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Scandinavian forensic psychiatric practices – an overview and evaluation

PÅL GRØNDAHL

Grøndahl P. Scandinavian forensic psychiatric practices – an overview and evaluation. Nord J Psychiatry 2005;59:92–102. Oslo. ISSN 0803-9488.

The Scandinavian countries share a social-democratic and humanistic view in that mentally disturbed offenders should not be punished or sentenced to prison if they are considered unaccountable for their actions. The countries differ, however, for example regarding referrals for medico-legal examinations. This article gives: 1) an overview of the Scandinavian forensic psychiatric practices regarding organization, legislation, resources and use of methods, and 2) a study of forensic psychiatric assessments as they are done in the Scandinavian countries. From each country 20 forensic psychiatric court reports concerning male murderers were examined. Each report was scored in five sections: characteristics of the defendant, setting of the observation, acting professions, methods used and premises for the experts' conclusions. Data were summarized with descriptive measures. Danish and Swedish experts had a more frequent use of tests and instruments than Norwegian experts. Swedish experts used the Global Assessment of Functioning Scale (GAF), and they diagnosed the observant according to DSM-IV. The Scandinavian experts rarely referred to the tests they had applied nor did they refer to any kind of theory or literature as a basis for their conclusion. Only a few reports expressed doubt concerning the validity of the conclusion. Stating all the premises of the forensic psychiatric examination might improve the quality of the reports by doing them more explicit and verifiable. More use of standardized actuarial-based methods and more attention to knowledge about clinical judgemental processes is recommended.

• *Court reports, Evaluation, Forensic experts, Forensic psychiatry, Overview.*

Pål Grøndahl, Ph.D., Centre for Research and Education in Forensic Psychiatry, Ullevaal University Hospital, Gaustad, Sognsvannsveien 21, NO-0320 Oslo, Norway, E-mail: pagron@c2i.net; Accepted 15 October 2004.

The psychiatrists or clinical psychologists who choose to work within forensic psychiatry may be considered both brave and masochistic. Forensic psychiatric experts are rather exposed in the courtroom through critical examinations by members of the court, and in the media concerning high profiled cases. They are also, occasionally, criticized by representatives from the social sciences.

The forensic psychologist or psychiatrist has regularly been attributed many roles. According to Rosenqvist (1), the forensic expert is sometimes given the role of a person who can twist the truth in any direction. Some even believe that the expert can "see" what a person thinks inside his or her head.

In being the court advisors, the forensic psychiatric experts play a very important role in legal questions regarding mentally disturbed offenders. The experts' conclusions can – if the court agrees to these – make a strong impact as to what kind of medico-legal consequences that will be initiated towards the defendant.

To ensure good quality of the court reports, a national medical commission was established in 1900 in Norway. Similar national control systems were established in Denmark 1909 and in Sweden 1912. Despite these control measures, the practice of forensic psychiatric evaluations has been repeatedly criticized. The critique has claimed that the experts have not ensured the defendant a correct perception and expectation of the purpose of the investigation. It has also been claimed that the defendant has not always been informed about the nature of the consent, and that rules of confidentiality exist other than in an ordinary doctor–patient relationship (2). There has also been a debate about the experts' basis for giving testimonies of presumed dangerousness (3–5). Use of negative and pejorative comments about the defendant has been discussed and criticized (4, 6, 7). Critique has also been raised due to insufficient use of objective and reliable methods in forensic court reports (8). The question is how this differs in the Scandinavian countries and what system

 DOI: 10.1080/08039480510022927

seems to give the "best" forensic examination given the resources and priorities in each country.

The aim of this article is to give an overview of Scandinavian forensic psychiatric practices and to compare their assessment methods. For illustration, two cases – Ole and Birger – will be followed.

Ole is 23 years old and has a diagnosis of schizophrenia. When 18 years old he was hospitalized due to psychotic symptoms. He was discharged after a month. A year later, he was readmitted because he was convinced that his mother was poisoning his food. He was discharged after 6 weeks. At the age of 23, without presage, he killed his mother, still convinced of her poisoning him.

Birger is 35 years old and the diagnosis has differed between unstable/borderline and antisocial personality disorder. From an early age, he started with heavy drinking and use of illegal drugs. He has been hospitalized in psychiatric care several times, but only for a few days due to suspicion of vague psychotic symptoms. While drunk, he started a fight with a friend and killed him because he believed the friend had stolen a beer from him.

To my knowledge, only a few studies have examined the quality of the forensic reports; Ellingsen (6) studied forensic reports in Norway issued in 1980. He found that the experts had an unsystematic use of the forensic psychiatric concepts and stated their conclusions in an unverifiable manner. Grøndahl & Holum (8) interviewed 12 Norwegian experts regarding their methods and use of psychiatric forensic concepts. They found that the experts made little use of standardized tests and methods as a basis for their conclusions. The experts' concept of psychosis was rather precise, but the concept of automatism, and criteria for special measurements of the defendant were less concise. Elmgren (9) evaluated statements from the legal council from 1997 mainly regarding conclusions of serious psychiatric disturbance. The council evaluated 31 court reports of about 600 issued reports from that year (about 5%). The reports were evaluated upon requests from the court or other instances. She found that the legal council in Sweden changed the conclusion in 13 of the 31 evaluated reports. In a new study, Elmgren (10) found that the legal council in 2000 evaluated 34 reports of 600 issued reports (5%); 16 of the 34 controlled reports were changed. She concluded that this was a rather high proportion of changes and that such control measures of the court reports were necessary (9). Davidsen (11) compared 12 Norwegian and six Swedish forensic court reports in a qualitative study. He found that the Norwegian reports varied in number of sessions with the defendant, where the sessions took place, and how the experts used the forensic psychiatric concepts. The Swedish reports on the other hand were far more homogeneously designed. Hartvig et al. (12) evaluated the 42 court reports issued in Norway between 1981 and 2000 where the experts had concluded that the defendant was suffering from automatism at the time of the crime. The authors disagreed regarding the conclusion in 12 of the reports, and they expressed doubts about the conclusion in additionally 15 cases. Furthermore, in 14 of the cases (33%) the court had disagreed with the experts. The authors concluded that several of the reports lacked sufficient quality regarding the validity of the term automatism, which in turn might threaten the legal safeguards of the defendant.

