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Forensic psychiatry in Europe

The European Union now includes 27 member states. The Council of Europe stretches even further with 45 member states. A comprehensive definition of Europe geographically embraces all of Eastern Europe, including the western part of Russia and the western part of Turkey. Increasing mobility and national cooperation within Europe requires enhancing mutual knowledge and understanding of the context of evaluation and treatment of mentally disordered offenders and similar individuals who manifest antisocial behaviour and violence. A recent study confined to the previous 15 member states of the European Union provides a useful baseline for subsequent European comparisons (Salize & Dressing, 2005).

Definition of forensic psychiatry

Definitions of forensic psychiatry vary but its essence relates to the assessment and treatment of people with mental disorder who show antisocial or violent behaviour. Key elements include the interface between mental health and the law, affording expert evidence in civil and criminal courts, and the assessment and treatment of mentally disordered offenders and similar patients who have not committed any offences. Forensic psychiatry is a sub-specialty of general psychiatry, which itself is a sub-specialty of medicine. Concurrently forensic psychiatry overlaps with law, criminal justice and clinical psychology and occurs in an evolving social and political context.

Historical factors

The theory and practice of forensic psychiatry in Europe can be traced back at least 200 years and even back into Greek and Roman antiquity (Barras & Bernheim, 1990). Influential trends in forensic psychiatry in the 19th and 20th centuries emanating from France (Lloyd & Benezech, 1992), Germany (Gaupp, 1974) and Britain (Sullivan, 1924) were accompanied by further positive contributions in countries such as Austria, Denmark, Sweden and Finland. In Russia, during the Soviet period, forensic psychiatry was well developed but its reputation damaged by the abuse of psychiatry in the detention of religious and political dissidents. Twelve years of Nazi rule in Germany from 1933 until 1945 decimated the hitherto leading role played by German psychiatry. After the reunification of Germany in 1990, differing trends in forensic psychiatry in the former West and East Germany required gradual blending into that appropriate for the enlarged Federal Republic of Germany (Konrad, 2001). Further issues in Europe of historical and contemporary interest include developments in the former Yugoslavia, where in one case a former head of State, Radovan Karadzic, a psychiatrist, remains at liberty but with a warrant for arrest on charges of crimes against humanity (Dekleva & Post, 1997).

Criminal responsibility

Mainland Europe has retained a much stronger tradition of emphasising criminal responsibility in relation to mentally disordered offenders compared to Britain, where, except in charges of murder, the issue is marginal. Mental responsibility for a crime is, however, primarily an issue of morality, although a clinician can advise a court on how the mental disorder if present may impair cognition, perception, affect and judgement. A finding of insanity implies a complete absence of criminal responsibility, whereas in many cases the responsibility of the mentally disordered offender is reduced rather than eliminated. The perspective preferred in Britain, Ireland and Scandinavian countries is the pragmatic one focusing on whether or not the offender is mentally disordered and in need of treatment, rather than on their responsibility for the offence (Salize & Dressing, 2005). In The Netherlands there is a well-established system known as *Terbeschikkingstellung* or 'TBR', whereby some offenders suffering usually from severe personality disorder, assessed as a serious risk to others and found to be of diminished responsibility are sentenced to punishment combined with therapeutic measures (Van Marle, 2000). During the Soviet period there were phases during which a finding of diminished responsibility was available, and in post-Soviet Russia it was reintroduced in 1997 (Ruchkin, 2000).

In most of Europe it is now the case that provision is made for diminished responsibility findings in appropriate cases. Schizophrenia and related psychoses, organic psychoses and intellectual disability would usually attract such an outcome, with more variability in cases of

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affective disorder, personality disorder, substance misuse and paraphilias. Only in Germany (Nedopil & Otterman, 1993) and Austria (Schanda *et al*, 2000) is there also specific provision for involuntary detention following a conviction for an offence related to substance misuse.

Forensic psychiatric facilities

Across Europe, mentally disordered offenders can be found in forensic hospitals, general psychiatric hospitals, less commonly in psychiatric wards in district general hospitals, and in prisons and in the community. Gunn (1976) described models of care involving an integrated system where patients who have committed offences were transferred back from forensic units to general psychiatry when stable, and a parallel system, whereby they remained in forensic out-patient care after discharge from secure facilities. Currently probably only Germany provides a system predominantly of parallel care, whereas in most of Europe there is a mixture of an integrated and parallel nature. In some European Union member states aggressive, violent or high-risk patients with mental disorder who have not committed offences may also be admitted to forensic facilities (Salize & Dressing, 2005).

