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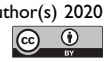
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Constructing criminal insanity: The roles of legislators, judges and experts in Norway, Sweden and the Netherlands

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Abstract
This article provides a discussion about criminal insanity regulation in Norway, Sweden and the Netherlands, with a focus on the roles of legislators, judges and experts in the concretisation of the legal meaning of criminal insanity. The authors recognise that these three countries reflect different ideal type rule constructions that are interesting to study comparatively. The article addresses the following overall questions: To what extent and in what way do the different rule constructions also involve different views on the roles of legislators, judges and experts? And in case of competing models, which is the better solution? To investigate and eventually answer these questions, the authors analyse the content and legislative considerations of the relevant rules, how these rules are applied and understood by judges and experts, and how different understandings of insanity, of legislators, judges and experts, depend on each other. The authors show how the different rule constructions represent different considerations on the adequate roles of the legislator, judges and experts. They argue that what is important is not what precise division of roles that is settled, but

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that this interplay functions to secure clear and robust rules, and that each of the three countries has room for improvement in this regard.

Keywords
Criminal insanity, criminal law, forensic psychiatry, comparative law, legislation

Introduction

How the law should regulate criminal insanity, and more broadly deal with mentally disordered offenders, is a contested matter. Different countries have different rule constructions.[1] Countries may also review and change their rules from time to time, for example, in the aftermath of a serious and complicated insanity case. One recent example is the law reform in Norway in the aftermath of the case that followed Anders Behring Breivik's killing of 77 people in Oslo and on Utøya in Norway on 22 July 2011.[2]

A core reason for the continuous controversy around the insanity rules is that criminal insanity is a 'multidimensional phenomenon' located at the intersection of law (including its philosophical dimensions) and medicine.[3] The criminal insanity doctrine does not only involve (positive) legal premises but is also closely tied to philosophical premises about human agency and responsibility, as well as empirical premises about how mental disorders affect the individual. Criminal insanity rules must thus both reflect philosophical accounts of why mental disorders are (or are not) relevant to responsibility and draw from medical knowledge about these disorders.[4] At the same time, the rules must as *legal* rules comply with demands of legal certainty, equal treatment and premises related to the law's function as a sociopolitical instrument more generally.[5]

Bearing this complexity in mind, it is not surprising that one of the most contested matters regarding the regulation of criminal insanity is the functional division of labour between judges and juries on the one hand and medical/mental health experts on the other. The insanity rules have been criticised for providing the experts with too much power in deciding the outcome of criminal

1. For a comparative overview of criminal insanity regulations, see RJ Simon and H Ahn-Redding, *The Insanity Defense, the World Over, Global Perspectives on Social Issues* (Lexington books, Lanham 2008); Carl-Friedrich Stuckenberg, 'Comparing Legal Approaches: Mental Disorders as Grounds for Excluding Criminal Responsibility' (2016) 4 *Bergen Journal of Criminal Law and Criminal Justice* 48–64 <https://boap.uib.no/index.php/BJCLCJ/article/view/1026> accessed 2 February 2020.
2. See L Gröning and GF Rieber-Mohn, 'NOU 2014:10 – Proposal for New Rules Regarding Criminal Insanity and Related Issues, Norway Post 22 July' (2015) 3 *Bergen Journal of Criminal Law and Criminal Justice* 109–31 <https://boap.uib.no/index.php/BJCLCJ/article/view/830> accessed 17 February 2020; L Gröning, 'Hvordan skal vi avgjøre om alvorlig sinnslidelse innebærer utilregnelighet? Refleksjoner om lovforslaget i Prop. 154 L (2016–2017)' (2017) 5 *Bergen Journal of Criminal Law and Criminal Justice* 77–85 <https://boap.uib.no/index.php/BJCLCJ/article/view/1384> accessed 17 February 2020.
3. See L Gröning, KH Melle and UK Haukvik, 'Criminal Insanity, Psychosis and Impaired Reality Testing in Norwegian Law' (2019) 7 *Bergen Journal of Criminal Law and Criminal Justice* 27–59 <https://boap.uib.no/index.php/BJCLCJ/article/view/2879> accessed 17 February 2020.
4. For an account that integrates perspectives from philosophy, law and psychiatry, see Gerben Meynen, *Legal Insanity. Explorations in Psychiatry, Law, & Ethics* (Springer, Switzerland 2016).
5. See further L Gröning, 'Tilregnelighet og utilregnelighet: Begreper og regler' [2015] 102 *Nordisk Tidsskrift for Kriminalvidenskab* 112–48.

insanity cases and insanity judgments have been denounced for relying on underdeveloped or invalid assumptions about mental disorders.[6] In this article, we aim to contribute to this discussion about criminal insanity regulation by comparing and analysing the regulation in Norway, Sweden and the Netherlands, with a focus on the roles of legislators, judges and experts in the concretisation of the legal meaning of criminal insanity.

The outline of the article is as follows: In the second section, we will provide some starting points, explaining how we approach the comparative analysis. In the third, fourth and fifth sections, we will describe how Norway, Sweden and the Netherlands, respectively, deal with mentally disordered offenders. We will have a certain focus on Norway and provide a somewhat more detailed explanation of the Norwegian system. In the sixth section, we provide our comparative analysis before we draw some conclusions.

Starting points for the comparative analysis

How different countries deal with mentally disordered offenders has been subject to comparative analysis which has provided us with knowledge about criminal insanity rules in different countries and related legal and forensic systems and procedures. The roles of the judges and experts have also been analysed in this context. To a lesser extent, however, the role of the legislator, and the division between legislators, judges and experts, has been studied. At the same time, the role of the legislator is central to the regulation of criminal insanity, not least because the criminal law must comply with rule of law requirements of legal certainty and equal treatment.[7]

We will in the following provide an analysis of the (statutory) insanity rules in Norway, Sweden and the Netherlands, and how the rule constructions in these countries relate to different views upon the adequate division between legislators, judges and experts. These countries share a civil legal culture, in terms of shared constitutional values, but also represent different more specific legal systems and cultures. They also have rule constructions that represent different solutions to the handling of mentally disordered offenders.

Norway has a long tradition of a rule based upon a 'medical model' that defines criminal insanity exclusively through a specified medical condition, disregarding how the condition impacted on the defendant's commission of the crime. As a clear manifestation of this model, criminal insanity has for many years been equated with being 'psychotic' at the time of the offence. As a result of the law reform that followed the 22 July case, a new rule will enter into force on 1 October 2020 that replaces the psychosis criterion with criteria which opens for wider judicial discretion.[8] The Netherlands uses an 'open rule' that does not provide for any specified definition of insanity but leaves that matter to judicial (and expert) discretion. In contrast to Norway, however, this rule is understood also to include requirements that the relevant medical conditions impacted on the commission of the crime. Sweden, lastly, has chosen not to regulate insanity at all in terms of criminal responsibility, but only as a matter for sentencing – which provides the judges as well as the experts with large discretionary power.

6. Deborah W Denno, 'The Place for Neuroscience in Criminal Law' in D Patterson and MS Pardo (eds), *Philosophical Foundations of Law and Neuroscience* (OUP, Oxford 2016) 69–84; Beatrice R Maidman, 'The Legal Insanity Defense: Transforming the Legal Theory into a Medical Standard' (2016) 5 BUL Rev 1831–63.
7. See further in the 'Concluding comparative reflections' section below.
8. See further in the 'Norway: A medical model' section below.