These studies address the problem that forensic court reports systematically are lacking or imprecise in their use of both forensic psychiatric concepts and methods. Furthermore, the premises for the conclusion have not always been stated in a verifiable manner.

The Scandinavian forensic systems have many common features (13). The mandate is common, i.e. to establish if the defendant was suffering from severe mental disorder at the time of the crime and at the time of the observation. Furthermore, all three countries use the inquisitorial system where the expert usually is appointed to aid the court like an "amicus curiae", i.e. a "friend" of the court, and to appear in an educational manner, i.e. acting neutral (14). A comparative study in the Scandinavian countries is, therefore, relevant regarding choice of methods and premises, which constitute the basis for the conclusions in the forensic reports.

The Scandinavian forensic systems

Organization

DENMARK

Forensic psychiatry is not a recognized medical speciality in Denmark, and there is no independent specialized forensic organization. The Medico-legal Council ("Retslægerådet") is an independent consultative medical board. The council is consulted for approval in all cases where the forensic psychiatric examination concludes that the defendant is mentally ill and a special provision order is suggested (15). Ambulant forensic reports are made in sectored parts of Denmark, although some reports are made by individual experts. Some forensic examinations are also carried out in general psychiatric hospitals when the offender is in inpatient psychiatric care.

NORWAY

In Norway, two general specialists in psychiatry, or one specialist in clinical psychology and one psychiatrist, are appointed by the court in order to make a forensic examination. No forensic speciality exists, neither for psychiatrists nor for clinical psychologists. Forensic psychiatry in Norway is not organized within a specialized independent organization. A national super-

vising authority, the Forensic Medicine Commission – Psychiatric group (''Den rettsmedisinske kommisjon''), exerts a standardizing and controlling function. The control and approval by the Commission of all forensic reports is mandatory. There are no specialized forensic psychiatric examination clinics.

SWEDEN

Most of the forensic disciplines are organized within The National Board of Forensic Medicine (Rättsmedisinalvärket). This central unit is responsible for administration, organization and quality control of all the forensic psychiatric examinations (13). The board is not responsible for psychiatric care; this responsibility lies within the county councils. Defendants in prison, or otherwise detained, are transferred to one of the regional forensic psychiatric examination units located in Stockholm and Gothenburg, or to one of the authorized clinics in Umeå or Malmö. The defendants stay there for 3 weeks to complete the examination. A non-detained offender comes to the clinic for sessions during a 6-week period. The court may in some cases require approval from the legal council (Rättsliga rådet) in order to assess the quality of the examination.

When is a forensic psychiatric examination required?

DENMARK

A forensic examination must be performed when the psychiatric condition of the defendant may influence the verdict of the court. The most common criteria for initiating a forensic examination are: 1) when the offender is suspected to suffer from a severe mental illness, 2) when the offender has (or is suspected of having) committed a serious crime, or 3) when the offender is under 18 or over 60. A forensic examination is also initiated in the few cases of possible detention.

NORWAY

A forensic psychiatric examination will be initiated in cases when there is a suspicion that the defendant is or were suffering from psychosis or was influenced by a mental illness in such a way that he/she had a reduced evaluation of his/her actions. Similarly, if the criminal act was of an especially serious nature (homicide, attempted homicide, rape, arson, etc.), the court may decide that a forensic examination should be initiated.

SWEDEN

According to *section 1, law regarding forensic examination* (''lagen om rättspsykiatrisk undersökning''), the court can decide to initiate a forensic examination in order to clarify the following questions: 1) If there are medical reasons to transfer the defendant to a forensic ward, and 2) whether the defendant committed the crime is influenced by a severe mental disorder (allvarlig psykisk störning – APS) (16), and 3) if the answer is yes on question 2: Should the offender be given a special court assessment before discharge?

The major criterion for initiating a forensic psychiatric examination is a suspicion of serious psychiatric disturbance. Neither age nor the seriousness of the committed crime is included as reasons for forensic psychiatry to be involved.

Legislation

DENMARK

The current forensic legislation is built on the penal code from 1930. Section 16 of the Danish penal code states that: ''Persons who, at the time of the act were irresponsible owing to mental illness or similar conditions or a pronounced mental deficiency (such as intellectual development disorder) are *not* punishable'' (17). Mental illness should in this context be considered the same as psychosis (18). A defendant, not regarded as suffering from psychosis or similar, but still considered mentally abnormal *may*, according to *section 69*, be sentenced by the court to special provision, including psychiatric treatment as an alternative to ordinary penalty. *Section 68* of the Danish penal code contains the type and extent of the special provision orders for mentally disturbed defendants.

If the examination concludes that a defendant *is* suffering from psychosis or similar, or is mentally retarded, and the court agrees in this conclusion he will not be sentenced for the crime according to section 16. The court can, however, give court restrictions, i.e. give a special provision order according to section 68 to prevent future offences. This order can, in serious cases, involve ''placement'' (''anbringelse'') on an inpatient basis in a psychiatric ward/hospital or at a maximum-security unit. In such cases, the court decides what (security) conditions the offender should be given at the hospital, and at what time the placement may be suspended, i.e. not time-limited provision order. Without such court restrictions, the medical staff will decide the conditions if the offender is given psychiatric treatment on an inpatient or outpatient basis (Fig. 1).

A mentally abnormal person *without* psychosis can be sentenced to treatment according to section 69, subsection 1. These persons can be given special provision orders according to section 68. The others will be given ordinary sentences or, in some very few cases (three to five each year), be placed in a special detention institution, if considered dangerous (Fig. 1).