A comprehensive range of secure psychiatric facilities is available across most of Western Europe, but Belgium is only now planning such provision (Naudts *et al*, 2005) and in Italy the well-known decision of 1978 to close general psychiatric hospitals left untouched and poorly developed facilities for forensic admissions (Fornari & Ferracuti, 1995). In Eastern Europe, high and medium secure units are available in Russia (Ruchkin, 2000), whereas in Poland there are new forensic facilities (Ciszewski & Sutula, 2000) and in Bulgaria there is a high-security unit within a general psychiatric hospital (Dontschev & Gordon, 1997), but forensic psychiatry is still very limited in other Eastern European countries.

Across most of Western Europe, with the deinstitutionalisation of general psychiatric hospitals over the past 30 years, there is now a trend towards a degree of reinstitutionalisation, with increasing numbers of admissions to forensic hospitals (Priebe *et al*, 2005), although reasons for this may also include higher rates of comorbid substance misuse and the higher level of concern about risk within society generally. The lowest prevalence rates in Europe of patients who have committed offences are found in Italy, Portugal and Greece. In Russia the trend towards deinstitutionalisation seen in Western Europe has not occurred (Ruchkin, 2000).

Relationship between general and forensic psychiatry

Patients detained in forensic psychiatric hospitals tend to show multiple disabilities, including antisocial behaviour, substance misuse and poor insight and reduced adherence to treatment. Concern has also been expressed that the increase in forensic admissions in Europe may partly be a reflection of insufficient length of stay of a subgroup of patients with schizophrenia or related psychoses and also prone to violence in general psychiatric hospitals (Schanda *et al*, 2004). One of us (H.G.) also takes the view that a further factor may also be the decline in prescription of depot antipsychotic medication. Clearly, there is a tension at the boundary between general and forensic psychiatry (Szmukler, 2002). Admission to general psychiatric hospitals of patients who have committed offences can be met with considerable reluctance even when they are initially stabilised in a forensic unit. Conversely forensic units are not always appropriately receptive to accepting patients for transfer into secure facilities from general psychiatric colleagues. As a majority of patients in forensic units have had previous contact with general psychiatric services or will require transfer to general psychiatry when stabilised, close interaction between general and forensic psychiatry is essential.

Psychiatry in prison

Prisons have historically been and remain to an extent a facility confining sizeable numbers of people who have a mental disorder. Major problems facing prison health services in Europe were acknowledged in the early 1990s (Tomasevski, 1992) and subsequently a greater emphasis on improvement in mental healthcare in prisons in Europe has been felt necessary (Gatherer *et al*, 2005). Currently a European Union funded study into mental healthcare in European prisons is being undertaken (H. J. Salize, personal communication, 2007). Across Europe prisons mostly have special units for mentally disordered prisoners, but usually not in sufficient numbers (Blaauw *et al*, 2000). Transfer of prisoners with mental illness to psychiatric hospitals in Europe is often problematic owing to disputes about diagnosis or concern regarding the level of security required. Only in the Scandinavian countries are prisoners with psychoses rarely to be found. Research into suicide in European prisons is ongoing (Konrad, 2002; Fruehwald *et al*, 2003; Dahle *et al*, 2005).

Female patients who have committed offences

Female offender patients in Europe constitute between about 15 and 17% of the total (Salize & Dressing, 2005). Most of the literature on forensic psychiatry in Europe has focused on males. In Britain the relatively high numbers of female patients in high-security hospitals has been reducing markedly over the past decade, on the basis that most can be safely managed in a lesser degree of security.

Sex offenders

Although most sex offenders are sentenced to prison and do not have mental illnesses, elements of personality disorder, affective dysregulation, substance misuse, organic factors and paraphilia are frequently encountered (Gordon & Grubin, 2004). In Europe, Denmark probably

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has the most established tradition in the treatment of sex offenders, using a combination of biological and psychotherapeutic approaches (Hansen & Lykke-Olesen, 1997). Effective programmes of treatment of sex offenders are also employed elsewhere in Europe including France (Minne, 1997) and Belgium (Cosyns, 1998), and cross-national projects on sex offenders are also in progress in various countries in Europe (Salize & Dressing, 2005).

