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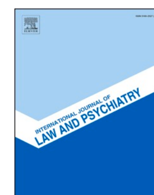

# The dangers of using diagnoses outside of established psychiatric nosology in the courtroom: Analysis and discussion of current Swiss legal precedent from a medical perspective

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ABSTRACT

Akin to many jurisdictions, Switzerland has a dual system of sanctions comprising sentences and measures. To order a therapeutic measure per Article 59 or 63 of the Swiss Criminal Code, the presence of a “severe mental disorder” must be determined. Before the new legal precedent, this required a medical diagnosis according to recognised classification systems like the ICD or DSM. The court then decided if a disorder was “severe” in the legal sense, thereby requiring such a therapeutic measure. However, in two 2019 rulings, the Swiss Federal Supreme Court concluded that a severe mental disorder could legally exist without a diagnosis according to the ICD or DSM, if it is based on offence- and risk-relevant personality-related factors amenable to risk-reducing therapy. We examine the details and context of the rulings, alongside their wider dangers. Specifically, we outline how undue influence could be exerted by non-ICD/DSM diagnostic systems, which were developed within individual theoretical schools of thought and lack empirical validation, like in these two court cases. Such non-manual diagnoses could make the presence of a severe mental disorder dependent upon whether an expert witness employs a particular diagnostic system, which would undermine principles of legality. Moreover, the Court’s requirement that the disorder is based on personality-related risk factors amenable to risk-reducing therapy is problematic because research has highlighted the low effectiveness of treatment provided independently of a psychiatric disorder. Finally, broadening entry criteria may increase the number of offenders who require psychiatric treatment, thus endangering the quality of care for those with ICD/DSM-based diagnoses that are known to respond well to treatment (e.g. schizophrenia). In short, fulfilling the Court’s request that any non-manual diagnoses are based on personality-related risk factors that are amenable to risk-reducing therapy is not possible for such non-manual diagnoses. Using unvalidated diagnoses could also render the system susceptible to ethical issues and hypothetical misuse, which may adversely affect society’s most vulnerable people. To counter these dangers, we suggest that in order to be admissible in court, any diagnostic system must mandatorily fulfil sufficient scientific standards.

## 1. Introduction

The Swiss Criminal Code (SCC)[2] distinguishes between sentences (“*Strafen*”), such as a fine, community service, or imprisonment, and measures (“*Massnahmen*”). For the latter, therapeutic measures, such as in-patient therapeutic measures (per Art. 59) and out-patient treatment

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[2] An English version of the SCC is available here: https://www.fedlex.admin.ch/eli/cc/54/757_781_799/en

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(per Art. 63), are distinct from indefinite incarceration (per Art. 64).

In line with Art. 56 SCC, a therapeutic measure is imposed if "a. a penalty alone is not sufficient to counter the risk of further offending; b. the offender requires treatment or treatment is required in the interest of public safety; and c. the [specific] requirements of Articles 59-61 [or] 63 (…) are fulfilled". This paper focuses on Articles 59 and 63.[3] The requirements of these two Articles entail that the offender is suffering from a "severe mental disorder" and that "a. the offender's mental disorder was a factor in a felony or misdemeanour that he committed; and b. it is expected that the measure will reduce the risk of further offences being committed in which his mental disorder is a factor" (Art. 59 SCC).

Measures are reviewed regularly and can be extended if necessary. The number of extensions is theoretically unlimited, meaning that the duration of a measure can far exceed the sentence related to the seriousness of the crime, which typically determines the duration of imprisonment. In this sense, measures are similar to detention and treatment without consent of individuals with mental illness under mental health laws in common law countries such as England and Wales (Royal College of Psychiatrists, 2015). In contrast with neighbouring jurisdictions, such as Germany, diminished responsibility is not a prerequisite for a therapeutic measure in Switzerland (see. e.g. Koller, 2019). According to the SCC, it is possible to order a therapeutic measure based on an existing mental disorder that contributed to the offence and increases the risk of re-offending, even if it is assumed that the mental disorder had no influence on the person's culpability when the crime was committed.

In cases where a measure is considered, the court will commission a psychiatric expert witness (Art. 56 SCC). This expert gives evidence regarding the presence and relevance of mental disorders at the time of the offence, the defendant's culpability, and their risk of future reoffending. In addition, the expert witness provides an opinion on whether the risk of future reoffending could be reduced by a therapeutic measure and, if so, which measure they perceive to be most adequate. The court considers the expert witness' assessment when making its decision, although it remains a legal question as to what type of therapeutic measure is ordered (if any is ordered at all). Accordingly, in the Swiss legal system, the expert has an advisory function, although deviations from the expert's recommendations rarely occur in practice. Consequently, psychiatric experts are sometimes pejoratively criticised as "judges in white" (Graf, 2015).