Hence, these three countries reflect different ideal type rule constructions that are interesting to study comparatively. To what extent and in what way do the different rule constructions also involve different views on the roles of legislators, judges and experts? And in case of competing models, which is the better solution? In order to investigate and eventually answer these questions, we will for each country analyse the content and legislative considerations of the relevant rules, how these rules are applied and understood by judges and experts, and how these different understandings of insanity, of legislators, judges and experts, depend on each other. Such an approach involves in the end the recognition that criminal insanity as a multidimensional phenomenon cannot be concretised at one of these levels alone.

Norway: A medical model

The legal rule

Criminal capacity at the time of the offence is in Norwegian law, as in most countries, a basic condition for criminal responsibility. Only certain conditions that are currently specified in the Penal Code section 20, first paragraph, letters a–d entail criminal incapacity. The rule in section 20 will be replaced by a new rule on 1 October 2020. For the purpose of our analysis of the different rule constructions in the different countries, it is however important to understand the earlier rule, its background and why there has been a legal reform. On this basis, we will describe the new rule in 'The legal reform after 22 July 2011 and the new rule for criminal insanity' section below. Until 1 October 2020, section 20 first paragraph determines that the perpetrator is absolved from criminal responsibility if he or she was (a) under 15 years old, (b) psychotic, (c) severely mentally disabled or (d) had a severe impairment of consciousness at the time of the offence.[9]

The rule about criminal insanity, which is our focus, is found in letter b – 'psychotic'. Criminal insanity as a matter of psychosis reflects in this regard a specific medical model that identifies insanity with a medical condition exclusively – disregarding whether the condition affected the defendant's cognitive or control capacities and the commission of the crime.[10] The criterion 'psychotic' refers more specifically to the medical characterisation of psychosis. The rule requires that the perpetrator's ability to make a realistic assessment of his or her relationship to the surrounding world was significantly impaired at the time of the act.[11] This is commonly understood as a requirement that the psychosis must be discernible at the time of the offence through obvious symptoms.[12] It is not sufficient for the perpetrator to have a diagnosis of a psychotic disorder, such as schizophrenia. A person who suffers from a psychotic disorder but currently without significantly impaired reality testing/psychosis due to, for example, medication or natural

9. For a further explanation of these rules, see L Gröning, EJ Husabø and JRT Jacobsen, *Frihet, forbrytelse og straff: en systematisk fremstilling av norsk strafferett* (2nd edn Fagbokforlaget, Bergen 2019) 484–506.
10. The different circumstances entailing incapacity all understood as excuses in the general structure of the criminal law, where it is the perpetrator's criminal capacity at the time of the offence that must be proven by the prosecution. It is also worth noting that also the other grounds for criminal incapacity, in contrast to many countries, are defined by specifying a particular condition – young age, unconsciousness and mental retardation – which, when established at the time of the offence, lead to unconditional exoneration from criminal responsibility.
11. See Ot. prp. nr. 87 (1993–1994) s 22, NOU 1990:5 s 38, NOU 2014:10 s 49, Prop. 154 L (2016–2017). See also Gröning, Husabø and Jacobsen (n 9) 495–96.
12. See Gröning, Husabø and Jacobsen (n 9) 496.

fluctuation in psychosis symptoms does not qualify for criminal insanity.[13] What significantly impaired reality testing more specifically requires, in terms for instance of specific symptoms, is to a certain extent unclear in Norwegian law, which also opens for judicial (and expert) discretion.[14]

According to section 62 of the Penal Code, the court may decide to commit an offender who is exempt from punishment pursuant to section 20 first paragraph letter b to compulsory psychiatric care. This outcome is regulated in the Penal Code as a 'special criminal sanction' that is not formally 'punishment'.[15] Punishment can in Norwegian law only be used on offenders who are criminally sane and responsible.

Legislative considerations behind the rule

Why has Norway established such a medical model that identifies insanity only with mental disorder, disregarding how it impacted on the commission of the crime? The rule was introduced by an amendment in 1997 into the former 1902 Penal Code in section 44 that entered into force in 2002.[16] The medical model as such has, however, existed much longer than that. Already the 1842 Criminal Code was to a certain extent built upon a medical model, and it was fully established in 1929 when the 1902 Penal Code was revised.[17] In the earlier version of the rule, however, the legal criterion for insanity was 'sinnssyk', which translates precisely as 'insane'. This criterion then also included mental retardation of a high degree and serious instances of autism spectrum disorders. Through the 1997 amendment, this criterion was removed, and was split into the two new criteria that today are specified in section 20 letters b and c: 'psychotic' and 'mentally retarded to a high degree'. The psychosis criterion was retained without changes in section 20 in the current 2005 Penal Code.

The medical model was (and still is) justified by arguments about legal certainty and an adequate functional division between the legislator and the courts. In the preparatory works, it is stated that deciding the question of exemption from punishment should depend as little as possible on the judge's own discretion. Conditions of criminal insanity must therefore be described in terminology that is recognised in psychiatric science.[18] This focus on legal certainty is generally strong in Norwegian criminal law.[19]

At the legislative level, the view that psychosis impacts in a certain way on the perpetrator's capacity for responsible behaviour has been a primary justification. Generally, justifications for punishment in Norwegian law emphasise that criminal responsibility presupposes that the

13. In this regard, Norwegian law operates with a relatively high threshold for criminal insanity. As a comparative example, the Danish criminal insanity rule includes those with a diagnosis of a psychotic disorder, and there is no equivalent requirement of seriousness, see further Kamber, 'Psykisk syge lovovertrædere i et komparativt lys' [2013] 100 *Nordisk Tidsskrift for Kriminalvidenskab* 358–68.
14. Gröning, Melle and Haukvik (n 3).
15. See further Martin Mindestrømmen, 'Impending Danger: The Meaning of Danger as a Legal Requirement for Involuntary Psychiatric Treatment in the Norwegian Criminal Justice System' (2019) 7 *Bergen Journal of Criminal Law and Justice* 110–35 <https://boap.uib.no/index.php/BJCLCJ/article/view/2883> accessed 17 February 2019; Øyvind Holst, 'Court-Ordered Compulsory Psychiatric Care and the Prosecutor's Control Function' (2019) 7 *Bergen Journal of Criminal Law and Justice* 136–47 <https://boap.uib.no/index.php/BJCLCJ/article/view/2884> accessed 17 February 2019.
16. See lov 17. januar 1997 no 11 and Ot. prp. nr. 87 (1993–1994).
17. See Svein Atle Skålevåg, *Utilregnelighet: En historie om rett og medisin* (Pax Forlag, Oslo 2016) for the historical development of the medical model in Norway.
18. See Ot. prp. nr. 87 (1993–1994) 28.
19. See Gröning, Husabø and Jacobsen (n 9) 63–65.

perpetrator has had a choice of (more than one) action and can be blamed for the choice taken. The principle of guilt/fault is here the primary foundation: only those who could and should have acted differently, and therefore can be blamed, should be held responsible and punished. Some offenders must, however, be deemed to be in such a confused and abnormal state of mind at the time of the offence that they should not be held accountable for their actions. Offenders with a pronounced severity of psychotic symptoms have, in this regard, been assumed to lack the capacity for responsible behaviour.[20] In addition to this guilt-based justification for the psychosis criterion, crime prevention is emphasised as another purpose of law. The view is typically that there is no benefit from holding liable those who are in a confused or profoundly abnormal state of mind. The criminal justice system's regulating effect on behaviour – that is, its ability to induce members of the public to obey the law through deterrence and the formation of norms – is not weakened by absolving these persons of criminal responsibility.[21]

The establishment of the medical model must also be understood in light of the development of psychiatry in Norway, and its influence on the legal understanding of insanity. The development of the medical model in Norway was here surrounded by a scientific optimism, and a belief that insanity could be identified by psychiatry, through scientific methods.[22]

