should begin with information about the reason for and the nature of the examination, the questions put by the judge and the role of the examiner as independent expert. It should be made clear that the suspect does not have to cooperate with the examination.

Contrary to the treatment situation, there is no question of secrecy on the part of the examiner. He is obliged to report all that he hears and this should be made clear to the suspect at the beginning so that he can take this into account. However, this lack of professional confidentiality does not mean that the examiner, psychiatrist or psychologist is not bound by his professional code; he must not exert unnecessary pressure on the suspect or cause psychiatric damage by a careless termination of the contact. The relationship between examiner and examinee should be partly for the benefit of the person being examined, who should, for example, be treated with respect and should benefit from the examination by gaining insight into his deeds. The examiner will have to actively guard against ending up in a pseudo-treatment relationship, in which the person being examined gives him confidential information that is not intended for use in the report. The methodical form and management of the relationship also play a role in the examining situation. Nevertheless, when the suspect makes confessions about crimes that he has not been charged with, then the examiner must immediately stop the examination and refer him to his lawyer. The examiner cannot carry out criminal investigations, which means that new questions

need to be put by the judge in order to include the new crimes in the behavioural examination. In addition, the knowledge of other, possibly more serious crimes make it impossible for the examiner to answer the original questions without involving, from a behavioural point of view, the new crimes, which are, after all, involved in the personality of the suspect.

Finally, the person being examined needs to receive the assurance that the report will only be used by the court and by persons who are authorised to treat him in connection with the same crimes. There is no intention whatsoever to use this forensic psychiatric report outside the legal system, such as in custody disagreements and insurance questions, in view of the fact that the collection of the data and the means of argumentation are determined by the legal questions. Unfortunately, there are a number of cases in which judicial psychiatric reports have led a life of their own in other (legal) fields, to the disadvantage of the person examined.

The court's report is of particular importance because it enables the court and the public prosecutor as well as the lawyer to form an idea about the state of mind of the suspect at the time of the crime with which he is charged. An increasing number of psychiatrists and psychologists are involved in reports being drawn up nowadays. Although in the past usually done by a psychiatrist, the advent of the psychologist reporting to the court (together with or separate from the psychiatrist) has heralded the arrival of multidisciplinary reporting. Other academic experts, who have taken over the field of psychological debate and test-diagnostics as a separate department, can also take on the role of examiner and reporter. At the request of the examining judge, the psychiatrist often first issues a short report concerning the desirability of having a judicial psychiatric report. It is also possible for the district psychiatrist to inform the examining judge of the necessity of such a report without having been asked in advance. The examining judge may then issue an order for ambulant or clinical research.

The questions put to the experts can vary in the way in which they are stated, but in principle will cover the following five questions:

1. Does the suspect show any signs of inadequate development and/or pathological illness of his psychic capacities?
2. If so, is there a relationship between this inadequate development and/or pathological illness and the crime of which he is accused?
3. If so, what is the nature of the relationship and to what extent does it exist?
4. To what degree can the suspect be said to be accountable for his actions?
5. Do you have any advice concerning the choice of treatment that may prevent a repeat of the crime of which he is accused?

The elaboration of these questions forms the evaluation of the accountability of the offender for the benefit of answering the question of diminished responsibility. The examination is thus intended in the first place to look at

the presence or absence of an inadequate development and/or a pathological disorder of the mind. These terms both appear in various places in Dutch law books and have an evident meaning for both the lawyer and the behavioural expert. Specific psychiatric diagnoses are not stated in the Dutch law itself. Inadequate development means that certain mental functions, such as the conscience and the emotional inner life, or intellectual powers have not grown to their full capacity. The term pathological disorder points to the presence of psychiatric symptoms, symptoms of mental illness. Psychiatric and psychological examination supplement each other in the sense that the psychiatrist makes the diagnosis according to the medical model with 'poor health' and 'good health' as points of reference, and the psychologist works from the point of deviation and deviating behaviour relative to a certain norm of healthy behaviour.