In 2019, the Swiss Federal Supreme Court (SFSC), Switzerland's highest court, whose rulings are considered legal precedents for future jurisprudence,[4] handed down two rulings that have important implications for what can constitute as a severe mental disorder in a legal sense. Prior to the new legal precedent, high standards had been applied in Swiss criminal law when assessing both the existence of a mental disorder and its legal relevance (i.e., its pathological significance; Graf, 2017). Ordering a therapeutic measure used to be contrary to common practice if a psychiatric diagnosis could not be defined based on one of two internationally recognised classification systems; namely the International Statistical Classification of Diseases and Related Health Problems (ICD; World Health Organization, 2016) and the Diagnostic and Statistical Manual of Mental Disorders (DSM; *American Psychiatric Association*, 2013). Now, according to the new legal precedent, it is also possible to apply a diagnostic system that is completely independent from the ICD or the DSM, as long as the diagnosis complies with "scientific standards". In the authors' understanding, the Swiss Federal Supreme Court (SFSC) did not specify the admissibility criteria of these "scientific standards" as we shall discuss later. In other words, an offender who does not meet the criteria of an ICD/DSM diagnosis, i.e., has no mental disorder from a *medical* point of view (that is, no disorder that can be classified within the established and internationally recognised psychiatric nosology)[5], can still be considered a person with a "severe mental disorder" from a *legal* stance.

We consider this paradigm shift to be highly problematic for several reasons. After outlining the new legal precedent in some detail, we will highlight our concerns.

## 2. Key points from the new legal precedents

In two recent findings, the SFSC attended to the question of what qualifies as a severe mental disorder. In its ruling 6B_933/2018[6], the SFSC firstly addressed whether a "forensic-psychiatric diagnosis"[7] must necessarily be included in an internationally recognised classification system such as the ICD or the DSM. Secondly, the SFSC delineated the circumstances under which a disorder has the severity required by law for mandated treatment to be imposed on a defendant, i.e., whether it qualifies as a severe mental disorder. In this first case considered by the SFSC, the forensic psychiatric expert witness had not formally diagnosed a mental disorder. Rather, they had identified "offense-relevant personality traits of a pathological value", specifically accentuated narcissistic personality traits (ICD-10 Z73.1), and had further identified a pronounced "dominance focus", according to the Forensic Operationalised Treatment-Risk-Evaluation System (FOTRES; Urbaniok, 2016; see below for some more information on FOTRES), consisting of a need for control, striving for dominance, and ignoring the needs of others.

The SFSC began by outlining how, according to current legal practice, not every "mental abnormality" fulfills the entry requirement of a severe mental disorder. Rather, it is only those "psychopathological conditions that are of a certain degree of severity or that, in a medical sense, are a mental illness of relatively serious nature and form" (E 3.5.2). The SFSC then elaborated on the "legal term of a severe mental disorder" (E. 3.5.3.). According to the SFSC, the term is "functional in nature as it is based on the purpose of the measure", which was to:

> (r)educe further offences that are committed in relation to the offender's [mental] state, i.e., to improve the legal prognosis. (…) The functionally conceived concept of a severe mental disorder is intended to cover the cases of the legally indicated need for therapy. Accordingly, the conditions that are the subject of such therapies need to fit their legal purpose (E. 3.5.3).

This last argument will play a central role in the SFSC's additional remarks, even though the statement was subsequently qualified. As a

[3] Art. 60 covers the treatment of addiction if relevant in the context of the felony or misdemeanour committed. Art. 61 covers measures for young adults (offenders under 25 years of age) who suffer from a serious developmental disorder that is relevant in the context of the felony or misdemeanour. Neither measure requires the presence of a "severe mental disorder" as an entry criterion.

[4] It should be noted that whilst in some countries, such as England and Wales, new precedents from the highest courts are binding for all subsequent cases (Doctrine of Legal Precedent), in Switzerland the rulings of the SFSC are only officially binding for the lower court whose case the SFSC considered. However, lower courts usually do not deviate from the rulings of the SFSC. This is to avoid risking their judgement being overruled by the SFSC if brought before it as the SFSC will seek to maintain consistency with its previous rulings.

[5] The authors recognise that the ICD and DSM are periodically updated and are therefore ever-evolving. As such, it is conceivable that there are psychiatric disorders and symptoms that are not yet classified by these diagnostic manuals. However, it is our view that the forensic-psychiatric field should operate within established nosology, especially in its application to legal contexts, because of the serious consequences for those involved.

[6] The full text in German is available here: https://www.bger.ch/ext/eurospider/live/de/php/aza/http/index.php?highlight_docid=aza%3A%2F%2Faza://03-10-2019-6B_933-2018&lang=de&type=show_document&zoom=

[7] Quotes presented in this section are taken from the ruling, with a reference to the relevant section of the ruling for longer quotes. The quotes were translated to English by the authors of this paper.

qualification, the SFSC highlighted that the functional nature was not the only aspect that mattered: "If it were only a matter of risk effectiveness of treatment, the scope of therapeutic measures – which presuppose a severe mental disorder – could be extended to other reasons for deviant behaviour", such as a dissocial lifestyle (E. 3.5.4.). The SFSC acknowledged that it was important to "avoid the medicalisation and pathologisation of common criminality".