The role and mandate of the experts

In Norway, forensic experts are appointed by the courts, not by the parties,[23] and normally two independent experts are appointed. The courts use a standard mandate, composed in collaboration between the Prosecutor General, the Court Administration, and the Norwegian Board of Forensic Medicine.[24] Under this mandate, the forensic experts are asked to evaluate the mental condition of the perpetrator in relation to the psychosis criterion in the Penal Code s 20. More specifically, when forensic experts evaluate a defendant, they first establish a diagnosis based on the criteria listed in the ICD-10 manual.[25,26] This is to provide a more transparent basis for the clinical (and the following legal) evaluation. On this basis, they will under the current mandates also evaluate whether the perpetrator was psychotic as the Penal Code requires, which requires them to make legal statements about the meaning of the rule.[27] In order to secure a certain quality and provide for a uniform forensic practice, the Norwegian Board of Forensic Medicine monitors all of these evaluations. In 2018, there were in total 479 evaluations that concerned criminal insanity

20. See NOU 2014:10 111.
21. See NOU 2014:10 85–86. See also Gröning and Rieber-Mohn (n 2) 113.
22. See Skålevåg (n 17) 128–29.
23. It should be noted here that the prosecution according to Norwegian law have a duty to be objective, see further Gert Johan Kjelby, *Påtalerett* (Cappelen Damm, Oslo 2017) 241–57.
24. See newsletter no 22 from the Norwegian Board of Forensic Medicine for the content of this mandate. Available at <http://www.sivilrett.no/nyhetsbrev.339568.no.html> accessed 2 February 2020.
25. This practice was established through a newsletter from the National Board of Forensic Medicine in February 2004 that provided a distinct recommendation that every person observed should be diagnosed according to the criteria in ICD-10. See newsletter no. 10. Available at <http://www.sivilrett.no/nyhetsbrev.339568.no.html> accessed 2 February 2020.
26. World Health Organization. The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines (Geneva: World Health Organization, 1992).
27. NOU 1990:5 42.

(Norwegian population: 5.5 million).[28] A training course for psychiatrists and psychologists is also offered by SIFER (national network for security, prison and forensic psychiatry).

Apart from the requirement that ICD-10 should be used, there are no unified diagnostic guidelines for Norwegian forensic practice. Structured diagnostic interviews and symptom severity assessment tools are used by some but not all forensic experts. A core challenge in this context is that there is no clear and uniform understanding about what significantly impaired reality testing amounts to in forensic practice – and such an understanding is also difficult to draw from medical research.[29] Mental health institutions are often geographically separated, which may allow for local diagnostic schools. Although the National Board of Forensic Medicine is understood to contribute a more consistent forensic practice, a certain diversity still remains. Moreover, the experts' focus on criteria-based diagnostics (ICD-10) may link criminal insanity to specific diagnostic categories. Paranoid schizophrenia is, not surprisingly, a frequent diagnosis where Norwegian experts conclude that the defendant was psychotic and criminally insane.[30]

The interplay between judges and experts

It is always the court that has the final say about whether a defendant is psychotic and should be absolved from responsibility. However, the courts rely, to a significant extent, on forensic experts and justify their legal conclusions through clinical and diagnostic evaluations.[31] Therefore, the courts' legal argumentation about insanity is in most cases full of medical language, and hinges largely upon psychiatric diagnoses and symptoms. Generally, the courts do not provide any further clarification of the *legal* meaning of the psychosis criteria other than what follows from the preparatory works.[32] Reading criminal insanity judgments often leaves one wondering how the court found its way from the diagnostic evaluation of the offender to the legal conclusion about psychosis and insanity. It is mainly in cases where there is disagreement between the experts that the courts provide a more independent evaluation. However, the courts in these cases typically do not provide any clarification of the *legal* cut-off points for psychosis amounting to criminal insanity. Instead, the focus is on reviewing the *medical* statements of the experts. The well-known Breivik case provides an illustrative example, although it contained an unusually long evaluation from the court. In this case, two pairs of experts came to different conclusions about his diagnosis and sanity; the first pair of experts evaluated him as psychotic, and the second pair evaluated him as non-psychotic.[33]

28. See the annual reports from the Norwegian Board of Forensic Medicine for further statistics. These reports are available at <https://www.sivilrett.no/arsmeldinger.339263.no.html> accessed 17 February 2020.
29. Gröning, Melle and Haukvik (n 3).
30. See the annual reports from the Norwegian Board of Forensic Medicine (n. 28). For the significance of schizophrenia in other countries, see LA Callahan and others, 'The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study' [1991] *Bulletin of American Academy of Psychiatry and Law* 331–38; Michael L Perlin, 'The Insanity Defense: Nine Myths That Will Not Go Away' in MD White (ed), *The Insanity Defense: Multidisciplinary Views on its History, Trends and Controversies* (Praeger, Westport 2017).
31. This is based upon an investigation of all published judgments between 1 January 2013 and 1 November 2018, available at <https://lovdata.no/> accessed 17 February 2020.
32. See further Gröning, Melle and Haukvik (n 3).
33. See Oslo District Court, TOSLO–2011–1888627–24–RG–2012–1153, available in English at <http://lovdata.no/info/information_in_english> accessed 2 February 2020. See also Ingrid Melle, 'The Breivik Case and What Psychiatrists Can Learn from It' [2013] 12 *World Psychiatry* 16–21; Gröning (n 2).

It should here be noted that in some cases where the experts have found that the defendant was not psychotic, the courts have concluded differently from the experts despite the agreement between the expert's evaluations. Most often, however, the court then justifies its disagreement with the experts with reference to the strict standard of proof, and the fact that the expert's conclusion raises too much doubt about the defendant's condition. There are also a few examples where the court emphasises the weight of evidence compared to the expert evaluation in its reasoning.[34] Neither in these cases do the courts typically provide any further legal clarification of the psychosis criterion, or what is required for an impaired reality testing to be serious enough to fulfil this criterion. An analysis into court practice rather confirms that criminal insanity is to a certain extent left to the discretion of the forensic experts.

The legal reform after 22 July 2011 and the new rule for criminal insanity

The rule in the Norwegian Penal Code section 20 had not been subject to much attention until the criminal case in the aftermath of the terrorist attack in the centre of Oslo and on Utøya on 22 July 2011 triggered a wide-ranging discussion about its adequacy. It was questioned whether the criterion 'psychotic' provided for an adequate delimitation of insanity, and whether it provided the experts with too much power to determine legal questions. With this discussion as backdrop, a law commission was appointed to investigate the need for changes. This commission proposed in *NOU 2014:10* to preserve the medical model, though in a considerably watered-down form that also includes 'conditions that are equated with psychosis'.[35]

As a more radical suggestion, the commission proposed to change the role of the experts, in order to reduce their possible influence on the court's judgments. The commission has taken the position that experts should limit their participation to the discipline they know and are educated in, and that the judge has a clear and independent responsibility to irrevocably decide whether the defendant should be convicted or acquitted. Under the commission's proposal, the experts' task is to assess the offender's state of mind exclusively on the basis of clinical and scientific evaluation and in accordance with the international classification system for mental disorders, which is currently ICD-10. The experts should in their statement render a conclusion within this scientific system but should not take position on whether the law's requirement of 'psychosis' (or equivalent) is fulfilled.