For the benefit of the Dutch court, another question is often added to those listed above, one derived from the *McNaughten-rule* (1843) and used in many countries. This rule asserts that the suspect is mentally healthy unless proven otherwise. Two mental abilities need to be intact in the first place: awareness of the nature and the results of the criminal behaviour, and insight into its illegal nature. The element of free will can also be added to both these cognitive elements of human behaviour, so that no judicial choice needs to be made between determinism and indeterminism of the human spirit. The key question is: Is the person concerned less able to determine his own free will than the average person?

6 Diminished responsibility

Central to the judicial psychiatric assessment and report, which can be both ambulant and clinical in implementation, is the degree of responsibility of the person being examined. The degree to which there is a relationship between the disorder and the crime (or crime charged) is decisive in that the person involved can bear less responsibility for his crime if the influence of the disorder is greater. It is the medical model that determines when someone has a broken leg and cannot walk even if one wishes to, and that thus determines when one is not responsible for one's illness. Nevertheless, this model is difficult to standardise, so evaluations are likely to differ in practice. If a judge has the idea that he or she is not able to hold the defendant fully responsible, he or she will ask the forensic behavioural expert for advice concerning the extent to which the suspect is amenable to their (the judge's) assessment.

What is important here is the degree in which the illness has driven someone to a certain delinquent behaviour. Judicially, illnesses and deficiencies are recognised as limitations to a person's free will, so that the

perpetrator is accounted less responsibility for (criminal) acts that were carried out (partly) as a result of illness. The juridical criterion for the psychic disorder is “having an impaired development and/or pathological disturbances of the psychic capacities”. By relating this criterion to the offender-patient, a unique depiction is created of the combination of the crime and its perpetrator. In this way it is possible to put offence, offender and the connecting psychic disorder within the legal grounds for a certain degree of responsibility.

Of course, this broad definition of psychic illness does not mean that these experts have *carte blanche* to diagnose as they see fit and instinctively allot someone a particular limitation (as in, “anyone who does such a thing must be mad”). Only when the diagnosis has been determined – assuming that it can be determined, because it is also possible that no disorder is found – will attention shift to the question if there is a relationship with the crime. The forensic method for this is, by assuming a certain intention and opinion on the part of the person and by way of presupposition, to link the found forensic psychiatric and psychological phenomena to these intentions and opinions. After that, it is the specific situation leading up to the crime that emphasises these characteristics of the perpetrator or even causes a drastic deterioration in his illness. The relationship between disorder and crime can be recognised in the motives of the perpetrator, the circumstances of the crime and its nature.

In the Netherlands, five grades of accountability are used, even though Dutch criminal law does not distinguish degrees of diminished responsibility. Of course, such a division into five levels does not do real justice to the complexity of the relationship between the crime and the disorder that is behaviourally possible. After all, the behavioural personality model works via continuity, and not via categories. But the fact that these five categories (and not, say, eight or ten) are used has to do with the fact that they provide judges with a practical division for the benefit of accountability. A distinction is made between undiminished responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility and irresponsibility.

Undiminished responsibility means that the person had complete access to his free will at the time of the crime with which he is charged and could therefore have chosen not to commit it. Irresponsibility means that the person concerned had no free will at all to make a conscious choice to satisfy his motives (disturbed as they may be) and needs. Irresponsibility means that the person cannot be held accountable for his acts, which means that punishment in itself is excluded and compulsory placement in a psychiatric hospital for the maximum period of one year will be indicated. The difference between diminished and severely diminished responsibility is that in the first, the role played by free will was greater and a correspondingly greater amount of punishment can be imposed. What is important here is the

determination of the moment when aspects of the disorder became manifest in the situation (“the scene of the crime”) that eventually led to the perpetration.