NORWAY

A new forensic legislation was introduced in Norway in 2002. According to *section 44* of the penal code, people who are considered psychotic or unconscious or severely mentally retarded (an approximate rule is IQ $<$ 55)

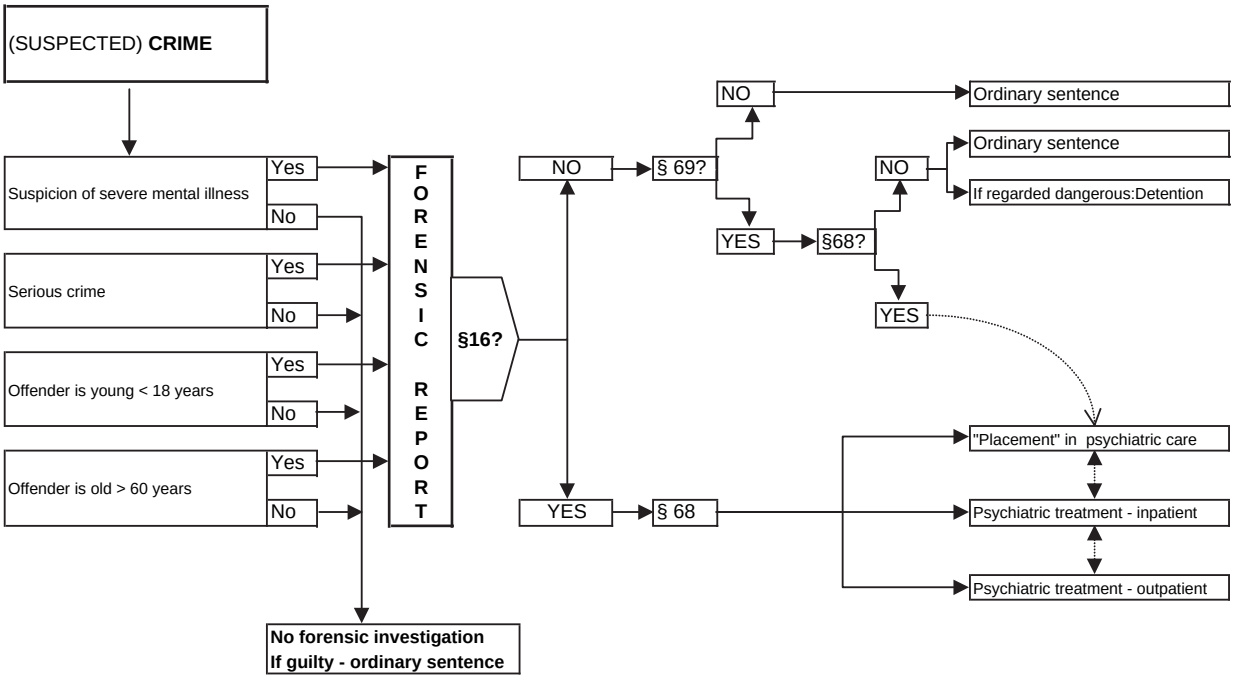

Fig. 1. Danish forensic psychiatric system.

cannot be punished. If the psychiatric examination concludes that the offender is psychotic, and the court agrees, he cannot be sentenced to prison. However, he may be transferred to psychiatric care according to *section 39* of the penal code (Fig. 2).

If the offender is severely mentally retarded, he can be transferred to compulsory care, according to *section 39a*.

Diminished consciousness due to self-inflicted intoxication does not automatically exclude punishment, according to *section 45* of the penal code. According to *section 56c*, a defendant who is not considered psychotic, but acted under a mental illness in such a way that he had a reduced evaluation of his acts, may be given reduced sentence.

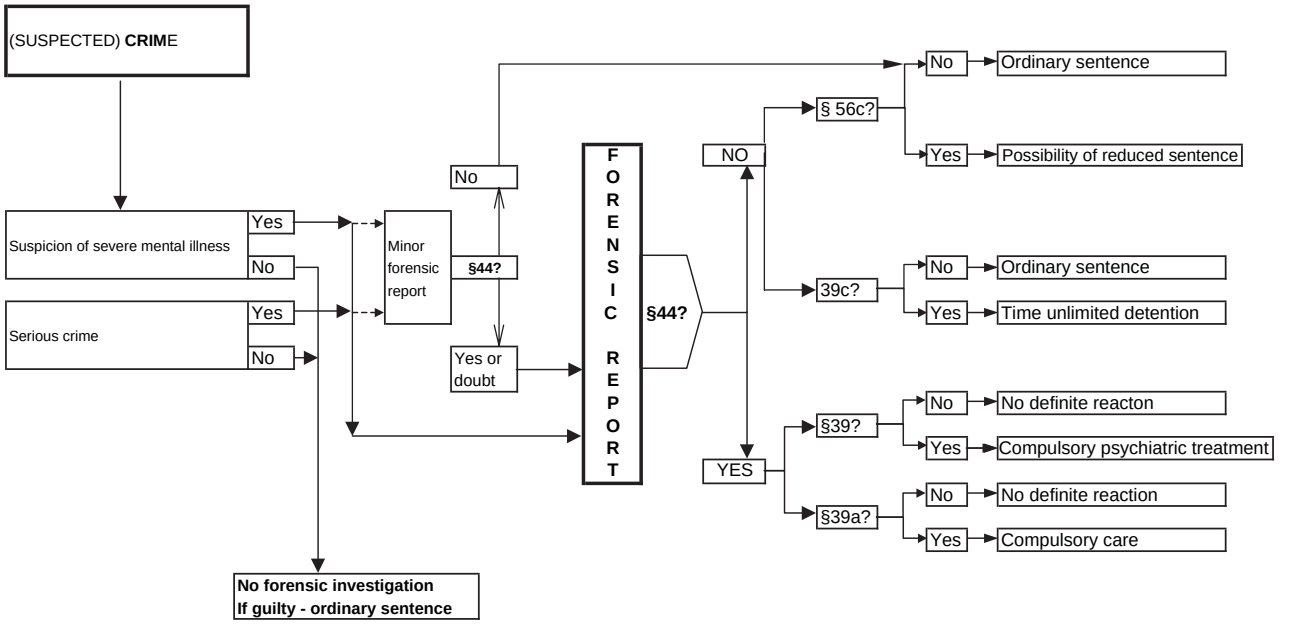

Fig. 2. Norwegian forensic psychiatric system.