As a response to this proposal, the Norwegian Ministry of Justice and Public Security delivered their bill in Prop. 154 L (2016–2017) in June 2017. As regards the role of the experts, the Ministry entirely followed the commission's proposal. The Ministry did, however, not follow the law commission's proposal of the amendments in the insanity rule. The Ministry proposed, instead, a rule that removes the psychosis criterion and replaces it with a criterion that requires that the defendant was not accountable due to serious mental disorder.[36] This rule leaves to the courts to specify the cut-off point for criminal insanity. The proposed rule provides, however, some guidance for this decision. In a second paragraph of the rule, it is stated that when deciding whether a

34. See judgment from Gulating Lagmansrett 19 January 2015 (LG-2015-60583), judgment from Borgarting Lagmansrett 17 June 2013 (LB-2013-58668) and Judgment from Halden Tingrett 22 March 2018 (THALD-2017-172135).
35. See Gröning and Rieber-Mohn (n 2). Linda Gröning, one of the authors of this paper, was a member of this law commission.
36. For a commentary on this proposal, see Gröning (n 2).

person is not accountable, emphasis should be placed on the degree of failure of understanding reality and functional ability.

The intention behind the Ministry's proposal was, similarly to that of the law commission, to introduce a criterion that makes it possible to include other conditions equally serious as psychosis, while retaining psychosis as the central condition for excuse.[37] Still, the proposed rule allows for significantly larger judicial discretion.[38] As such, it breaks with a long tradition of emphasising legal certainty and the role of the legislator – in favour of an increased role of the judge in the determination of the threshold for insanity. Mainly for this reason, the proposal has been widely criticised. The majority of the Justice committee in the Parliament shared this critical view and recommended that the proposal be sent back to the Ministry for further consideration.[39] However, the committee minority that supported the Ministry's proposal consisted of representatives of the political parties in the government.[40] In the final recommendation, the criterion 'serious mental disorder' was replaced with the even more elusive criterion 'severe divergent state of mind', but with no intended substantive differences.[41]

The new rule will enter into force on 1 October 2020. It is thus too early to say something about its application in legal practice and whether it will lead to major changes. What is certain, however, is that the reform will not change the core characteristics of the medical model tradition in Norway; that mental disorder as such is sufficient for insanity. Although the word 'psychotic' will be removed, insanity will still be determined only in relation to the severity of the defendant's mental condition, and without any assessment of how this condition impacted on the commission of the offence. The severity of a psychosis will remain central.[42]

The Netherlands: An open criterion

The legal rule

Criminal insanity is also part of the Dutch criminal justice system. Article 39 of the Dutch Criminal Code (DCC) reads: 'A person who commits an offence for which he cannot be held responsible by reason of mental defect or mental disease is not criminally liable'.[43] This rule provides the legal basis for legal insanity. Notably, it merely states that a person's lack of criminal responsibility must be a result of his mental defect or disease. The rule does not specify what qualifies as such a defect and in which cases it can result in exculpation, or what type of influence exculpates a

37. Prop. 154 L (2016–2017) 64–70.
38. It should be mentioned that psychopathy is explicitly excluded from the sphere of relevant conditions, see Prop. 154 L (2016–2017) 13, 76–77. See also NOU 2014:10 130.
39. See Innst. 296 L (2018–2019) 3–4, 8–9.
40. These political parties have majority in the Parliament. Therefore, the voting in the Parliament was in favour of the proposal, with 52 against 46 votes.
41. This change was made because the criterion 'serious mental disorder' is used also in mental health legislation, but with another meaning than what was intended for the criminal insanity rule.
42. See Prop. 154 L (2016–2017) 13, 69; Innst. 296 L (2018–2019) 3–4.
43. Netherlands, *The Dutch Penal Code (The American Series of Foreign Penal Codes)* (F.B. Rothman, Littleton 1997). On the situation in the Netherlands explained in this section, see E Messina and others, 'Forensic Psychiatric Evaluations of Defendants: Italy and the Netherlands Compared' [2019] 66 *International Journal of Law and Psychiatry* 8. Of note, recently, the wording of Article 39 has changed as far as the reference to the mental disorder is concerned. The implications of this change are not yet clear.

defendant. The Dutch rule is, due to its lack of a legal definition, considered to be an 'open' criterion for insanity. It stands in contrast to the current Norwegian rule that, as explained, defines insanity in terms of being psychotic. It is also an even more open rule than the new Norwegian rule that at least provides for some clarification of the kind of impairments that should be emphasised in the court evaluation. Although there are some other examples of such an open norm, such as the Danish rule, it appears that most legal systems have rules that specify the required effects of a disorder on the defendant's commission of the crime.[44] A well-known example is the Anglo-American M'Naghten rule, which states that a mental disease can exculpate a defendant if, as a result of that disorder, he did not know the nature, quality and/or wrongfulness of the act.

The open Dutch criterion has also been subjected to interpretation, for example, in legal textbooks and it has been concretised, in different ways, and in legal practice. It has been understood to include both diminished responsibility and (full) criminal insanity (diminished responsibility does not exclude criminal responsibility in the sense of art 39 DCC).[45] According to de Hullu, regarding art 39, establishing a *causal* relationship between the mental defect or mental disorder on the one hand and the delinquent act on the other is crucial.[46] This criterion for legal insanity is very different from that of M'Naghten, which does not require that such a causal relationship is established; as long as the defendant, as a result of a mental disorder, did not know the nature, quality and/or wrongfulness of the act, he is legally insane.[47] It is also different from the new Norwegian rule as it emphasises not only the seriousness of the defendant's condition but also that this condition influenced the commission of the crime.

Similarly to Norway, an offender who is considered (fully) insane cannot be subjected to punishment, but only to (security) measures. The most far-reaching security measure in the Netherlands is called *tbs* (Dutch: *terbeschikkingstelling*). This penal hospital order can be extended every 1 or 2 years, and, in most cases, does not have a fixed end. The requirements include that the defendant suffered from a mental disorder at the time of the crime and that he or she poses a threat to society (art 37a DCC).

Legislative considerations behind the rule

The Dutch rule has, as the Norwegian, a long tradition. In order to understand why the Netherlands has this kind of rule, we have to move back to the second half of the 19th century. The Minister of Justice, Modderman, then argued for such an open criterion in order to leave it up to the court to decide about the defendant's sanity.[48] He felt that the criterion should be so broad that neither the psychiatrist nor the judge would be restricted by it. Meanwhile, there was an intense debate about this criterion, and Modderman, earlier, in order to find a compromise, proposed to formulate the

44. See Kamber (n 13) on the Danish rule. For an overview of different rule constructions, see Simon and Ahn-Redding (n 1) and Stuckenberg (n 1).
45. See J Bijlsma, *Stoornis en strafuitsluiting: Op zoek naar een toetsingskader voor ontoerekenbaarheid* (Wolf Legal Publishers, Oisterwijk 2016).
46. J de Hullu, *Materieel strafrecht* (6th edn Wolters Kluwer, Deventer 2015).
47. The interpretation in terms of 'causation' is more like the *Durham rule* or 'product test', according to which a defendant is 'not criminally responsible if his unlawful act was the product of mental disease or mental defect'. *Durham v United States*, 214 F 2d 862 (DC Cir 1954). On this matter, see also Meynen (n 4).
48. What is written about the history of art 39 is based on Bijlsma (n 45).

criterion in terms of 'understanding the nature and criminality of the act' or being able to act in accordance with one's decision.[49] But this proposal was not accepted, and in the end, the 'open' formula for legal insanity became part of the DCC. Apparently, the basic consideration behind this criterion, formulated in 1886, is the freedom of the court to decide about the matter. Since then, from time to time, the open formula has been criticised, but it survived – with a minor modification. Recently, Bijlsma (2016) and Meynen and Kooijmans (2015) have argued for specifying a criterion for insanity.[50] Basically, what has been argued for is a criterion that reflects both control (volitional) and knowledge (epistemic) problems that may occur due to a mental disorder.[51] A recent ruling by the Court of Appeal in the Hague reflected – to some extent – the criterion proposed by Bijlsma.[52]

The role and mandate of the experts

Forensic experts have a significant role in insanity cases under Dutch law. Roughly, 4000 defendants are evaluated per year (Netherlands population: 17 million). Most assessments are performed by forensic psychologists. In the majority of the cases, the assessment is ordered by the prosecution, but the judge may also order the evaluation. In a very small minority of the cases, the defence lawyer asks for a psychiatric/psychological evaluation, often as a 'second opinion'.