Whilst the SFSC conceded that a mental disorder could disrupt several areas of an individual's life, it also concluded that:

> (t)he rule that a disorder of pathological significance is present if the deviation also becomes apparent in other areas of life, however, does not always apply. There are disorders that, due to their high specificity, only express themselves in criminal behaviour, whilst the observable behaviour tends to remain inconspicuous (E 3.5.4).

The SFSC recognised that the assessment of a mental disorder needed "as far as possible" to be based on an "acknowledged classification", as operational criteria are necessary to ensure a (severe) mental disorder is described in a reproducible way (E 3.5.5.). That said, the SFSC went on to note that the concept of treatment under Art. 59 and Art. 63 SCC was "offence focused" ("*deliktorientiert*") with the aim of reducing the risk of reoffending and supporting rehabilitation. Thus, it could not be equated with the treatment concept in general psychiatry, which is based on the ICD and the DSM. Consequently, the SFSC declared:

> (t)he conditions included in the ICD-10 and the DSM-5 are not exhaustive (…). For those cases in which an expert diagnosis cannot be coded within the ICD or the DSM, it is still possible to determine a severe psychiatric disorder if it is ensured that it is decisively based on offence- and risk-relevant personality-related risk factors that are amenable to risk-reducing therapy (E 3.5.5).

Crucially, the SFSC found that the legally required severity of a mental disorder could not be solely defined based on an existing diagnostic classification system. Rather, the "severity of the mental disorder corresponds to the extent to which the disorder is reflected in the offence (i.e. its relevance for the offence; '*Deliktrelevanz*')" (E 3.5.6.). As such, a severe mental disorder "results from the intensity of the association between the disorder (which is significantly pronounced according to medical criteria and has been unequivocally established in advance) and the offence". The SFSC emphasised the importance of considering a case holistically. In summary, several minor pathological findings may interact, thereby yielding either the legally required severity of a mental disorder or resulting in the affirmation of the presence of a mental disorder, for which the symptoms identified would not have individually met the threshold of a diagnosis (E. 3.5.6).

Based on the reasoning above, the highest Swiss court supported the finding of the lower court that the diagnoses of an "accentuated narcissistic personality" and a "dominance focus" were not a mental disorder in a strict sense, but rather "long-lasting offense-relevant personality traits with pathological value" that did qualify as a severe mental disorder (E 3.5.6).

The SFSC reaffirmed this ruling in a second case, 6B_828/2019,[8] in which an expert witness diagnosed an unspecified disorder of sexual preference (ICD 10 F 65.8) in the form of a "chronic rape disposition"[9], "accentuated dissocial personality traits (ICD-10: Z73.1)" and a condition following a "simple activity and attention disorder (ICD-10: F90.0)". According to this expert witness, a "rape disposition" was a disorder of sexual preference that was not explicitly listed in the ICD system. For this reason, it was coded as the ICD-10 residual category *other disorders of sexual preference* (E 1.3). The SFSC confirmed in its ruling that "the diagnosis does not have to be listed in a classification system such as the ICD or the DSM in all circumstances", and that the absence of the term "chronic rape disposition" in those manuals "does not speak against the assumption of a severe mental disorder in the sense of Article 59" (E 1.4).

## 3. Discussion

The authors do not dispute the role of the courts in establishing the severity of mental disorders. However, together with other researchers (e.g., Bommer, 2020; Habermeyer, Lau, Hachtel, & Graf, 2020), we are concerned that the diagnosis of such disorders has become independent of internationally recognised standards within these new legal precedents. The ruling 6B_933/2018 was even awarded the title of "judicial error of the year" by the jury of *Plädoyer*, a Swiss legal journal, because in their opinion, the judgement paved the way for "unlimited disease mongering of criminality" ("*unbegrenzte Pathologisierung der Kriminalität*") (Schmid, 2020, p. 73). Before discussing individual concerns in more depth, we consider the broader context in which the rulings took place.