If the offender is found to be accountable for his/her actions at the time of the act, he/she may in certain cases be sentenced to detention according to *section 39c*. Such an action may be decided if the court finds the act especially serious and finds that society needs protection because of the risk of new serious criminal acts. The detention is not time limited, but the court shall point out a minimum and maximum time for the detention. The maximum time may be prolonged if the court so decides.

SWEDEN

The current forensic legislation was introduced in Sweden in 1992. The Swedish legislation differs from Denmark and Norway, considering that all defendants found guilty are convicted and held responsible regardless of their mental state at the time of the offence (9). If they acted under a severe mental disorder, they will not be sentenced to prison, but to psychiatric care. *Chapter 30*, *section 6* of the Swedish penal code (Brottsbalken – BrB) states that "a person who has committed a crime under the influence of a severe mental disorder must not be sentenced to prison" ("fängelseförbudet"). The concept "severe mental disorder" includes psychotic disorders regardless of aetiology (also alcohol-induced psychosis and psychosis induced by drugs), severe depressive disorder with a risk of suicide, in some cases severe personality disorder, and severe compulsive behaviour such as kleptomania, pyromania and some types of paraphilias.

According to BrB *chapter 31, section 3*, the court cannot decide to commit a defendant to psychiatric treatment by the supervision of the court unless a forensic examination has been conducted. *The Forensic Psychiatric Care Act (1991: 1129)* regulates compulsory psychiatric treatment for people who have committed a crime while suffering from severe mental disorder. This Act deals with two separate patient categories: patients *with* or *without* special court assessment before discharge (Fig. 3).

The court decides in each case whether the person has a risk of relapse of serious criminality. When the person is subjected to special court assessment, the court carries the responsibility of permitting any temporary leave of absence as well as discharge from the hospital. The psychiatrist in charge can, in cases without special court assessment, determine the extent of the detention required (19).

The forensic report

DENMARK

A psychiatrist, who is considered an independent expert, carries out the forensic examination. Sometimes a social worker and a psychologist participate in order to obtain social background history and psychological tests. The psychiatrist is responsible for the forensic examination, the report and the conclusion.

The report should contain information regarding mental disorder and criminality in the family, social history, the defendant's medical/psychiatric history, previous criminality, the subject's own description of the crime, a general physical examination, clinical psychiatric evaluation, and finally discussion and conclusion. Sometimes psychological testing is included. Most examinations should be done within 6 weeks, but there is no official time limit.

NORWAY

In some cases, a minor psychiatric examination may precede a major forensic psychiatric examination. If the conclusion in the minor report is that the offender might fall under sections 44 or 56c and in some cases section 39 in the penal code, a major psychiatric examination most often will be initiated.

According to Rosenqvist & Rasmussen (20) there is no standard requirement for the forensic psychiatric report. There is, though, a tradition for what the forensic psychiatric report should contain. In addition to the more formal content (present charges, earlier convictions and forensic examinations, etc.), a résumé of the case file and psychiatric background data (family, childhood, somatic and psychiatric history and current health status) should be included. In addition, the report should contain data from sources other than the offender (i.e. background information eventually from family, partner, etc.). If the experts have performed tests, these should be accounted for. Strong moderation is usually recommended regarding use of projective psychological tests. Finally, a chapter that discusses premises for the conclusions and a statement of the conclusions are mandatory. The Forensic Medicine Commission – Psychiatric group has the last few years encouraged the forensic experts to make ICD-10 diagnoses concerning the offender if possible.

SWEDEN

The court may request a less extensive ("minor") examination, i.e. a section 7 report. The minor forensic examination is performed by a specially trained psychiatrist, and provides an evaluation of the subjects' mental health, and gives recommendations whether a major forensic examination should be conducted and/or the need for psychiatric treatment evaluated (19). A minor report is regarded sufficient for the court in cases where no special court assessment is needed (21).

A team including a specialist in forensic psychiatry, a psychologist, a social worker and usually a member from the ward performs the major forensic psychiatric examination. Each member in the team has specialized tasks. The social worker collects data regarding personal data