Training in forensic psychiatry

Marked differences exist across Europe in the standards of training in forensic psychiatry (Gunn & Nedopil, 2005). Only Britain, Ireland, Sweden and Germany have a separate certificate of specialist training. Denmark has forensic training but no specialist qualification. The Netherlands has no specialist training in forensic psychiatry. Training in forensic psychiatry is well developed in Russia and Bulgaria but less so elsewhere in Eastern Europe. The Association of European Psychiatrists (AEP), to which most national psychiatric associations in Europe, including the Royal College of Psychiatrists, are affiliated, also has a small but growing forensic section, which organises sessions on forensic psychiatry. An informal group of forensic psychiatrists in Europe, led by Professor John Gunn (UK) and Professor Norbert Nedopil (Germany) is also now actively working to improve forensic psychiatric training in Europe.

Ethics in forensic psychiatry

The psychiatrist giving evidence in court in regard to a defendant charged with a criminal offence does so in a context in which he has no therapeutic relationship with the accused and there is no traditional doctor–patient relationship (Bailey *et al*, 2004). A long-running debate in the USA focused around whether or not psychiatrists giving evidence in court in criminal trials are in the process practising medicine, the so-called Stone:Applebaum controversy (Stone, 1984; Applebaum, 1997). Nonetheless the knowledge and expertise on which the psychiatrist bases his evaluation is that of medicine and psychiatry and the ethical framework is that grounded within his profession (Nedopil, 2004). The British view has been well articulated for over 50 years in recognising that a psychiatrist preparing a court report must remain impartial but remain concerned for the welfare of the offender (Scott, 1953). Forensic psychiatry does however have both an obligation to do what is in the best interests of a patient while concurrently seeking to protect the public from serious harm. Usually these two parameters coincide with each other, but occasionally may conflict.

Post-war European development has placed increasing emphasis on preservation of human rights, including pertaining to individuals with mentally illness. The European Court of Human Rights protects the human rights of persons subject to involuntary psychiatric commitment by creating supranational law in the spheres of 'unsoundness of mind', the lawfulness and conditions of detention, the right to a review of detention by a court, the right to information, and the right to respect for private and family life (Niveau & Materi, 2006). In five cases brought before the European Court of Human Rights, modifications have needed to be made to national mental health legislation, including England and Wales, Belgium and the Netherlands. Separately, monitoring of all aspects of detention and custody in the Council of Europe is carried out by the Committee for the Prevention of Torture and Inhumane and Degrading Treatment, which has reported adversely on aspects of psychiatric care in various countries including Greece and Turkey (Niveau & Materi, 2006). The protection of human rights of detained patients in European legislation may however be more evident than that which pertains to the victims of patients who have committed offences. In Russia, despite improved mental health legislation and ethical reform in the post-soviet period, monitoring of mental healthcare remains insufficiently robust.

Conclusions

Forensic psychiatry in Europe occurs within nations of different legal traditions whose history has been affected by varying political doctrine. While harmonisation of forensic psychiatry in Europe may not as yet be entirely feasible, common principles can be shared regarding the provision of services for mentally disordered offenders and similar patients who have not offended.

The legislative framework in Europe for the involuntary civil admission of mentally disordered patients varies widely across member states and clearly standardisation of reporting is required for adequate comparative analysis (Dressing & Salize, 2004). Similarly the assessment and reassessment of mentally disordered offenders and professional training standards vary markedly across European member states (Dressing & Salize, 2006). There is now, however, some momentum across Europe towards collaboration in forensic psychiatry in regard to consideration of agreement of the optimum ingredients required for training and best clinical practice. Over 15 years have now elapsed since Europe was divided according to ideological difference, and forensic psychiatry can now evolve in a Europe whose nations share a more common perspective. Research into forensic psychiatry in Europe will now require a cross-national approach, while increasingly fertilisation of ideas will benefit from mutual cooperation and coordination. A multilingual framework for communication would be the ideal. However, the reality is that the English language serves as a common medium of scientific discourse.

Declaration of interest

None.

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