On an international level, there has been a continuing debate on a number of aspects related to the relevance of diagnostic systems and the medical basis of legally relevant mental states (e.g. Brown, 2016; Malatesti, Jurjako, & Meynen, 2020). Specifically, in Switzerland, there was a discussion as to whether an offender had to be suffering from a mental disorder as defined in the ICD or the DSM to receive a court-mandated therapeutic measure under the SCC (personal communication, M. Liebrenz, 12.12.2021). Legal journals only partly covered this topic (and medical journals even less so). Interestingly, much of the discussion actually took place in the public eye. For example, in a Swiss newspaper, *Neue Zuercher Zeitung*, Noll and Endrass (2018, January 31), two employees at the Office of Corrections in Zurich, wrote a guest commentary on the issue. They argued that in everyday prison life they encountered dangerous offenders who have noticeable psychiatric abnormalities ("*psychiatrisch auffällig*") but "do not meet the sometimes (overly) rigid criteria for a specific diagnosis according to the ICD or the DSM". As an example, they described the case of a "highly dangerous violent offender who commits his crimes because of a mixture of psychopathic traits, dominance and killing fantasies" but since these characteristics are "not listed in the official diagnostic manuals (…), diagnostically speaking, they do not even exist". Nevertheless, this offender would be "in need of treatment". As such, Noll and Endrass demanded a change from a "general psychiatric diagnosis" to a "forensic classification system" for the indication of therapeutic measures ordered under criminal law. Heer, Habermeyer, and Bernard (*Neue Zürcher Zeitung*, 2018, February 15), Swiss legal and medical scholars, responded in a follow-up commentary. These authors pointed to the fact that a court-mandated therapeutic measure "was not tied to the existence of a diffuse mental problem but was rather explicitly tied to a severe mental disorder" and that a "specific forensic diagnostic system would lead to a diagnostic parallel world". The authors also noted that the dangerousness and the treatability of offenders is notoriously difficult to assess and predict. It could thus be said that if the entry criterion of a severe mental disorder is additionally watered down, this would further complicate reliable assessments.

Following a regional judiciary and psychiatry conference in 2019, local medical and legal experts edited an interdisciplinary volume (Heer, Habermeyer, & Bernard, 2019). This publication focused on this debate and gave a platform to various viewpoints, some of which were highly contentious in our opinion. Amongst other things, the preface to the volume stated:

> The (SFSC) (…) like the legislature, has also not endeavoured to circumscribe the indeterminate legal concept of a "severe mental disorder". The contributions in this conference volume initiate the necessary well-founded discussion amongst practitioners from

[8] The full text in German is available here: https://www.bger.ch/ext/eurospider/live/de/php/aza/http/index.php?highlight_docid=aza%3A%2F%2Faza://05-11-2019-6B_828-2019&lang=de&zoom=&type=show_document

[9] A risk characteristic included in FOTRES.

various disciplines. However, this is also intended to stimulate a continuation of this debate, which is by no means closed.

The SFSC cited this volume prominently in its rulings.

The rulings of the SFSC discussed above, which permitted diagnoses detached from internationally recognised diagnostic systems, could superficially be seen as a preliminary conclusion to this interdisciplinary discussion. Below, we discuss our theoretical and practical concerns regarding these rulings in more detail.

### *3.1. Classification systems of mental disorders and problems in defining "scientific standards" outside of established psychiatric nosology*

Before classification systems of mental disorders were developed, making it possible to work within a shared psychiatric nosology, terminology and diagnoses differed widely between different schools of thought. This became a particular problem once treatment for specific disorders was available (Clark, Cuthbert, Lewis-Fernández, Narrow, & Reed, 2017; Jablensky & Kendell, 2002; Lempérière, 1995).

The SFSC itself acknowledged and described the relevance of internationally recognised classification systems such as the ICD. According to the SFSC, such classification systems.

> (i)ntend to standardise the international handling of diagnoses and the clinical pictures designated by them. (…) By means of uniformed nomenclature and definitions, they should create transparency, allow for comparability and comprehensibility and thus improve the reliability of diagnoses with regard to therapy research, scientific communication about the defined disorders and psychiatric or psychotherapeutic treatment itself (6B_933/2018, E.3.5.5.).

However, the SFSC also stated that a therapeutic measure should be available "for the entire range of 'mental phenomena' that can be diagnosed based on scientific criteria" and deviate from the norm; therapeutic measures should not be informed by a specific classification system (6B_933/2018, E 3.5.1.). In particular, the SFSC highlighted that the ICD/DSM were not created for forensic-psychiatric purposes, which was why "a severe psychiatric disorder in the context of a therapeutic measure would not necessarily need to be tied to a diagnosis according to the ICD or the DSM" (E.3.5.5.). A severe mental disorder could still be established within the law as long as it was based on "offence- and risk-relevant personality-related (*persönlichkeitsnahen*) risk factors that are amenable to risk-reducing therapy" (E 3.5.5). If this was the case, the SFSC argued, "a demarcation from the non-pathological tendency to delinquency (activated by external, situational factors) in accordance with the purpose of the law (…) is guaranteed" (E. 3.5.5.).

The current classification systems have their shortcomings, as others have noted (Walvisch, 2017).[10] However, they do have important advantages, as has been previously discussed. If we start using diagnoses based on personality-related risk factors that, as in the two rulings discussed here, are part of a local forensic psychiatric tool, such as FOTRES, this raises several well-known problems relating to whether there is a sufficiently strong evidence base for the concepts or "diagnoses" used and whether evidence-based treatment is available, amongst others. Notably, whilst an earlier version of FOTRES (Urbaniok, 2007) has been initially conceptualised as a risk management tool (see also Rossegger et al., 2011), the third edition (Urbaniok, 2016), which now includes "diagnostics" in its objectives has not been adequately evaluated as a diagnostic tool; there is a lack of empirical evidence that FOTRES is fit for diagnostic or prognostic purposes (Habermeyer, Lau, et al., 2020; Habermeyer, Mokros, & Briken, 2020). If there is no evidence-based treatment available, the Court's request for "factors that are amenable to risk-reducing therapy" cannot be satisfied. Consequently, a diagnosis that is based on such risk factors would not be legitimate and the requested "demarcation from the non-pathological tendency" would remain unclear.

