Forensic Psychiatry

Report on a Working Group

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1. INTRODUCTION

In collaboration with the Government of Italy, the Regional Office for Europe of the World Health Organization held a Working Group on Forensic Psychiatry in Siena from 13 to 17 October 1975.

The meeting was convened as part of the Regional Office programme in mental health, which started in 1968 and concentrates on four main areas: community mental health services, child and adolescent mental health, alcoholism and drug dependence, and education and training. Forensic psychiatry relates to all these areas and reference to it has been made at previous meetings, particularly in the Working Group on Problems of Deviant Social Behaviour and Delinquency in Adolescents and Young Adults, Helsinki, June 1972 *(1)*; the Symposium on Major Issues in Juvenile Delinquency, Bratislava, August 1973 *(2)*; and the Working Group on Youth Advisory Services, Lübeck, May 1975 *(3)*.

The concept of criminality, as related to the prevailing laws of a country and to an individual psychiatric appraisal on the offender, is open to discussion, and the rapidity of changes in present-day society renders the task of the forensic psychiatrist more and more complex. There is a great need to consider the present status of forensic psychiatry under different control and treatment systems, and to discuss different attitudes towards forensic psychiatry and its role in the prevention of crime and in the control and treatment of offenders.

In addition to reviewing the situation, the meeting, with its multidisciplinary approach, offered constructive suggestions for future research and action.

There were 21 participants, from the disciplines of sociology, psychology, criminology, psychiatry, forensic psychiatry, public health administration and law. Information was also provided by some participants on the activities of the United Nations Social Defence Research Institute, the International Society of Criminology and the World Psychiatric Association. All the participants (see Annex V) attended as WHO temporary advisers. Welcome addresses were delivered to the opening session by Senator B. Pinto, Under-Secretary of State at the Ministry of Health, Rome, and Professor R. Vannugli, Director of International Relations, Ministry of Health, Rome. Other speakers were: from the Region of Tuscany, Dr Garzanti, Secretary for General Affairs; from the City of Siena, Mr C. Vannini, Mayor of Siena; Professor A. Gerola representing the Province of Siena; and from the University of Siena, which hosted the meeting, Professor M. Barni, Rector of the University, and Professor Ricci on behalf of the Faculty of Medicine.

Opening the meeting on behalf of Dr Leo A. Kaprio, Regional Director of the WHO Regional Office for Europe, Dr M. Postiglione, Chief, Disease

Prevention and Control, thanked the authorities, welcomed the participants and illustrated the scope of the meeting within the context of the Regional Office's programme in mental health.

The participants elected Professor M. Barni as Chairman, Dr B. Borup Svendsen, WHO consultant, as Vice-Chairman, and Dr J. Gunn as Rapporteur. Dr M. Postiglione acted as Secretary of the meeting.

2. ATTITUDES TO FORENSIC PSYCHIATRY

The meeting began with a tribute to the late Dr Anthony May, former Regional Officer for Mental Health at the Regional Office, who had especially looked forward to this meeting.

Unlike most international gatherings to which forensic psychiatrists contribute, the Working Group was intended to be a specific discussion of the functions of forensic psychiatry and a reappraisal of the subject as a discipline. Currently there is some doubt about the validity of forensic psychiatry as a separate subject, and it is important for forensic psychiatrists to listen to reputable critics. Such a re-evaluation is particularly timely in view of the major reorganization taking place in psychiatry, especially forensic psychiatry, in many parts of Europe. There is, for example, an apparent decline in the need for the services of the forensic psychiatrist in countries such as Denmark, which have hitherto been active in the development of the discipline.

Historically, there have been three main phases for forensic psychiatry. The first and pessimistic phase developed about a hundred years ago under the influence of the Italian positive school; it saw offenders as disturbed individuals who required not punishment but separation from society for the benefit of the latter. A second, and more optimistic, tradition began soon after the First World War, primarily in Anglo-Saxon countries, and generated the hypothesis that offenders have psychological problems which are amenable to treatment. Centres such as those at Herstedvester in Denmark, the Van der Hooven Clinic in the Netherlands and Grendon Underwood Prison in England were developed in response to this philosophy. The prevailing mood of today is sceptical, and the medical model is thought to be inappropriate for understanding a great deal of crime. Crime is more often seen as either a normal adaptational phenomenon or a reaction to social stress.

The participants were asked to consider a number of specific questions:

(1) Should forensic psychiatry have a specific role or should it be merged with criminology and penology?

(2) Should the forensic psychiatrist deal with all offenders or just mentally abnormal offenders?

(3) Where are the tasks of forensic psychiatry to be performed, within the ordinary hospital system or within the correctional system?