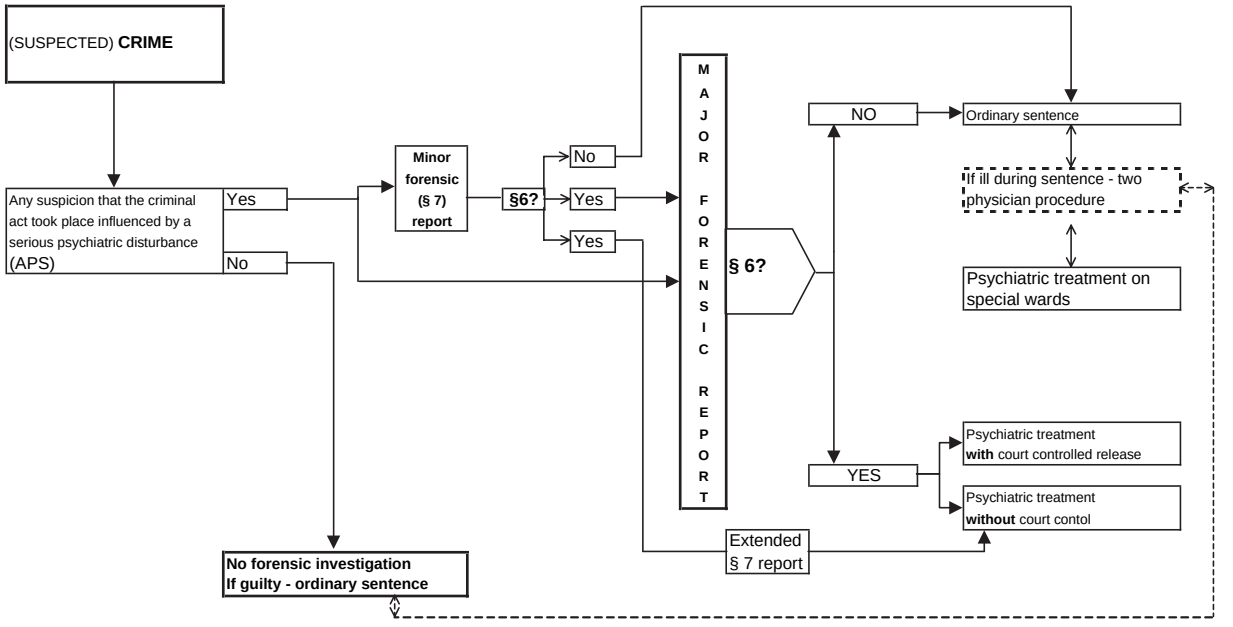

Fig. 3. Swedish forensic psychiatric system.

from various sources. The psychologist performs psychological tests (personality, cognitive and neuropsychological), and sometimes provides analyses of the psychodynamic mechanisms behind the alleged crime. The forensic psychiatrist is responsible for the somatic and psychiatric examination. The nursing staff contributes with ward reports (19). The forensic psychiatrist is responsible for the final report and its conclusions.

The court report should be presented in a manner witch makes it possible for the court to make an independent decision. Conclusions concerning APS, causality, need for psychiatric care/ward and risk of new criminal offences should be presented (9). The report should contain the above-mentioned psychological tests and DSM diagnosis. In short, the examination should conclude on the following questions: 1) Did the offender commit the crime influenced by a serious psychiatric disturbance (APS) which prohibits a sentence to prison? 2) If so, should the offender be given special court assessment before discharge or not?

Extentlresources

In *Denmark*, no official figures exist for the number of reports made each year, or the total costs of the Danish forensic psychiatric examinations (Peter Kramp, personal communication). Each year, *approximately* 600 forensic reports are made, including about 50 conducted in psychiatric hospitals and about 50 conducted by independent psychiatrists. The Ministry of Justice has a fixed rate of about 2900 EUR for each forensic report conducted in the counties. For total expenses, see Table 1.

In *Norway*, no official figures exist regarding the number of minor or major psychiatric examinations (22). For minor reports, an estimated figure for 2003 is 750, (author's calculations). In 2003, the figure was about 500 for a major examination (author's calculations). The cost for a minor report is approximately 480 EUR. For a major report, the cost is nearly 3800 EUR (Table 1).

In *Sweden*, 1907 section 7 reports and 688 major forensic examinations (512 inpatient and 176 outpatient) were conducted in 2003. The National Board of Forensic Medicine issues fixed rates for each evaluation. For inpatient examination in 2003, the rate was about 20800 EUR, and for outpatient the rate was 8550. Today these rates will be somewhat higher (Table 1).

Ole and Birger

DENMARK

The examination of Ole reveals that he was psychotic during both the offence and the examination, and he is regarded as suffering from schizophrenia. He will, therefore, be included under section 16, and under section 68 he will probably be sent to hospital psychiatric care. After a while, if the court so decides, he may be transferred to outpatient care.

Birger will most *likely not* be included under section 16, but probably under section 69 due to his personality disorder. If the court regards him especially dangerous, he may be detained. More probably he will not be included by section 68, and therefore get an ordinary sentence.

Table 1. Expenses for forensic psychiatric examinations in Scandinavia (in Euro†).

	Denmark	Norway	Sweden
Number of minor reports	*	750	1907
Cost each report	*	475	690
Sum expenses minor reports	*	356,250	**1,315,830**
Number of major (inpatient) reports	50	*	512
Cost each report	21200	*	20850
Sum expenses major inpatient reports	1,060,000	*	**10,675,200**
Number of major (outpatient) reports	550	500	176
Cost each report	2900	3800	8600
Sum expenses major outpatient reports	1,595,000	1,900,000	**1,513,600**
Total	2,655,000	2,256,250	**13,504,630**

*Not testable.
†Author's calculations.

NORWAY

Ole, who is suspected of severe mental illness, may firstly be subjected to a preliminary psychiatric examination. This will probably conclude with a need for a full psychiatric examination. If he is found to be suffering from active psychotic symptoms, both at the time of the offence and at the time of the examination, Ole will be included under section 44. If so, he will probably also be included under section 39, and he will be sentenced to psychiatric care.

Birger might also undergo a minor psychiatric examination. If this examination concludes with some doubt concerning his criminal accountability, a major forensic psychiatric examination will be recommended. If so, the most probable conclusion will be that Birger was neither psychotic nor suffering from severe mental retardation. It might be a question regarding his state of consciousness at the time of the murder. Because the eventually diminished consciousness was self-inflicted, he will not get a reduced sentence, and he will be sent to ordinary prison. If he is found to be at a risk of committing dangerous acts, the court might consider using section 39c, detention, instead of a time-limited punishment.

SWEDEN

Ole might be suspected of suffering from a serious psychiatric disturbance, and first be subjected to a minor forensic examination (section 7). In cases where the court finds that the offender is of little risk of relapse into serious criminality, an extended section 7 report (performed by a specialist in forensic psychiatry) might be sufficient for the court to send Ole to psychiatric treatment without court control. However, it is most likely Ole will undergo a full forensic psychiatric examination. After 3 weeks in a forensic psychiatric clinic, Ole most likely will be found suffering from APS according to section 6. In that case, the court will, because of the serious nature of the crime, probably send him to psychiatric treatment with court control.