This issue could be addressed by outlining scientific standards that need to be met by the "diagnostic system" used. As mentioned, the SFSC contended that a disorder can be diagnosed independently of an operationalised diagnostic system "in accordance with scientific standards". The SFSC did not, however, further specify what these scientific standards are. In our view, this latter point offers an opportunity for demanding that admissible forensic-psychiatric evidence adheres to rigorous, scientifically validated standards, which would thereby mitigate against the hypothetical adverse implications of these rulings (see. 3.5).

Finally, if we move outside established psychiatric nosology, whether a diagnosis is made will depend on whether the commissioned expert witness employs this specific tool. Of course, there are inter reliability issues with the ICD and the DSM systems and two experts using the same classification system may not arrive at the same conclusion, but the issue discussed here is even more fundamental: whether the "diagnostic system" is used at all. This also undermines the principle of legal equality and makes it more difficult for the individual to anticipate which acts are punishable by which sanctions, a circumstance that may violate the principle of legality according to Art. 1 SCC (Bommer, 2020).

### *3.2. Lack of scientific evidence for the non-manual "diagnoses" used in the two new legal precedents*

From a scientific point of view, it could be argued that two relevant mental phenomena mentioned in the rulings, "dominance focus" and "chronic rape disposition" (both risk factors within FOTRES - Footnote 4) fall short of the (vague) criteria outlined by the SFSC. They may neither be diagnosable according to scientific criteria since data on their (construct) validity, interrater reliability and test-retest reliability have to the authors' knowledge not been published in peer-reviewed academic literature. Nor is it clear whether they are amenable to risk-reducing therapy because of a lack of (published) research on the question. Instead, the concepts were developed and are used within an individual school of thought. In short, despite these unspecific guidelines regarding the requirements for such a diagnosis by the SFSC, it seems questionable whether the concepts in their present form actually meet them.

In the case of the ruling 6B_933/2018, in addition to the identified "dominance focus", the expert witness also identified characteristics of an "accentuated narcissistic personality", "with the accentuated personality being the fundamental condition and the dominance focus the chief cause of the delinquent behaviour" (E. 3.5.7.). According to the ICD-10, an "accentuation" (contrary to a narcissistic personality disorder) is characterised precisely by the fact that it does not impair the person to a significant extent and thus does not reach the threshold of a pathological value, i.e., an accentuation remains a normative variant. This point is also emphasised in a German standard textbook in forensic psychiatry:

[10] In the forensic psychiatric literature (e.g. de Tribolet-Hardy, Lehner, & Habermeyer, 2015) as well as in the general psychiatric literature (e.g. Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, 2013), the weaknesses of today's diagnostic systems are discussed, especially in the context of the publication of the 5th edition of the "Diagnostic Manual of Mental Disorders" of the American Psychiatric Association (Falkai and Wittchen, 2015). The principle of all classification systems is a priori reductionist, which means that assigning a person to a specific diagnosis is only possible if one accepts the concomitant loss of a lot of content-related information. However, according to Sass (2015), the operationalised classification systems with international and intercultural standardisation of the psychiatric diagnostic language remain an important development over the last three decades, despite the unavoidable discrepancies between the complexity of mental disorders and the real context of those affected that are due to the reductionist tendencies associated with operationalising specific disorders.

> According to our extensive experience of recent years, as a rule of thumb it can be assumed that no forensically relevant disorder is present if the categorisation of a mental condition under a distinct ICD-10 diagnosis (of a mental disorder) is not successful. This is especially true for personality disorders (Graf, 2017, p. 465; translated by the authors of this paper).

Similarly, in a chapter in a handbook on psychiatric assessment, Dreßing and Foerster argue:

> because if, on the basis of a [psychiatric] examination, a psychiatric diagnosis according to the ICD-10 or the DSM-5 cannot be made either for the time of the examination or – in the case of retrospective assessment – for (…) the time of the crime, no forensic-psychiatric conclusions can be drawn. Diagnoses outside the two generally acknowledged manuals are worthless for the assessment (Dreßing & Foerster, 2021, p.7; translated by the authors of this paper).

Whilst the SFSC did not claim that the accentuation qualified in its own right as a severe mental disorder, it maintained that the combination of this accentuation with another concept, the dominance focus, constituted "long-lasting offence-relevant personality traits of pathological significance" (6B_933/2018, E. 3.5.6). Relying on risk factors from a forensic operationalised system (in this case FOTRES, see Footnote 4) that has not been widely researched (see. e.g. Habermeyer, Lau, et al., 2020) and using such a risk factor to justify a diagnosis, appears to us to be a considerable step backwards.