Since 2010, in the Netherlands, a nationwide register of court experts has been established, the Netherlands Register of Court Experts (NRGD), which includes the behavioural experts. Experts not listed in the NRGD may still assess defendants and write reports, but then the judge has to decide about that first. Usually, the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) will function as an intermediary to find an expert for the case. The NIFP not only approaches the expert, but it also provides peer feedback on the draft report. NIFP psychiatrists, psychologists and lawyers may also be consulted in difficult cases by the experts. A training course for psychiatrists and psychologists is offered by the NIFP, which comprises a theoretical and a practical part. The practical part consists of performing five assessments under supervision.

A small percentage of the examinees (approximately 200 per year) is evaluated at the Pieter Baan Centre, a forensic observation clinic that can be used for difficult – and/or serious –cases.[53] Examinees are evaluated during a period of (often 6) weeks, by a multidisciplinary team. If experts who have performed an ambulatory evaluation of a defendant are unable to reach a conclusion or in case they disagree, the court may also decide that the defendant has to be (further) evaluated at the Pieter Baan Centre.

Since the evaluations are usually ordered by the prosecution or the court, the defendant may or may not agree with such an evaluation. The defendant is free to cooperate or not to cooperate with the evaluation. In recent years, increasingly, the so-called 'uncooperative' examinee has become a

49. Bijlsma (n 45) 38.
50. Bijlsma (n 45); G Meynen and T Kooijmans, *Een standaard voor ontoerekeningsvatbaarheid en de functionele diagnostiek* (Expertise en Recht, 2015).
51. On both components, see Meynen (n 4).
52. J Bijlsma, *Wederrechtelijkheid of morele ongeoorloofdheid: welk inzicht moet de ontoerekenbare* verdachte *ontberen?* DD, 2019/61.
53. Gerben Meynen, 'Legal Insanity and Neurolaw in the Netherlands: Developments and Debates' in D Patterson and S Moratti (eds), *Legal Insanity and the Brain: Science, Law and European Courts* (Hart Publishing, Oxford 2016)

problem.[54] In the Pieter Baan Centre, a considerable percentage of defendants refuses to (fully) cooperate with the examination, which may seriously hamper the assessment. In some cases, it turns out to be impossible to formulate an advice to the court. Recently, a special unit has been established for those defendants who are uncooperative.

The psychiatrists and psychologists who evaluate a defendant are required to answer specific questions. This is the standard format[55]:

- If the defendant does not cooperate[56] with the assessment, what is your view/opinion about this refusal?
- Is the examinee suffering from a mental disorder and/or developmental disorder, and if so, how can this be described in diagnostic terms?
- What was the mental condition during the time of the alleged offence?
- Did the (possible) mental and/or developmental disorder influence the examinee's behavioural choices and actions at the time of the alleged offence?
- If this was the case, could you indicate (with motivation):
  - How this happened.
  - Whether this results in the advice to consider the examinee's accountability to be diminished or absent.
  - If the advice is to consider the accountability to be diminished, specify this in behavioural terms.

In answering these questions, the experts are expected to follow the guidelines by the NRGD and, in addition, their own professional guidelines, such as the guideline developed by the Dutch Association for Psychiatry, *Guideline on psychiatric assessment and reporting in criminal cases*.[57] Of note, the psychiatrists and psychologists are required to formulate a specific advice about the defendant's sanity (or criminal responsibility). Since this is done in the absence of specific legal criteria for insanity (see above), it is basically up to the expert to formulate why, in a particular case, the defendant should (not) be considered insane. The experts will thus, in a way, concretise the criteria for insanity in each individual case and offer their argument to the court about the defendant's criminal insanity. For instance, psychiatrists may refer to various concepts such as lack of free will, control or knowledge to support their conclusion regarding the defendant's legal sanity.

As the above-mentioned questions make clear, diminished responsibility is also an outcome of the assessment in the Netherlands. In other words, three grades of responsibility are used: responsible; diminished responsibility; legal insanity. In practice, diminished responsibility means that the prison sentence may be reduced and/or that it may be combined with a forensic psychiatric

54. MH Nagtegaal, *Vijftien jaar weigerende verdachten in het Pro Justitia onderzoek. Prevalentie, informatiebehoefte officieren van justitie en rechters, en afdoeningen door de rechter* (Wetenschappelijk Onderzoek- en Documentatiecentrum (WODC), Den Haag 2018).
55. There are more questions, regarding risk of recidivism and risk management, but given the focus of the article they have been omitted. The reference to the disorder has changed recently (see earlier in note 43).
56. See below about the uncooperative defendant.
57. Nederlandse Vereniging voor Psychiatrie, *Richtlijn psychiatrisch onderzoek en rapportage in strafzaken* (De Tijdstroom, Utrecht 2013).

intervention, such as *tbs*.[58] There are no formal rules for sentence reduction: it is up to the court to weigh all the relevant factors and to determine the prison sentence.

The interplay between judges and experts

The expert's advice is offered to the prosecution or the court on paper. The standard format of such a report consists of 14 chapters containing, among others, the examinee's biography, history of mental health problems, judicial history and answers regarding each of the above-mentioned questions. If there are unclarities, the expert may be asked to elucidate the matter by testifying in court. The expert's advice is usually followed. Studies found that the advice of the Pieter Baan Centre was being followed by the court in 86–90% of the cases.[59]

However, the court is not bound by the expert's advice. In case of differences of opinion between the experts used in a case, the court will also have to choose which (if any) advice to follow. A recent study also showed that in legal practice, courts use different criteria for legal insanity.[60]

Interestingly, courts may also establish a mental disorder in cases where the experts – after weeks of intensive clinical observation – could not diagnose a mental illness in an uncooperative defendant.[61] The Court of Appeal has argued – and the Dutch Supreme Court has agreed – that the disorder does not have to be based on the *DSM* and that the disorder does not have to be established by a behavioural expert. The judge is considered to have his own responsibility in these matters, but no legal criterion for 'disorder' has been formulated.[62] Several times now, a court has established the presence of a mental disorder in the absence a diagnosis by a psychiatrist or psychologist and has considered the defendant's responsibility to be diminished.[63] This was typically done in cases where the defendant was uncooperative during the forensic psychiatric evaluation. The court took into account, for instance, forensic reports about evaluations of the defendant in earlier criminal cases. It has been argued that it is possible that the judge establishes the presence of the disorder in such cases as the notion of disorder in art 39 would not refer to the medical domain but to a legal notion of disorder.[64] Meanwhile, concerns have been raised about this practice, for instance, since no framework for the legal notion 'disorder' has been established: it is unclear what the criterion or boundaries of such a court-determined 'disorder' would be.[65] In addition, the