Birger might be subjected to the same procedure as Ole, but though the crime is serious, it is not compulsory with an examination, only if there is a suspicion of APS. Whether Birger is found suffering from APS is doubtful. If he is found suffering from a serious personality disturbance, he *might* be found suffering from APS, because of the broad definition of this legally defined condition, and sent to psychiatric treatment. Most likely, he will not be found suffering from APS and given an ordinary sentence.

Evaluation of the Scandinavian forensic psychiatric systems

The question that arises is how the forensic psychiatric experts work, given each countries legislation and organizational frames, i.e. what methods do they use and what premises constitute their conclusions? To evaluate this 60 Scandinavian court reports were studied.

Method

The study sample consisted of 20 forensic psychiatric reports from Denmark, Norway and Sweden. To obtain comparability, the reports were chosen according to the following criteria: 1) the crime charged should be homicide or attempted homicide; 2) the defendant should be a male with Scandinavian origin (to omit language and cultural problems); and 3) the reports should be from the period 1999–2001.

All reports were scored according to a standardized rating form developed by the author. The form consisted of 53 variables divided into five main sections: 1) basic demographic data on the defendant; 2) setting of the observation; 3) profession of the expert; 4) methods used; and 5) premises that founded the basis for the conclusions. The form was developed in order to obtain systematic coverage of information that was positively stated and evaluated in the reports.

Two aspects were registered regarding the setting of the observation: the first was the *time span* between

when the crime was committed until a) the court decided that a forensic report should be made, b) until the experts got the case, c) the first meeting with the defendant and d) when the report was finished. The second aspect was the *place* of the observation, *duration* and *number* of sessions with the defendant.

The material was analysed by SPSS-PC version 11.0 to obtain descriptive statistics of the variables. Continuous variables were analysed by ANOVA with Bonferroni's correction for multiple comparisons and categorical variables by chi-square. To check inter-rater reliability, an experienced forensic psychiatrist independently scored 10 of the reports concerning sections 3, 4 and 5. The inter-rater reliability was estimated by Pearson's r. Only absolute numbers of 20 from each country and of 60 from the whole sample are reported. The level of significance was set at $P < 0.05$, and two-sided tests were applied.

The National Forensic Authorities of all the countries approved the study.

Results

Inter-rater reliability

The inter-rater reliability of the author and the psychiatrist (PH) on the three last sections (3, 4 and 5) of the form was: methods 0.83, profession of the experts 0.95, premises 61 and total 0.83.

Registered data concerning the defendant

Valid background data concerning the defendant was registered in all reports. All contained age, education level, employment and psychiatric history. However, in 18 cases, there was no indication whether the defendant had undergone earlier forensic examination. Similarly, seven reports lacked information concerning whether the defendant was intoxicated at the time of the crime.

The setting

As a whole, it was evident that the time between the committed crime and the finished forensic report was significantly shorter in Sweden compared to Norway, with Denmark in between (Table 2).

In Sweden, all forensic examinations took place in a forensic psychiatric clinic. In Norway, nine of the observations took place in a prison and five at the expert's office. The rest took place in other settings and in two cases, place of observation was not given. In Denmark, six of the examinations were conducted in a psychiatric institution and three in a forensic psychiatric clinic. One observation took place in the office of the expert and the rest was not accounted for. The number of hours spent with the defendant was not registered in any of the reports. Numbers of sessions with the defendant was only registered in 16 of the Norwegian reports with a mean of 3.3 sessions (minimum two, maximum 10).

The experts

A psychiatrist always had the main responsibility for the reports. In Sweden, there was always a team making the report: psychiatrist, psychologist, social worker and one representative from the ward staff, with a mean of five experts involved. In Denmark, teamwork took place in some cases (psychiatrist, psychologist and social worker). In four cases, the psychiatrist worked alone.

The content of the report and methods used

The methods applied by the experts varied between the countries. However, all the experts conducted a clinical interview with the defendant, and most of them had collected information from a third party (55 of the cases). The five reports lacking such information were Norwegian. All experts stated information about the defendant's present psychiatric state. Nevertheless, the countries differed concerning the other methods applied, regarding both number and kind of methods used. The Swedes applied significantly more tests and other instruments compared to Norway and Denmark ($P < 0.001$). This was evident both concerning use of diagnostic inventories and global functioning scales (such as SCID I and II, GAF), different risk assessment instruments (HCR-20 and PCL – SV), and clinical medical examination. However, MMPI was most frequently applied by the Norwegian experts (Table 3).

The Danish reports came in a position between the Swedish and the Norwegian reports, regarding use of different tests and instruments. The two methods most commonly applied by Danish experts were Rorschach and WAIS, and in the majority of the cases, they conducted a clinical medical examination of the defendant.

The Scandinavian reports had a mean length of 22 pages. The mean length in Denmark was 16.5 and in Sweden 22 pages. Norway had significantly longer reports with a mean of 28 pages ($P < 0.001$).

Premises for the experts' conclusions

A clear conclusion according to the mandate was stated in all the reports including a statement of the present mental status of the defendant. Sweden, however, was the only country that systematically recorded the defendant's diagnosis in 19/20 reports. In both Norway and Denmark, this number was five out of 20. No reference was made to medical, psychiatric, psychological or other types of literature or theory in the reports, except for one Norwegian report. In 57 of the reports, the experts expressed no doubts concerning the validity of their conclusions.

Table 2. Mean time in the completion of a forensic psychiatric report (in days).