(4) Should special institutions exist for the mentally abnormal offender, should they be treated among other offenders, or should they be grouped among the rest of the mentally abnormal?

(5) What should be the aims of treatment?

(6) Should the psychiatrist always be responsible for the treatment?

(7) What should be the relationship of forensic psychiatry to general psychiatry?

(8) Are forensic psychiatrists able to contribute to the prevention of crime?

It was appreciated that definitive answers to these questions are unlikely in the immediate future but as these are some of the big issues in forensic psychiatry they were stated at the outset to focus the attention of participants.

The first phase of the meeting was devoted to a series of papers given by non-psychiatrists. Lawyers, sociologists, criminologists and offenders were invited to give their views as the employers and the customers of the forensic psychiatrist.

2.1 The view of the lawyer

By definition the forensic psychiatrist often works in association with lawyers. The lawyer sees two main tasks for the forensic psychiatrist. The first is to help judges and administrators, either at the trial or within the correctional system, to understand the mental state of an accused or of an offender. The second is to recommend and sometimes to carry out treatment programmes, particularly those that are aimed at preventing or controlling criminal behaviour.

One of the most frequent requests made of the forensic psychiatrist by the lawyer is to provide an assessment of the mental state of an alleged offender at the moment when a crime is committed. He is also expected to comment on a defendant's capacity to stand trial, the effects of intoxicants on his mental capacity and the mental responsibility of juveniles.

Such questions illustrate the difficulties of collaboration between the forensic psychiatrist and the lawyer, for despite the great experience of both parties, this question poses a difficulty which still remains unsolved. The judge wants to know whether the offender is criminally responsible, and if so, the degree of his responsibility. On the other hand, the psychiatrist uses medical methods to assess whether the offender has a mental disease and whether there are any methods appropriate for his treatment. Responsibility is a legal and penal concept which psychiatry does not normally use. Most reports, while setting out the psychiatric details, then proceed to make an illogical jump in trying to answer the specific legal questions. It is not possible for psychiatric science to assess precisely the quantum of free will or the corresponding moral responsibility of each subject, whereas that is exactly what the criminal justice system demands.

After sentence, further difficulties in communication are encountered. By its very nature the penal system is one in which all the goals are set by correctional staff and all offenders are forced to accept "help". This means that the basic tenets of treatment, such as voluntary acceptance and self-determination, cannot be realistically applied. Furthermore, as treatment becomes more scientific, so it increases the gap between the treaters and the treated in the prison system. The treaters are perceived by the treated as representatives of a dark and mysterious science which does not necessarily have the interests of the offender at heart. Almost inevitably, the treaters are usually perceived as representatives of the penal system.

2.2 The view of the criminologist

Criminology is itself in a state of flux and conflict and consists of many different schools, ranging from the "neo-positivists" to the "radical criminologists". These schools often have fundamentally irreconcilable approaches. It is within this context that the current criminological view of psychiatry has to be understood. In terms of their development, criminology and forensic psychiatry have been closely related. Perhaps we can identify three phases of development. Firstly, a control phase in which both criminology and forensic psychiatry viewed the criminal as the main object of interest. Then a diverging phase, in which criminology paid more attention to the structure of society itself. Now a phase in which some groups of criminologists see the treatment ideology of forensic psychiatry as destructive. This third phase means that criminologists and psychiatrists are now opposed to one another. Furthermore, the forensic psychiatrist can no longer claim political neutrality. It is conceivable that some reconciliation can come about if forensic psychiatry were to move away from the treatment of individuals in institutions to the establishment of systems of community psychiatry for offenders.

There are different ways of looking at the same problem. For example, shoplifting can be viewed as a social phenomenon in relation to modern cities, or shoplifters can be examined as individuals. There are three ways of viewing crime: (1) legal; (2) social; (3) psychological or individual. Forensic psychiatry is bound to view crime from the individual's point of view.

Perhaps the task of forensic psychiatry should be to free the individual sufficiently to allow him to make his own choices within the legal and social framework in which he lives. The forensic psychiatrist should not do things *to* an offender or *for* an offender but *with* an offender.

2.3 The view of the offender

Unfortunately, it was not possible to have an offender present his point of view but a representative from an offenders' organization was able to join in the discussion using a prepared manuscript which had been read by some prisoners.

The offender's viewpoint starts from the philosophy that confinement is irrational. Therefore, to the degree that the psychiatrist is an upholder and an agent of a confinement system, the psychiatrist is opposed to the interests of the offender. A psychiatrist ought to be an agent of the offender, not of the penal system.

Sometimes the offender is frightened and resentful of the psychiatrist, because the latter is a man of power in terms of the interplay occurring in the courts; he pries into human tragedy and then uses the information gained in a professional relationship directed against the offender. A prisoner can feel totally humiliated by hearing himself described, in public, as "insane", "unstable", "lacking emotion", "dangerous".