58. See meanwhile Bijlsma and Meynen, who argue that, formally, the role of 'diminished responsibility' is very limited. J Bijlsma and G Meynen, 'Heeft ons strafrecht de ''verminderde'' toerekeningsvatbaarheid wel nodig?' (2017) 92(5) *Nederlands Juristenblad* 262–310.
59. Nagtegaal (n 54). See Gerben Meynen, 'Een medische of een juridische stoornis?' [2019] 61 *Tijdschrift voor Psychiatrie* 74–75.
60. Bijlsma (n 45).
61. T Kooijmans and G Meynen, 'Who Establishes the Presence of a Mental Disorder in Defendants? Medicolegal Considerations on a European Court of Human Rights Case' [2017] 8 *Frontiers in Psychiatry* 199. Of note, the discussion in this paragraph about the disorder primarily concerns tbs (Article 37a), but it is relevant for legal insanity as well.
62. S Ligthart, T Kooijmans and G Meynen, 'TBS en stoornis. Enkele overwegingen voor de wetgever' [2019] 16 *Nederlands Juristenblad* 1148–53.
63. See, eg, ECLI: NL: RBOBR:2017:1036, Rechtbank Oost-Brabant, 3 March 2017. Ligthart, Kooijmans and Meynen (n 62).
64. PAM Mevis, S Struijk and MJF van der Wolf, *Juridische haalbaarheid van voorgestelde oplossingen voor de weigeraarsproblematiek omtrent tbs-oplegging* (Erasmus Universiteit, Rotterdam 2018).
65. Ligthart, Kooijmans and Meynen (n 62) 1148–53.

question has been raised whether it would be acceptable that patients whose 'disorder' has not been established by a medical doctor, but exclusively from a legal point of view, are involuntarily admitted to mental hospitals.[66]

Sweden: A model for sentencing flexibility

The legal rule

In contrast to Norway and the Netherlands, Sweden does not have specific rules for criminal insanity, and hence does not allow for acquittals on this ground. Defendants who fulfil the intent requirement, and other requirements of a crime, are held criminally responsible, regardless of their mental state at the time of the crime. However, the defendant's mental state is relevant when it comes to sentencing, and at this level Sweden can be said to have an 'insanity rule'.

More specifically, the Swedish Penal Code includes a presumption against imprisonment in cases where the defendant committed the crime 'under the influence of a severe mental disorder'. The sanction in that case is forensic psychiatric care. Section 6 of ch 30 of the code reads:

> A person who commits a crime under the influence of severe mental disorder should preferably be sentenced to a sanction other than imprisonment. The court can sentence to imprisonment only on exceptional grounds. In the assessment of whether there are such grounds, the court should consider
>
> 1. the penal gravity of the crime,
> 2. whether the defendant has no need or limited need for psychiatric care,
> 3. if the defendant him- or herself caused the mental condition in connection with the crime, through intoxication or in other similar ways, and
> 4. other circumstances.

However, the code also includes a statutory exception:

> The court cannot sentence to imprisonment if the defendant, as a consequence of a severe mental disorder, lacked the capacity to understand the meaning of the act, or to adjust their actions according to such understanding.[67]

Section 3 of ch 31 regulates sentencing to forensic psychiatric care:

> If a person who has committed a crime for which the sanction cannot be limited to a fine suffers from a severe mental disorder, the court may commit him to forensic psychiatric care if, with regard to his

66. Meynen (n 59). From a different perspective, this legal practice has been criticised by AR Mackor, 'Grenzen aan de autonomie van strafrechters: wie bewijst de stoornis en het recidiverisico?' (2012) 17 *Ontmoetingen: Voordrachtenreeks van het Lutje Psychiatrisch-Juridisch Gezelschap* 55–67.

67. The exception does not apply in cases where the severe mental disorder is caused by the defendants themselves, eg, through intoxication. On the discussions surrounding abolishing legal insanity in Sweden, see Tova Bennet and Susanna Radovic, 'On the Abolition and Reintroduction of Legal Insanity in Sweden', in Moratti and Patterson (n 53); Susanna Radovic, Gerben Meynen and Tova Bennet, 'Introducing a Standard of Legal Insanity: The Case of Sweden Compared to the Netherlands' (2015) 40 *International Journal of Law and Psychiatry* 43–49.

> mental condition and other personal circumstances, admittance to an institution for psychiatric care combined with deprivation of liberty and other coercive measures, is called for.[68]

'Severe mental disorder' is a legal concept, and the basic requirement for involuntary psychiatric care, both in criminal and administrative law. The concept is not explicitly defined in the law nor in the preparatory works, but explained by a list of diagnoses that may constitute a severe mental disorder. The medical conditions associated with severe mental disorder are primarily psychoses. However, severe dementia, severe depression with suicidal ideation and personality disorders with psychotic episodes can also constitute a severe mental disorder under Swedish law. Whether a mental disorder should be regarded as severe in the legal sense depends on both its nature and degree. For example, schizophrenia is considered severe by nature but not always by degree, while depression is not severe by nature but may be severe by degree.[69]

Emphasis is, as in Norway, put on the defendant's ability to accurately assess reality. In the preparatory work for the current law, it is stated that a severe mental disorder should primarily entail states of psychotic character: states of impaired reality testing with symptoms such as delusions, hallucinations and confusion. Hence, the concept shares some similarities with the Norwegian legal concept of psychosis. Assessing 'severe mental disorder' requires a legal understanding of the concept and it should not be confused with a strict clinical interpretation of what constitutes a serious mental disorder.

Furthermore, the criminal act must have been committed under the influence of a severe mental disorder. It is hence not sufficient to have a diagnosis of a psychotic disorder at the time of the crime, but neither is it sufficient to actually be psychotic; the rule requires a relation between the psychotic state, or the state of disturbed reality evaluation and the criminal act.

Criminal offenders who meet the requirement for prison prohibition may be sentenced to forensic psychiatric care if they still suffer from a severe mental disorder at the time of the forensic investigation and if with regard to 'their mental condition and other personal circumstances, admittance to an institution for psychiatric care combined with deprivation of liberty and other coercive measures, is called for' (Swedish Penal Code ch 31 section 3). Forensic psychiatric care can be ordered with or without 'special court supervision'. The latter entails that release is decided by an administrative court. Special court supervision is generally recommended for all violent crimes and is related to the assessment of relapse into criminality (see 'The role and mandate of the experts' section below).

Legislative considerations behind the rule

Why has Sweden established a model that does not allow for acquittals due to legal insanity? The current Penal Code came into force in 1965 with an amendment made in 2008. The amendment replaced a former 'prison prohibition' with a presumption against prison. Before 1965, the Swedish law did entail the concept of legal insanity or unaccountability. A condition for legal responsibility in the Swedish Penal Code of 1864 was that the defendant was accountable at the time of the crime. In the revised formulation from 1946 it is stated that a defendant who was committing an act 'under

68. Even though legal insanity or (un)accountability do not form part of the Swedish legislation, the typical cognitive and volitional requisites found in insanity clauses are found in the statutory exception, indicating an implicit stand that the grounds for not sending a defendant to prison is that the person did not know what he did or could not control his actions.

69. Prop. 1990/91:58. Psykiatrisk tvångsvård 85.

the influence of insanity, mental deficiency or some other mental abnormality of such a profound nature, that it must be considered on par with insanity' was not considered accountable and could not be held criminally responsible for the act.[70] The definition of insanity was kept in the Penal Code from 1965, but from here on a defendant suffering from such a condition at the time of the crime can no longer be exempted from criminal responsibility. People with serious mental disorders are hence now presumed to have capacity for responsibility and shall be sentenced for the crimes.