	Denmark	Norway	Sweden	*P*-value
From crime committed to court decision	28	109	42	0.047
From court decision to expert's receiving case file	12.5	Not registered	4.6	*
From receiving case file to first meeting the defendant	Not registered	Not registered	Not registered	*
From first meeting with the defendant to finished report	61	90	Not registered	*
From crime committed to finished report	**120**	**190**	**73**	**0.003**

*Not testable.

The mean length of discussion in all reports was approximately 2.5 pages. Denmark had a mean of 1.5 pages while the Norwegian reports had a mean of 2.2 pages. The Swedish reports consisted of 3.4 pages of discussion, which included the psychiatrist's total evaluation of the defendant ($P < 0.001$).

The tests and instruments used were not always referred to in the premises for the conclusions. An indication of this is seen in Table 4. The numbers refer to defendants who have undergone one or more tests, which have or have not been referred to.

Discussion

The forensic psychiatric systems differ in many respects in the Scandinavian countries regarding evaluation of *mens rea*, i.e. the state of mind in the offender at the time of the crime. These differences, nevertheless, seem mostly to be reflected legally and in the way of organizing forensic psychiatric examinations. Denmark seems to have the clearest criteria for initiating a forensic psychiatric examination, but they only control reports that conclude that the defendant is mentally ill and special provision order is suggested. This leaves the problem of false negative evaluations. Norway has a disturbingly long time span from committed crime to a finished report, which has legal and witness-psychological implications. All Norwegian court reports are subjected to quality control, while Denmark and Sweden only control selected reports. Surprisingly, a severe criminal act is not a criterion for initiating a forensic psychiatric examination in Sweden, which again runs the risk of false negative evaluations. Severe mental retardation is not considered a criterion for APS in Sweden, but on the other hand, their inclusion criteria for APS are very broad compared with the other Scandinavian countries. This apparently ideological view on defendant's culpability might be some of the reason behind some debated cases in Sweden in recent times.

Experts make forensic judgements and recommendations, but in the reports of this study, the basis for their assessments was rarely stated. Making a valid judgement is sometimes a quite difficult task due to contradictory information or lack of information. Clinical expertise

Table 3. Methods used in the Scandinavian psychiatric forensic court reports.

	Denmark	Norway	Sweden	Total	*P*-value
Scid I	0	0	2	2	0.113
Scid II	0	1	12	13	<0.001
GAF	0	0	19	19	<0.001
Panss	0	0	0	0	*
MMPI	0	4	2	6	0.108
Rorschach	7	0	3	10	0.012
WAIS	7	3	14	24	0.002
Other	14	5	17	36	<0.001
HCR-20	1	0	3	4	0.153
PCL-SV	1	0	7	8	0.002
VRAG	0	0	0	0	*
SVR-20	0	0	1	1	0.362
EEG	3	3	2	8	0.896
Pet/MR/CT	0	1	4	5	0.049
Clinical medical examination	13	1	19	33	<0.001
Other somatic tests	1	4	10	15	<0.001
Total	47	22	115	184	<0.001

*Not testable.

Table 4. Referrals to tests and instruments stated in premises for the conclusions.

	Denmark	Norway	Sweden	*P*-value
Referred to structured interviews (SCID I and II)	None	1/1	4/13	*
Referred to psychological tests or risk assessments	5/14	4/6	15/20	0.66
Referred to physiological examinations and tests	2/13	2/5	8/19	0.26

*Not testable.

has traditionally been regarded as something internal, personalized and implicit, i.e. exclusively belonging to the expert (23, 24). For the experts themselves, it will be very difficult to "unpack" their practised automatic judgement process and, thereby, to be subject for evaluation by others (25). Faust & Ziskin (3) give a systematic overview of factors limiting clinical judgement. Clinically based judgements will always be encumbered with uncertainties. Rabinowitz (26) shows several systematic errors in clinician's and expert's judgement processes: biases, overlooking symptoms, little attention of base rate, overconfidence, etc. Turk & Salovey (27) note that little consideration is given to the decision-making process, and subsequently decision-making is ignored in clinical textbooks.

Replacing all forensic psychiatric evaluations and predictions with statistical and actuarial models might yield more accurate predictions on group levels, but they cannot replace experts because they are better fit to recognize and synthesize exceptions to the models. Furthermore, current automatic assessment programmes and statistical prediction rules are so far of limited value (28). Gudjonsson (29) notes that: "With experience experts are commonly able to carry out an assessment which is more focused on the relevant and salient legal and psychological issues", and he continues: "What is striking about some cases of miscarriage of justice . . .", ". . .. is that the expert assessment, even when conducted by eminent and experienced experts, can on occasions be seriously flawed. It seems that few experts, no matter how brilliant and experienced, are infallible and immune from making mistakes."

According to Rosenqvist (1), several factors may influence the forensic assessments. Unclear mandate, experts lacking sufficient knowledge in both clinical and legal matters, and incomplete assessments of the defendant and badly written reports, are all factors that might threaten both the validity of reports and the legal safeguards of the defendant. To this list, I would add the lack of formal knowledge of decision-making theory. The Bjugn case in Norway is a good example, where the experts concluded that children had been sexually molested based on specific anatomical criteria. They concluded so without obtaining the basic knowledge of how many children might have the same criteria without any history of molestation, i.e. they drew falsely positive conclusions (24).

However, a broader use of standardized actuarial-based methods, presenting for the courts all the premises (the settings, applied methods, literature and theories) and stating the uncertainties behind the conclusions, might improve the quality of the forensic psychiatric reports in several ways: the court can make a decision closer to the same premises of the experts, and additionally, the reports will be more explicit and verifiable and, thereby, increase the legal safeguards of the defendant. Quality controls of all the court reports as practised in Norway should be mandatory in light of the above-mentioned points.