The offender's expectations of "treatment" can be totally destroyed by reality, where the treatment may mean simply that the prison he is sent to is run by a psychiatrist rather than another kind of legal administrator. Furthermore, the treatment ideology applied to psychiatric penal institutions humanizes them to some extent as places of confinement and hence makes them more likely to be used for longer periods.

The indeterminate sentence is a special problem for the forensic psychiatrist. In practice, it does not influence the rates of recidivism but it imposes a special cruelty, arising from uncertainty and constantly dashed hopes.

When the ordinary doctor works for an individual patient, he tries to preserve him from harm and respects his confidence. The forensic psychiatrist is a special kind of doctor because for him security comes before the need of his patient. He is in fact a well-educated, specialized prison guard. Prisoners are particularly afraid of the "psycho-cop" who decides issues of parole.

Prisoners believe the following principles of forensic psychiatry should be upheld:

(1) psychiatrists should make no statements until it is clear that the accused actually did the criminal act with which he is charged;

(2) psychotic prisoners should be treated by psychiatrists in a non-penal medical clinic;

(3) if a prisoner becomes psychotic during a prison sentence he should be transferred to an ordinary mental hospital;

(4) any prisoner should have the right to consult any doctor from outside the prison;

(5) courts and courts alone should make decisions about a prisoner's future.

2.4 The view of the sociologist

A court is a place for resolving conflict. Conflict can arise between individuals, or between the State and the individual. To resolve a conflict justly, a court has no special skills other than law, and it is open to the public. Medicine, on the other hand, is a profession and the doctor's role is usually quite clear; that of helping the patient fight his disability.

Originally, the forensic psychiatrist operated in court, as part of the ordinary medical tradition. He was on his patient's side, protecting him from the horrors of the penal system. For example, he tried to protect him from the gallows, or from torture. When systems of punishment changed to more humane confinement practices, the forensic psychiatrist gradually changed sides, so that now he is often on the side of the State and against certain members of the criminal population. Offenders are now afraid of psychiatrists because they have the power to increase the length of sentences, and they can impart a special stigma, that of mental instability.

Psychiatrists are expert witnesses of great power but in reality they are bad at predictions *(4)*. They are especially bad at predicting dangerousness and as a consequence they over-predict risk *(5)*. Moreover, psychiatric treatment does not reduce recidivism.

In Scandinavia, forensic psychiatry has been losing its influence. This carries the danger that the humanizing influence brought in by psychiatry may also be lost. A possible solution to this dilemma is to ask the court to weigh the suffering a disturbed offender has already received from others and punish him accordingly. Another solution is to change the nature of the conflict in criminal law from: State *v* the offender to victim *v* the offender. Most important of all, forensic psychiatrists should return to their medical role, that of obtaining protection for the accused *(6,7)*.

The sociologist sees a place for ordinary psychiatry in the conflict between the offender and society. Why not abolish the specialty of forensic psychiatry? Ordinary psychiatrists could then perform their traditional medical tasks on behalf of their patients, irrespective of whether they are offenders or not.

2.5 General discussion

Perhaps not surprisingly, the forensic psychiatrists did not agree that their specialty should be abolished. It was pointed out that even if forensic psychiatry is abolished, mentally abnormal offenders will still require treatment and it is probably better to employ for this someone who learns about the special problems in this field. Furthermore, in many countries forensic psychiatrists are not pure specialists but simply general psychiatrists employed occasionally to work for courts or for clients. Their fundamental psychiatric task is still, as indicated by the lawyer (section 2.1 above), to determine whether the patient is psychotic or not. Criticisms of inaccurate prediction and ineffective treatment have been levelled at every kind of professional in the legal and penal system and are not peculiar to psychiatry. It is not true to say that the traditional role of general psychiatry is only to act as a patient's agent and to treat those who wish to be treated. Throughout its history, psychiatry has always been related to some element of coercion. Every country has laws to protect the mentally deranged patient from himself or to protect society against the damage he can do. The Working Group was warned that the anti-therapeutic ideology may in fact be the vengeance ideology or the punishment ideology. If forensic psychiatry is to be swept away, then those who are concerned about the wellbeing of offenders should be clear about the system that is to replace the present one. It may be that some of the objections to forensic psychiatry could be met if such specialists concentrated on the mentally ill who commit crimes rather than on criminals who also have mental abnormalities. The psychiatrists from the British Isles agreed with the sociologist that the accusatorial system has distinct advantages for a psychiatrist, as he is clearly employed by one side or the other. However, the Continental psychiatrists felt that such a system can lead to dishonesty, with each party trying to put forward a slightly distorted view which best suits his client's interest rather than trying to be objective and scientific as he is elsewhere in medicine.