More generally, from the authors' perspective, the SFSC also did not adhere to the common definition of mental disorders and instead used the term "mental phenomena": "mental phenomena that can be diagnosed according to scientific criteria" that deviate from the so-called norm (6B_933/2018, E 3.5.1). The World Health Organization (1992, p. 5) defines a mental disorder as "a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here". Thus, mental phenomena that manifest themselves exclusively in criminal behaviour without observable impairment of functioning in other areas of life may result in a deviation from normal behaviour and experiences, but are insufficient to meet the above definition of a mental disorder. In combination with the use of non-manual diagnoses that do not meet scientific standards, the broad definition of mental phenomena involves a distinct risk of pathologising criminal behaviour by using diagnoses that do not operate beyond the criminal context.

### 3.3. Adverse implications for therapy and the effectiveness of treatment when moving outside established psychiatric nosology

According to the SFSC, the legal definition of a severe mental disorder (Articles 59 and 63 SCC) cannot be based solely on medical criteria; the court must place the psychiatric expert findings in relation to the offence. The concept of a severe mental disorder is, in the opinion of the SFSC, functional in nature and the therapeutic measure must improve the legal prognosis (6b_933/2018, E3.5.3).The notion that the definition of the legal concept of a severe mental disorder cannot be based solely on medical criteria likely holds true in a variety of jurisdictions (Gröning, Haukvik, Morse, & Radovic, 2022; Kröber, 2020). Yet, in the SFSC decisions, this has become detached from recognised psychiatric nosology. That is, a severe mental disorder can now be based on a non-manual "diagnostic system" or risk factors, neither of which are widely recognised nor sufficiently validated (see above). If non-ICD/DSM diagnoses are used, their scientific evaluation, evidence-based indication for therapies, and consequently also the systematic assessment of their success in terms of disorder-specific and legal prognostic outcomes will no longer be possible (Habermeyer, Lau, et al., 2020).[11] Hence, it seems that the "functional nature" of a severe mental disorder will no longer be ensured in these cases as the effectiveness of treatment to improve the legal prognosis remains unclear.

For various reasons, it is generally difficult to study the effectiveness of interventions in reducing offender recidivism (Graf & Habermeyer, 2019, p. 144). Most studies of sufficient quality in this area, which established an improvement in the legal prognosis through therapy, relate to the population of offenders with disorders within the established psychiatric nosology (e.g. Fazel, Fiminska, Cocks, & Coid, 2016) and are, strictly speaking, not transferable to offenders without ICD/DSM diagnoses.

Moreover, research suggests that using treatment programmes independently of a psychiatric diagnosis is not a promising alternative. A recently-published systematic review and meta-analysis of randomised controlled trials on the effectiveness of psychological interventions in prison to reduce recidivism that were delivered independently of psychiatric diagnosis found no strong evidence of reduced reoffending after participation in CBT-based programs (Beaudry, Yu, Perry, & Fazel, 2021). Other treatment efforts directed at specific groups of offenders without consideration of individual diagnoses have failed in the past, too; for example, the Sex Offender Treatment Programme in the UK, which was discontinued because of its lack of positive results (Mews, Di Bella, & Purver, 2017; see also Habermeyer, Lau, et al., 2020). Other interventions such as practising alternative actions in conflict situations, one approach highlighted by the SFSC, might be useful and desirable, but can be already managed within the framework of the normal execution of sentences.

In short, the separation of the legal concept of a severe mental disorder from the recognised classification systems will severely impede the scientific evaluation of the effectiveness of treatment should it become more common to use non-manual diagnoses as a basis for ordering a measure. It is likely that most diagnoses will remain within the established psychiatric nosology. However, in our view, there could be an increased use of non-manual diagnoses for cases that do not meet the criteria for an ICD/DSM-diagnosis, but which are considered to require more than just a regular prison sentence to mitigate their dangerousness.

### 3.4. Ethical and psychiatric-historical concerns

Relying on opinions, even well-conceived ones, which lack sufficient scientific basis and empirical support, entails the fundamental danger of a lack of verifiability, Lysenkoism (in the sense of a pseudo-scientific concept that asserts itself by political and ideological means),[12] and potential abuse. The idea that a severe mental disorder would be expressed only in criminal behaviour without affecting other areas of life is, as shown above, in contrast to disorder and disease concepts common in medicine and psychiatry. Regarding diagnoses of personality disorders, there have been warnings of a possible misuse of this diagnostic category "against vulnerable groups, especially young women, whenever they do not conform with the dominant social, cultural, moral and religious standards. Political dissidents and minorities are also

[11] There may be exceptions of non-manual diagnoses that have a strong evidence and broad research base regarding treatability, but for the diagnoses used in the cases discussed here, this was not the case.

[12] Lysenkoism describes a pseudo-scientific biological school, which was politically and ideologically abused and resulted in the destruction of serious biological/genetic research in some Eastern European countries, which has not been fully overcome to this day (see e.g. Kolchinsky, Kutschera, Hossfeld, & Levit, 2017, and Hossfeld & Olsson, 2002).

vulnerable to being diagnosed as having a personality disorder when they take positions in opposition to the local norms" (World Health Organization, 2005, p. 21).