The sample of 60 evaluated reports is too small (about 550–600 reports are issued each year in each of the countries, 60/5000 = 1.2%) to allow for more definite generalizations concerning the quality and content of the Scandinavian forensic reports. The sample, however, should be sufficient for a hypothesis-generating purpose, since significant differences are robust. Omitting groups of ethnic minorities, women and crimes other than homicide supported the limited generalization. The inter-rater correlation of 0.61 concerning premises for the conclusions may indicate that this item could be subject to different interpretations.

Forensic psychiatry is, contrary to some of its critics, dynamic. Obtaining a new cohort of reports can confirm or refute findings of this study. It could also check whether or not there is a time trend among forensic psychiatric experts towards more use of research-based methods.

Acknowledgements—My thanks to Chief psychiatrist Peter Kramp, and Retslegerådet (Denmark), Professor Alv A Dahl, chief psychiatrist Stein Ikdahl, director Bjørn Østberg, leader of the Forensic Psychiatric Commission Randi Rosenqvist, psychiatrist Pål Hartvig, statistician Trond Moger (Norway), Professor Sten Levander, psychiatrist Käthe Elmgren and Rättsmedicinalvärket (Sweden).

References

1. Rosenqvist R. Quality and standards in forensic psychiatric assessments. Nordisk Rettsmedisin. Paper presented at the IV Nordic Psychiatric Symposium. Helsingør August 2001;3/4:54–7.
2. Kongshavn H. Rettspsykiatrien – slik fangene ser den. Institutt for kriminologi og strafferetts skriftsserie 2; 1987.
3. Faust D, Ziskin J. The expert witness in psychology and psychiatry. Science 1988;241:31–5.
4. Halvorsen P. Rettspsykiateren – dommer uten kappe? Tidsskr Nor Lægeforen 2000;120:859–60.
5. Price R. On the risks of risk prediction. J Forensic Psychiatry 1997;8:1–4.

6. Ellingsen D. Kan vi stole på rettspsykiatrien? Universitetsforlaget; 1987.
7. Gunn J, Taylor PJ. Forensic psychiatry, clinical, legal and ethical issues. Oxford: Butterworth-Heinemann; 1993.
8. Grøndahl P, Holum L. Rettspsykiatriske erklæringer, holder de mål? Lov og Rett 1997;4:208–13.
9. Elmgren K. Bedömningar av rättspsykiatriska utlåtanden. I socialstyrelsens Rättsliga råd 1997. Rättsmedicinalverket 1999; Information 2.
10. Elmgren K. Sjuk eller frisk. Vård eller straff. Genomgång av rettspsykiatriärenden år 2000 i Rettsliga rådet. Socialstyrelsen. Stockholm 2001.
11. Davidsen PE. Norsk strafferettspsykiatri: En sammenligning av norske og svenske rettspsykiatriske erklæringer i relasjon til ny lov om strafferettslige utilregnelighetsregler og særreaksjoner i Norge. Hovedoppgave (unpubl). Universitetet i Tromsø 1999.
12. Hartvig P, Rosenqvist R, Stang HJ. Bevisstløshet i strafferetslig forstand i Norge 1981–2000 Tidsskr Nor Lægeforen 2003;123:1831–4.
13. Holmberg G. Forensic psychiatric practice in the Nordic countries. Nord J Psychiatry 1997;Suppl 39:7–14.
14. Memon A, Vrij A, Bull R. Psychology and law. Truthfulness, accuracy and credibility. New York: Wiley; 2003.
15. Sestoft D, Engberg M. Law and mental health in Denmark. Int J Law Psychiatry 2000;23:533–40.
16. Sveriges Offentliga Utredningar. Psykisk störning, brott och ansvar 2002:3.
17. Greve V, Undmarck Larsen B, Lindegaard P. Kommenteret straffelov: Almindelig del: Borgerlig straffelov af 15. April 1930, med senere ændringer (4th ed.) Copenhagen: Jurist- og Økonomforbundets Forlag 1991. In: Sestoft D, Engberg M. Law and mental health in Denmark. Int J Law Psychiatry 2000;23: 533–40.
18. Kullgren G, Grann M, Holmberg G. The Swedish forensic concept of severe mental disorder as related to personality disorders. Int J Law Psychiatry 1996;19:191–200.
19. Holmberg G. Swedish legislation and organisation concerning mentally disordered offenders. Paper at Nordic forensic psychiatric conference held at Helsingør; 2001.
20. Rosenqvist R, Rasmussen K. Rettspsykiatri i praksis. Universitetsforlaget; 2001.
21. Socialstyrelsens författningssamling (SOSFS) Föreskrifter och almenna råd Rettspsykiatrisk undersökning; 1996:14.
22. NOU 2001:12. (Norges offentlige utredninger) Rettsmedisinsk sakkyndighet i straffesaker. Oslo.
23. Dawes RM, Faust D, Meehl PE. Clinical versus actuarial judgment. Science 1989;243:1668–74.
24. Kirkebøen G. Skjønn, formler og klinisk praksis: Hvorfor vurderer erfarne klinikere så dårlig enda de vet så mye? Tidsskr. for Norsk Psykologforening 1999;36:523–37.
25. Hastie R, Dawes RM. Rational choice in an uncertain world. London: Sage; 2001.
26. Rabinowitz J. Diagnostic reasoning and reliability: A review of the literature and a model of decision-making. J Mind Behav 1993;4:297–316.
27. Turk DC, Salovey P. Cognitive structures, cognitive process and cognitive behaviour modification: II. Judgements and inferences of the clinician. Cognitive Therapy Research. 1985;9:19–33. In Rabinowitz (26).
28. Garb HN. Computers will become increasingly important for psychological assessment: Not that there is anything wrong with that! Psych Assess 200;1:31–9.
29. Gudjonsson G. Implications of poor psychological evidence. Expert Evidence 1993;2:120–4.

Pål Grøndahl, Ph.D., Centre for Research and Education in Forensic Psychiatry, Ullevaal University Hospital, Gaustad, Sognsvannsveien 21, NO-0320 Oslo, Norway.