A behavioural, three-way division takes place in order to justify the polymorphousness of psychopathology and its influence on behaviour, where slightly diminished and severely diminished responsibility can be found on either side of diminished responsibility. Severely diminished responsibility entails a further reduction of free will as a result of a severe psychiatric illness or a situation-determined exacerbation in the mental clinical image. Certain stimuli from the scene of the crime will then have a specific effect on the state of mind of the perpetrator, often resulting in a reality-testing disorder that spontaneously dies off after some time (psychotic episode) or that provokes a psychosis. Separate from the severity of the psychiatric picture and/or the impaired development is the degree in which the offence could have been avoided by the patient, which is another factor involved in determining the limits of irresponsibility and diminished responsibility.

Slightly diminished responsibility means that there are a number of prominent characteristics that make the perpetrator more susceptible to committing crime, such as impulsiveness and anxiety. However, free will is only slightly limited in this case because the motives for the crime are the usual ones that can also be expected in the average person. In cases of slightly diminished responsibility, the person still has a degree of freedom of choice such that a considerable reduction in the chance of recidivism is not to be expected following treatment of the inadequate development or pathological disorder. Nevertheless, treatment, in combination with a (prison) sentence, can help reduce recidivism when given in the form of a special condition in the conditional part of the prison sentence, as long as the person concerned is motivated. The specific vulnerability factors in the personality can be treated, to keep delinquent impulses under better control and avoid situations conducive to crime.

7 Risk assessment

Regarding custodial clinics, it has been apparent from the outset that risk assessment has to be carried out not only on the basis of static (non-variable) factors, but especially on the basis of dynamic (variable) ones. These factors must relate to the individual and his treatment as well as to his future and past. The emphasis here is on the evaluation of the treatment provided under a hospital order in the hope that it has improved the behaviour of the offender to such an extent that the inclination to re-offend has diminished. Static factors that determine a risk of recidivism in the future are inadequate

on their own because they fail to meet the objective of predicting this risk after treatment under a hospital order. They cannot be altered, such as the age at which the first crime was committed. On the other hand, they should not be ignored, because static factors have a powerful predicative value.

Risk assessment has a number of characteristics:⁸

1. Checklists with scales against which the answers are plotted;
2. These scales have been compared and tested on certain research groups, from which their standard is derived; in other words, they can be compared with one another;
3. The method is objective: the questions are always similar and asked in the same manner; the answers are evaluated on the basis of standard scores for the various groups that have been examined;
4. The information has been acquired in a structured manner and verified for completeness.
5. The information is clear as far as answers are concerned.

This method, however, also has its drawbacks. Specialists are needed, for example, who are specially trained to work out the tests and to translate the scores from the checklists into assessments about the individual. The validation of the checklists in the case of specific groups determines the way they are completed by other groups, who may occasionally interpret certain questions in a completely different manner or for whom the checklist is less applicable (I have in mind the difference between first offenders, offenders under a hospital order and persistently dangerous, long-term offenders under a hospital order). This validation also includes cut-off points; in other words, the degree of risk, deviation or illness accepted is arbitrary. These cut-off points are based on agreements made among experts themselves or between them and policymakers. A checklist should also contain enough dynamic factors if it is to be suitable for assessing the progress of treatment, otherwise an individual's prognosis will remain permanently dependant on his unchangeable past. The conclusions based on risk assessment therefore indicate the probability of future risks.

But clinical assessment of the 'risk of recidivism' posed by offenders under a hospital order is also based on probability. Clinical data, as well as behaviour in the ward and case history, are used to assign a certain degree of risk to a particular individual. On the one hand, this assessment appears to be more specific; additional personal information is taken into consideration, as situational factors and the nature of the crime can be immediately deduced from the case history of the individual. On the other hand, the expertise of the assessors can only be evaluated to a certain extent,

⁸ H.J.C. van Marle, 'Van gevaar naar risico: regelen in plaats van waarschuwen. Risk-assessment in de forensische psychiatrie' (2001) 43 *Tijdschrift voor Psychiatrie* 151 at 161.

as the number of years' experience is not representative and the standards they use to make their assessments cannot be made more explicit, as they are often based on a subjective form of expertise and training.