In addition, in our opinion, it is not the task of the judicial power to intervene in an open and ongoing scientific discourse (Habermeyer, Lau, Henning, & Graf, 2019) in favour of what is, internationally speaking, a minority opinion. We believe that in doing so, the Court legitimises a system from a legal perspective that has insufficient support from a scientific point of view, thereby influencing ongoing debates. Such an intervention, caused by social and political pressure and facilitated by the desire for absolute certainty, can hamper scientific development and may also result ethically questionable treatment without medical indication.

In this context, we should also recall the recent cautionary tales of psychiatric history, which can be found across diverse countries and political systems. An example, in which diagnostic systems or concepts that were developed locally within individual schools of thought or cultural circles were later abused politically is "sluggish schizophrenia". This was advanced by the Moscow School of Psychiatry and, in particular, by its scientific leader, Andrei Snezhnevsky (Van Voren, 2010, p.109). Whilst the concept originated in 1930s USA, Snezhnevsky developed it further after his school was awarded the leading role regarding the theory of higher nervous activity by the USSR Academy of Sciences and the USSR Academy of Medical Sciences in 1950. Crucially, Snezhnevsky believed that schizophrenia was much more prevalent than previously thought, because of its initially relatively mild symptoms that were thought to progress to more severe symptoms only at a later stage. Consequently, schizophrenia was diagnosed at a higher rate in the Soviet Union compared to other countries (World Health Organization, 1973). In particular, sluggish schizophrenia broadened the scope of this disorder because, according to Snezhnevsky, patients with this diagnosis were able to function almost normally in a social sense. Symptoms could resemble those of a neurosis or paranoia; for Snezchenvsky, these patients overvalued their own importance and might exhibit grandiose ideas of reforming society. Thus, symptoms of sluggish schizophrenia may include "reform delusions,", "struggle for the truth", and "perseverance" (Bloch, 1989). Accordingly, Snezhnevsky's ideas proved to be a convenient framework to "deal with" dissenters and political opposition. Extensive research indicates that at least one-third of political prisoners in the USSR were sent to psychiatric hospitals for compulsory treatment (Van Voren, 2010, p.109).

The dangerous and severe personality disorder (DSPD) experiment (e.g. Tyrer et al., 2010; Völlm & Konappa, 2012) between 2000 and 2013 in England and Wales (Trebilcock, 2020; Tyrer et al., 2015) is also relevant. The DSPD programme was a reaction to a high-profile case, where an individual with a personality disorder killed a mother and her daughter. This individual had previously been in contact with the psychiatric system and was deemed a risk to others. However, because he was considered "untreatable" by psychiatrists, he could not be detained (cf. "treatability test"[13], Mental Health Act 1983; Völlm & Konappa, 2012, p. 166). The suggested new legislation would have introduced the possibility of indefinite preventive detention of an individual without a criminal conviction who met the criteria of DSPD (Ullrich, Yang, & Coid, 2010). Whilst a specific DSPD legislation was not enacted in the end, the mental health legislation was changed to remove the treatability clause for these patients, instead only requiring that "appropriate treatment" is "available" (Völlm & Konappa, 2012, p. 166; Ullrich et al., 2010). Realised under existing mental health legislation, the DSPD programme allowed for the detention of an individual if (1) they were considered to be dangerous (risk of offending >50% on two risk assessment tools), (2) they had a severe disorder of personality, and (3) the risk presented appeared to be functionally linked to the significant personality disorder (Duggan, 2011; Tyrer et al., 2010).

Distinct from the Swiss cases in that a DSM/ICD diagnosis of a personality disorder was a requirement of a DSPD "diagnosis" in most instances, a score above 30 on the Psychopathy Checklist Revised (PCL-R) was also sufficient to meet the second criterion of a severe personality disorder (Duggan, 2011). DSPD was a new "diagnosis" introduced for the sole purpose of this programme and planned legislation. This is alarming since "only one out of the three key requirements for diagnosis (…) could be regarded as generally acceptable" (Tyrer et al., 2010, p. 96–97). Establishing whether a person fulfills the risk criterion is difficult and may likely have resulted in offenders being detained unnecessarily because of a lack of reliable instruments (Buchanan & Leese, 2001); to prevent one serious violent act, as many as six (false positive) individuals would have needed to be detained according to calculations by Buchanan and Leese (2001), which highlights ethical issues related to indefinite detention based on the prediction of risk (Völlm & Konappa, 2012). The link between the risk and the personality disorder lacks a clear evidence-base as well (Duggan & Howard, 2009) and has been largely neglected in assessment reports (Tyrer et al., 2007). This is problematic since, as Duggan and Howard (2009) outline, risk of recidivism can be independent of personality disorder in offenders with such a diagnosis.