The political decision of changing the law was preceded by a 50-year (at least) long scientific and political debate about the function of punishment and the nature of mental disorders.[71] A forensic psychiatrist – Olof Kinberg – was highly influential in the debate and he based his view in the old school of positive criminology.[72] According to this school, a crime is always an effect of something abnormal, either in the individual or in society. Human actions are the result of sufficient causes that are located on genetic, neurophysiological, psychological and social grounds and therefore there are no grounds for justifying punishment in that a person deserves punishment (retributivism). Kinberg argued that science has disproved the metaphysical idea of a free will and the function of the criminal system should therefore not be to punish the 'truly guilty' because they deserve to be punished, but to protect society and rehabilitate the individuals who have committed criminal actions. In the preparatory works for the 1965 code, emphasis is put on rehabilitation, as well as special and general prevention rather than retribution. One might concur that in contrast to many other legislations, such as that of Norway, it is assumed that crime prevention is threatened by absolving this group of persons of criminal responsibility.

The inclusive criterion on what should count as grounds for special criminal reactions in terms of forensic psychiatric care was later a subject of criticism: it was argued that there was a lack of consensus among the psychiatrists on the diagnoses that could be considered to be 'on par with insanity' and caution was raised that the criterion came to include a larger group of defendants than intended by the legislator.[73] In 1992, the legal concept of severe mental disorder replaced the disease-related concepts in both the penal legislation and the administrative legislation regarding involuntary psychiatric care.

The role and mandate of the experts

Psychiatric evaluations in Sweden are court-ordered. However, the prosecutor as well as the defendant, or his or her lawyer, may request a minor evaluation, a so-called 'section-seven investigation'. The investigation makes use of the police report, medical files and interviews with the subject. The purpose is, in short, to establish whether or not there are grounds to undertake a complete forensic psychiatric investigation. The complete forensic psychiatric investigation is performed by a team consisting of one psychiatrist, one psychologist, one social worker and one representative of the ward staff and normally takes 4 weeks. If the defendant is on remand (which is the case in the majority of investigations) he or she stays as an inpatient at the investigation unit.

70. Strafflagen 1946 ch 5 § 5.
71. See, eg, Roger Qvarsell, *Utan vett och vilja* (Carlsson, Stockholm 1993); Gröning (n 5).
72. Enrico Ferri, *Criminal Sociology. The Criminology Series; 2* (Fisher Unwin, London 1895); Cesare Lombroso, *Crime: Its Causes and Remedies* (HP Horton, trs, Little Brown, Boston 1911).
73. Lars Lidberg, 'Psykiskt störda lagöverträdare' (1983) 3 *Svenska psykiatriska föreningens förhandlingar* 14–18.

Even though each team member conducts her own investigation, and writes her own part of the report, the team meets and discusses the final assessment, which should weigh in psychiatric, psychological and social data, as well as observations of the defendant's behaviour at the ward. In a forensic psychiatric investigation, confidentiality is broken and the team has access to all registered records of the defendant; for example, social, medical and criminal. The evaluation should result in answers to whether the crime was committed under the influence of a severe mental disorder and if that disorder still is present at the time of the investigation. The team should also address the question of possible relapse into (serious) criminality. The court may also ask for an opinion of whether the defendant lacked the capacity to understand the meaning of the act, or to adjust their actions according to such understanding, and if so, whether the mental state was self-inflicted. The experts' answers to the first two questions are either 'yes' or 'no', while capacity to understand and control actions is often discussed in an argumentative manner.

The psychiatrist establishes a diagnosis based on criteria listed in the *DSM-5*.[74] The most frequent diagnoses are psychotic disorders. However, since mental disorder may be severe either due to its nature or its degree, depressions and personality disorders may count as a severe mental disorder if the functional impairment is significant (or rather, if the effect on the person's ability to properly assess reality is decisive).

During the last 5 years, approximately 1300 section-seven certificate evaluations and 500 complete investigations have been conducted per year and half of those undergoing a complete investigation are sentenced to forensic psychiatric care (Swedish population: 10 million).

The Swedish Penal Code is formulated in a way that, in itself, gives plenty of room for the experts' discretion. Since the psychiatric assessments are not tied to rulings of criminal responsibility, and the result of the forensic psychiatric investigation only affects the sanction (which might be psychiatric care), the issues at stake are in a way of a purely medical nature (sick or not sick and in need of care or not in need of care). Even though severe mental disorder is a legal concept, specialists in forensic psychiatry are deemed fully competent to leave an opinion of the issue. Since the amendment in 2008, it has also been the task of the psychiatric expert to assess the capacity to understand and control one's actions. It can however be questioned whether the experts have the prerequisites within their disciplines to answer this question.

The interplay between judges and experts

The experts' advice is offered to the court as a written report. Although the forensic psychiatric report is only consultative, its recommendations are almost always followed, and it rarely happens that the experts are called to testify in court. However, both the defence and the prosecution may ask the expert to elaborate on the report in court. On such occasions, it is predominately the psychiatrist who is interviewed, but sometimes the psychologist. In most cases, the questions from the court to the expert concern the interpretation of the assessment, rather than the concluding actual recommendation. In cases of uncertainty, from the teams or the court, the assessments can be subject to a second opinion from an expert panel at the National Board of Health and Welfare. When the opinion between the first team of experts and that of the panel diverges, the courts tend to decide in accordance with the latter.

74. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (Arlington, VA: American Psychiatric Association, 2013).

High-profile cases such as the murder of the Swedish foreign minister,[75] or the case of a father who shot and killed his son's harassers – the so-called Rödeby case[76] – typically lead to the obtaining of a second assessment. In the first case, expert opinions were diverging, both in terms of diagnosis and whether the impairments could be regarded as a severe mental disorder in the legal sense. The final ruling in this case by the Swedish Supreme Court was that the defendant did not suffer from a severe mental disorder.

Interestingly, the court also occasionally uses the forensic psychiatric assessment in the establishment of criminal intent. Intent should already have been established before the psychiatric evaluation, but the courts sometimes come back to the question, and change their view, in light of the forensic psychiatric report. In the Rödeby case mentioned above, the first forensic psychiatric evaluation as well as that from the expert at the National Board of Health and Welfare concluded that the defendant committed the act under the influence of a severe mental disorder, which was constituted by neuropsychiatric disabilities, in combination with depression and a maladaptive stress response. The defendant was, at the time of the act, also confused as a result of having taken sleeping pills, alcohol and also of being newly awake. He was also judged as having been affected by a severe panic reaction which was considered to be psychotic. The district court acquitted and stated that the investigation provided support for the defendant 'almost completely lacking the ability to consciously appreciate his actions and realise the consequences of them'.[77] He was therefore not considered aware that there was a risk of death and life-threatening injury, and he was also not considered indifferent to such an outcome, that is, he did not meet the criteria for intent. The Court of Appeal, on the other hand, judged that the defendant had sufficient awareness for forming intent.[78] This example illustrates a potential complication when it comes to usage of forensic psychiatric evidence. The psychiatric expert may see her or his assessment on the presence of a severe mental disorder used in an argument for or against intent and also be called to testify to that very issue.