Another drawback is that a clinical assessment is usually made in an implicit and intuitive manner and does not involve any objectification standards. Often the risks that are taken into consideration during clinical assessments and the nature of their severity are uncertain. In any case, the clinical decisions can be used for an individual patient in a particular circumstance, in granting various forms of leave and privileges, for example. Risk assessment always involves a (quantifiable) probability margin, that of 'false positive' and 'false negative' predictions, of a specific instrument within a specific population over a specific period. That is why, in an individual case and on the basis of that probability, another, separate decision is required for the application of a specific intervention, which is, after all, bound by time and situation. The advantage of this 'clinical' decision, incidentally, is that it is standardised, since arguments and risk factors can be described in full.

Over the past few years, risk-assessment instruments have acquired considerable influence in the discussion on evaluating the risk of recidivism. Some custodial clinics already implicitly use assessment data in the recommendations they make to courts concerning extensions of hospital orders. Courts are therefore saddled with various evaluation models (under the same Penal Code) for convicted individuals. This affects the principles of equality before the law and legal certainty enjoyed by every offender under a hospital order. How should the information in the recommendation to extend a hospital order be interpreted and to what extent is it objective? By the way, it is amazing that till now risk assessment in the Netherlands has been limited to criminal law – in this case the evaluation of offenders under a hospital order. In my opinion, risk assessment is equally applicable to all those psychiatric patients who have been placed involuntarily in general psychiatric hospitals by means of a court order.

8 Debate

The rules of the interface are that everyone is committed and thus knows both goals of the interpretation, but from their own professional point of view. Judges do not have to measure but they should know what certain measurements mean with regard to their case. Psychiatrists are not law experts but they should know that their answers to juridical questions have to fit into the juridical system. So they have to know the meaning and limitations of a sentence before they can give a practical advice, making permanent education among confrères necessary. Now that forensic

psychology, with its research emphasis on courtroom sessions, is making its way to the court, much criticism from that side has been voiced on the interface of law and forensic psychiatry. The main difficulty encountered by forensic psychology is that the concepts used in that interface cannot be measured, are not objective from an empirical point of view and are ill-defined. From my point of view this is not necessary, as the questions are answered within the juridical domain and are not suited for empirical research. The following will clarify this point of view.

From the behavioural sciences there is often criticism about the fact that forensic psychiatrists and psychologists use the phrases 'free will' and 'responsibility for the offence' freely, while there are no empirical measurements whatsoever for these concepts. My opinion is that these critics look only from the side of their own domain of knowledge to the interface of law and psychiatry, and do not speak the common language. The forensic examination is necessary to find answers to juridical questions and thus the ruling domain is the juridical. In this domain free will is a juridical and philosophical idea, not a 'thing' that can be measured in laboratory situations. The axiom of law is that it is there for everyone and exceptions should be few (for instance when a person's capacities to make decisions or control emotions are diminished by a psychiatric illness). For the law we are all the same and we all live under the same idea of free will. How free and how determined men are does not matter in this case; the reasoning starts with identifying the exceptions mentioned by the law itself, all others are equal in their decision making.

The same holds true with regard to the three degrees of diminished responsibility. These are very practical for judges, as they refer to different sanctions within the realm of criminal law. We have the prison sentence, detainment under a hospital order and a combination of the two. But in the psychiatric domain there are no measurements which can show the differences between these degrees in the examination of one person. Psychiatrists can draw conclusions about full responsibility (no mental disorders), total irresponsibility (a mental disorder has taken over the control of the mind of the patient, as in psychosis), and the intermediate area of diminished responsibility, where mental disorder and situational influences interact in an escalating process. Variations in the diminished responsibility, like slightly or severely diminished, are not measurable by psychiatric or psychological means. It is extracted from the findings of the forensic examination but weighed intuitively against other cases. At that moment the psychiatrist sits in the judge's chair, as he cannot motivate his conclusion on the basis of his own medical paradigm. It is an impressionistic conclusion, which has nothing to do with a medical attitude towards the patient and should be abstained from. The frontier of the interface has been reached.