Whilst we discussed the above two examples in depth, there are other notable examples throughout history; for instance, the adverse treatments for homosexuality in some countries or cultures should be mentioned. On the one hand, these led to the political abuse of (forensic) psychiatry and on the other hand to years of overtreatment of healthy individuals and mass protests from the international scientific community (Hall, 2017; James, 1962).

All of these historical cases present a clear warning for contemporaneous settings, demonstrating how psychiatry and psychiatric systems can be misused (either purposefully or inadvertently) and harm vulnerable groups.

### *3.5. Mandating scientific standards in diagnostic systems: A way forward?*

A unilateral expansion of the concept of a mental disorder by legal scholars beyond the already broadly applied entry criteria of the current classification systems gives rise to fears that there will be no more mentally healthy offenders in the future (see also e.g. Habermeyer, Lau, et al., 2020). Linked to this is the question as to whether the Swiss justice system would have the resources to maintain high-quality psychiatric-medical care if a steep increase in therapeutic measures should follow because of the new legal precedent. Even now, the basic medical care of offenders in Swiss prisons cannot be adequately guaranteed (Wolff & Schlup, 2020). Such an influx of offenders with court-mandated treatment who do not have a ICD/DSM diagnosis is likely to negatively affect the treatment of offenders with "classical" diagnoses such as schizophrenia, addiction, and attention-deficit hyperactivity disorder, for which established treatment with good empirical support exists (Chang, Larsson, Lichtenstein, & Fazel, 2015; Chang, Lichtenstein, Långström, Larsson, & Fazel, 2016).

Despite the concerns outlined above, however, the authors are somewhat encouraged that the SFSC emphasised the importance of a scientific basis in such alternative (forensic) diagnostic systems. For example, the SFSC mandated that there must be proof of compliance with scientific standards and criteria, and a focus on risk factors that are demonstrably amenable to risk-reducing therapy. However, in our opinion, this does not go far enough; the SFSC did not specify the exact standards that need to be met when a diagnosis is not (exclusively) based on a recognised classification system and their vague mention of "standards" and "criteria" provokes more questions than answers.

In some jurisdictions, clear standards have been developed regarding

[13] According to the 'treatability test', individuals with a personality disorder could only be detained if treatment was 'likely to alleviate or prevent a deterioration of [their] condition' (Mental Health Act 1983; Völlm & Konappa, 2012, p. 166).

the admissibility of scientific evidence in court (e.g. Daubert in the US; see e.g. Glancy & Saini, 2009; Woody, 2016). Whilst formulated in a US context, the Daubert standard has wide-ranging relevance, informing heterogeneous legal discussions (Faigman, 2013). Daubert emphasises distinct illustrative factors for the admissibility of scientific methodology, specifically: "whether the theory or technique employed by the expert is generally accepted in the scientific community; whether it's been subjected to peer review and publication; whether it can be and has been tested; and whether the known or potential rate of error is acceptable" (Daubert v. Merrell Dow Pharmaceuticals, Inc*, 1995*). In addition, Daubert requires that expert testimony be "based on scientifically valid principles" and "sound science", which "will require some objective, independent validation of the expert's methodology" (Daubert v. Merrell Dow Pharmaceuticals, Inc*, 1995*).

If it is allowable for diagnoses to be made which are independent of validated systems like the ICD and the DSM, it is a necessity that the SFSC adopt similar international conventions for the admissibility of evidence. Without clearly defined standards regarding the admissibility of evidence (which includes expert evidence, in this case regarding the presence of a mental disorder), there is a real possibility for inadequate or ineffective diagnosis and treatment for offenders and potential systematic ethical issues.

## 4. Conclusion

In this article we have discussed the wider context and the potential future implications of two SFSC decisions which allowed the diagnosis of a severe mental disorder to diverge from the ICD and the DSM classifications. We have argued that a diagnosis according to a broadly accepted diagnostic systems is a necessary, if not a sufficient, condition, before entering court mandated mental health treatment that may last for decades and go well beyond the time of a regular sentence. These recognised diagnostic systems, although not specific to forensic psychiatry and psychology, are based on a broad consensus, are well-studied, and their strengths and also weaknesses are known.

Through its rulings, the Court has opened the door for forensic-psychiatric diagnoses that are detached from these recognised systems; the proposed and locally applied new "diagnostic system" is not based on consensus, nor is it adequately evaluated. Resultantly, persons in Switzerland who may not be mentally ill based on established psychiatric nosology, but have committed a crime, could potentially be ordered a measure and subjected to therapies with unclear effectiveness. The authors believe that the welfare of offenders could be affected, as the system is left susceptible to ethical issues and arbitrariness.

Consequently, we suggest that the courts mandate that the admissibility of any diagnostic system must be underpinned by scientific consensus and a wide body of research which can validate its methodological rigour. Whilst these two rulings may have been well-intentioned, we believe that they could conceivably hold adverse implications for some of the most vulnerable people in Swiss society.

## Author note

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## Declaration of Competing Interest

none

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