Expected changes

Since the introduction of the Penal Code in 1965, several governmental reports have recommended that Sweden should reintroduce legal insanity or (un)accountability in criminal law. In the latest report from 2012,[79] different arguments for a reintroduction of accountability are discussed. Among them, arguments about the principle of guilt or fault, that there should be no sanction without culpability, about crime prevention, and that members of the society are not likely to comply with laws widely perceived as unjust, have been put forward. The 'internationalisation' argument is also mentioned. It is maintained that the fact that the regulation of insanity in the Swedish legal system is different from most jurisdictions leads to various practical problems.[80] The committee further discusses some arguments against a reform, expressing appreciation for a legal system that prioritises crime prevention and psychiatric treatment; concern that a reform could lead to stigmatisation and discrimination of offenders with mental disorders; and discomfort with the

75. NJA 2004: 702.
76. RH 2008:90.
77. Judgment from Blekinge tingsrätt 7 maj 2008.
78. RH 2008:90.
79. SOU 2012:17 Psykiatrin och lagen – tvångsvård, straffansvar och samhällsskydd.
80. SOU 2012:17 522.

potential impact of deprivation of legal capacity on the psychiatric treatment of the offender.[81] This report, just as the ones preceding it, reaching the same conclusion, has not yet led to a change in the law. The amendment from 2008 may be regarded as a hybrid between the existing Swedish law and one allowing for acquittals due to insanity insofar as it states that those who 'lacked the capacity to understand the meaning of the act, or to adjust their actions according to such understanding' cannot be sentenced to prison. This is the same wording as is proposed in the report from 2012 to describe a state that may lead to exculpation.

Concluding comparative reflections

In the beginning of our article, we raised certain questions for our comparative analysis: To what extent and in what way do the different rule constructions involve different views on the roles of legislators, judges and experts? And in case of competing models, which is the better solution?

We have now explained how Norway, the Netherlands and Sweden with their different rule constructions provide for different solutions to the roles of the legislator, judges and experts. Norway appears to be the country that has a tradition of emphasising most strongly the role of the legislator, and that criminal insanity must be specified in legislation. The new rule in Norway breaks, however, with this tradition as it allows for a significant judicial discretion. As such, the new Norwegian rule fits better with the 'open-rule' tradition in the Netherlands that emphasises precisely judicial (and expert) discretion. In contrast to the Dutch rule, however, the new Norwegian rule provides some further guidance as it states that 'emphasis should be placed on the degree of failure of understanding reality and functional ability'. Sweden has also specified statutory criteria for the handling of mentally disordered offenders, and thus provides for less discretion than the Netherlands.

When it comes to the roles of the judges and experts, it is clear that the experts have a strong influence on the (insanity) evaluations of the courts in all three countries. Even though the Norwegian and Swedish systems differ in a fundamental way with respect to the handling of mentally disordered criminal offenders, they are similar in their usage of the core concepts psychosis and severe mental disorder. In both cases, the concept is described by the legislators in terms of impaired reality testing, but exactly what this entails has been left to be specified by the experts. The tacit presumption being, apparently, that forensic practice can provide a sufficiently clear and uniform understanding of impaired reality testing that may provide the law with a clear cut-off point for insanity. The idea has been that the role of the experts is understood as functioning as a guarantee for an objective and consistent application of the rules – where the link between the legal criterion and the medical concept of psychosis and severe mental disorder, respectively, is understood to secure legal certainty. However, this contention seems not easy to realise in practice, where there is a lack of uniform understanding of (legal and psychiatric concepts of) psychosis. In the Netherlands, the open criterion formulated by the legislator does not only leave open the relation between illness and crime, but also the nature of mental illness that is relevant to the question of legal insanity – leaving this to the forensic experts and ultimately to the courts.

Which is then the best solution and what roles and mandates should be assigned to legislators, judges and experts? First, we think that there are strong arguments to regulate criminal insanity as a rule for shielding some offenders from criminal responsibility and punishment that they do not

81. SOU 2012:17 531.

deserve. In our view, to regulate 'insanity' only at the level of sentencing as Sweden does is not an ideal solution.[82] The main argument against such a solution is that it neglects the key rationale of the insanity doctrine, as a doctrine that concerns the individual's fundamental *capacity* for responsible behaviour. It blurs the distinction between reasons for eliminating (or mitigating) criminal responsibility and reasons for mitigating punishment. Meanwhile, the outcome of the three rules in the studied countries may not be that different. The Swedish rule will shield certain offenders from regular imprisonment and allow for specific reactions of compulsory psychiatric care. Similar reactions can be used against a defendant who is considered insane in Norway and the Netherlands.

Second, when it comes to division of labour between the legislator, judges and experts, the starting point should, in our view, be the basic rule of law requirement. It is imperative that the criminal insanity rules secure a sufficient degree of legal certainty as regards who will be absolved from criminal responsibility and who will not, and function to secure that two equally ill offenders are treated equally before the law. Traditionally, the maxim of *nulla poene sine lege* (no punishment without law) has also been emphasised in the criminal law and has been interpreted as a strong requirement of clear and precise rules, enacted by the legislator. Although the Norwegian psychosis criterion that soon will be abolished may have some advantages in this regard, the rules in all countries suffer from a lack of legal clarity.

However, what is lacking at the level of rules in this respect can to some extent be clarified through a clear and consistent legal practice, where the experts can assist the courts in developing well-defined and robust legal standards for insanity. It is, in fact, inevitable that criminal insanity is constructed and understood through an interplay between legislative considerations, expert opinions and legal judgments. What is important is not what precise division of roles is settled – different countries may have different cultures and systems – but that this interplay functions to secure clear and robust rules. Each of the three countries has room for improvement in this regard. This seems particularly true for the Netherlands with its open rule. And the Norwegian and Swedish examples show how seemingly clear rules may still need clarification in practice. In the end, it is always challenging to construct legal rules that are both justifiable in principle and functional for all the purposes of the criminal justice system.

The rule models used in Norway, the Netherlands and Sweden, that is, a medical model, an open model and a version of a mixed or two-step model (although constructed as a sentencing rule), have, however, in our view different implications. For instance, the medical model that identifies insanity exclusively with mental disorder ties normative considerations about insanity directly to factual premises about the existence of the relevant disorder(s). Provided that the seriousness dimensions of insanity-relevant conditions (eg psychosis) can be accurately specified, a medical model may in fact allow for the most straightforward regulation of insanity.[83] One could, at the same time, argue that a mixed model that requires a two-step test – concerning, first, the presence of a disorder and, second, certain functional impairments – has advantages in respecting and

82. It should be noted that a UN committee has recommended that states abolish their insanity declarations; see Guidelines on art 14 of the Convention on the Rights of Persons with Disabilities. *Committee on the Rights of Persons with Disabilities* 2015.

83. For a discussion about the potential of utilising recent mental health research perspectives on psychosis in legal research on insanity, see Gröning, Melle, Haukvik (n 3) 29–31. See also MS Moore, 'The Quest for a Responsible Responsibility Test: Norwegian Insanity Law after Breivik' (2015) 9 *Criminal Law and Philosophy* 645–93 for a discussion about the potential of the medical model.

communicating the distinction between psychiatry and the law. Whatever the model, there is a need for a further clarification of criminal insanity in these three jurisdictions.

The role of the experts should in our view also be established in legislation. Their task should be to give medically or psychologically informed advice to the court, but not to provide answers to the legal questions of responsibility. Insights from and advances in the medical and behavioural sciences regarding the presence and impact of a mental disorder should be shared with the court, but the ultimate question of criminal responsibility is up to the court. Such division of competences is most clearly communicated by a two-step model rule but does not necessarily require such a model. It will always be the judge who finally determines an insanity case, and many countries with two-step model rules allow the experts to conclude also on normative issues. In our view, the sharp division between legal and medical questions that the new Norwegian rule introduces, combined with the removal of the term 'psychotic', is an improvement that may inspire other countries.

In sum, we have provided a comparative perspective to analyse legal insanity – looking at legislator, expert and court – that helps to identify important choices a legal system must make regarding legal insanity. We hope this will contribute to enhancing the quality of how legal systems deal with the important notion of legal insanity.

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