The same problem is encountered in the reconstruction of the situation of the perpetrator and his offence. The psychiatrist works in the

past and tries to distil psychiatric ‘facts’ from the past and the present from the words of his examinee. How can they ever become real facts and what are they good for in court cases, in how far are they reliable? Here, too, the answer comes from the interface: a court examination is in the juridical domain. Facts gleaned from witnesses, perpetrators and experts are as good as they are; these facts are examined by experienced forensic experts and commented on by them as an advice to the court. And then the juridical ruling takes place in its own domain with its own criteria of justice, fairness and proportionality. Please note that it is an advice, so it brings with it the possibility of being rejected. Its contents should be clear and of sound judgement, the empirical facts well-clarified and shown in relation to other possible interpretations. If a suspect refuses to talk or denies the offence, no examination can take place, no answer found. As with any other patient in general practice, an examination is not possible if he does not co-operate, only circumstantial data can be known from other information. This is not enough information to turn up juridical answers about this person. Facts about the offence will not be found, as the forensic examination cannot be executed, but only the present state diagnosed. Psychiatric interpretations of the present to the past of the offence are not possible, as this past does not exist in the examining situation. Because in the interface the forensic psychiatric examination is ‘patient-context-past’-oriented, in these cases the examination itself is invalid and cannot be used in court.

With regard to the enforcement of detention under a hospital order, risk-assessment instruments are particularly important in evaluating the treatment process, as they record differences over the course of time. We cannot afford to ignore these instruments, since failure to use them has been shown to affect our evaluation of danger and is therefore unethical with respect to the patient and the general public.⁹ Those factors that can be altered during a treatment situation or during follow-up care are especially relevant for assessment in everyday situations. Historical factors cannot, after all, be changed. As a result, they cannot serve as a guiding principle for intervention, even though they are powerful predictors of future risks. That is why they must somehow be included in the everyday depiction, as their presence always entails an increased risk. A model in which static and dynamic factors are compared and correlated is therefore required for the clinical decision process.

Selecting treatment evaluation with the help of dynamic factors explicitly involves the choice of certain types of risk-assessment checklists,

⁹ W.M. Grove and P.E. Meehl, ‘Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical-statistical controversy’ (1996) 2 *Psychology, Public Policy, and Law* 293 at 323.

namely those allowing enough variable factors to be checked which reflect the results of the treatment provided under a hospital order. The assessments made at various times during the treatment already provide information about the responsiveness of the relevant individual to the treatment. These measurement points, however, cannot replace daily decisions relating to the patient's behaviour, such as clinical supervision and placement in an isolation cell. Furthermore, the patient's cooperation is required for the completion of the checklists, which must be based on trends in the treatment and not on incidental moments. The knowledge and skills of staff with clinical experience is essential for daily departmental management.

9 Concluding remarks

In the interface between law and forensic psychiatry the influence of modern examination techniques and risk assessment is growing increasingly. These techniques, however, are not forensic in the way that they can connect their empirical facts to the individual patient as the suspect who will be tried in a court of law. Their conclusions still need to be interpreted in the light of the juridical situation and the individual case history. The forensic behavioural experts are the interpreters. Their interpretation has its limits, as the emotional 'facts' should be reproducible in peer-review and the methods of examining and interpreting should be accepted by the relevant scientific field. The empirical sciences give more objectivity in their findings, but their influence still can be only auxiliary to the juridical reality and the daily practice of forensic treatment.