There was general acceptance that courts cannot be expected to be competent in psychiatry and that they will probably always require psychiatric testimony. One of the aims of modern psychiatric education should be to improve the standards of testimony presented in court. There was also complete agreement that psychiatrists should not try to change individuals' belief systems. If treatment is to be applied then it should be for

specific disorders, not just simply the management or the training of those who dislike the society in which they live.

3. PRESENT ORGANIZATIONAL STATUS OF FORENSIC PSYCHIATRY

Participants from several countries presented aspects of their own national systems to illustrate the rich variety of legal codes and forensic work practised within Europe. Obviously, limitations of space prevent discussion of more than a few of these in detail.

3.1 Austria

In the new Austrian penal code, established in 1974, diminished responsibility has been abolished because it was considered to create an unfair situation whereby a convicted man suffering from diminished responsibility could be sent first to prison for a shortish period and then to hospital. In place of diminished responsibility an indeterminate sentence with a supposed maximum has been established. Borderline cases and those persons deemed "psychopathological", who do not suffer from psychosis, can be sent to special psychiatric prisons, operated as part of the prison system. From these prisons an offender can obtain a conditional release before the end of his sentence, or he can be confined beyond the "maximum" point in his sentence if he is deemed dangerous. Prisoners may be freely transferred between psychiatric prisons and ordinary prisons. Five or six Austrian prisons now have medical departments and there are some 22 prison psychiatrists, about half of whom are associated with universities. The prison system also has special institutions for drug addicts who can receive indeterminate sentences of up to two years. In addition to the prisons, Austria has institutions for mentally abnormal offenders who are found to be not responsible (for example, they may suffer from a psychosis). These special institutions come under the Ministry of Justice and are therefore separated from the ordinary psychiatric hospitals which are under the jurisdiction of the health service.

The forensic psychiatrist has the usual functions of (1) providing court reports and (2) providing treatment.

3.2 Denmark

Psychiatrists in all parts of Scandinavia would be unhappy to work in the adversary legal system which pertains in the Anglo-Saxon countries.

Scandinavian psychiatrists feel that the adversary system leads to half-truths and distortions and a clash of opinions in open court, and it is felt that this system detracts from clinical objectivity and is not, for example, a good way of arriving at a diagnosis.

In Denmark, for example, for the past ten years or so the influence of psychiatry on the judicial system has been on the wane. Penal reforms were introduced in 1973 which took away practically all the special psychiatric arrangements within the penal system, including the detention centre for criminal psychopaths at Herstedvester where offenders were placed for an indeterminate period. As a consequence, the forensic psychiatrists have now virtually given up their role of treating offenders as such within the correctional system. Psychiatric reports for the court are usually required only in serious criminal cases. Twenty years ago, 15% of all offenders receiving more than a fine or "haefte" (a short term of imprisonment) were psychiatrically examined for the court; now the equivalent figure is 5%.

The main purpose of a psychiatric court report is to indicate gross mental abnormality, psychosis, and mental retardation. Offenders found to suffer from such conditions are transferred to the ordinary civil health services. For approximately 100 years physicians have not advised on the question of "responsibility"; this issue is left to the court. A psychiatric examination can be performed during a hospital admission, during a remand in custody (the majority), or while a defendant is on bail. Only one examination is made, for the court, and it is not specially conducted for the defence or the prosecution. Half the reports are made by psychiatrists, half by public health officers. The reporting doctor almost never appears in court, but about half of all reports – those for accused persons with considerable problems or those prepared for important cases – are presented to the psychiatric section of the Medico-Legal Council, which states whether it considers the conclusions of the report valid. Sometimes the reports are sent back to the author with amendments or requests for further investigation.

Nowadays probably too few psychiatric reports are made to the court. This means that some psychotics are being kept in ordinary prisons, and queues are developing for psychiatric observation in special secure institutions. This latter phenomenon is related to the desire of many hospital units to avoid having any closed wards at all.

About 20% of the patients examined are transferred to civil institutions and outpatient services. The remainder are dealt with as part of the penal system. Under the influence of the positive school of criminology, the penal law of 1930 established special youth prisons, alcoholic institutions, special work camps, security protection centres, prisons for psychopaths, and special detention centres for criminal psychopaths. For practical purposes, all these special arrangements (which were of indeterminate

duration) were abolished in 1973 along with the detention centre for criminal psychopaths in Herstedvester. This was because there was a growing dislike among many professionals (except perhaps psychiatrists) for the indeterminate sentence.

Now there is only one prison run by psychiatrists and a somewhat limited consultation service within the probation system. This means that the forensic psychiatrist has been removed from his role of treating the offender within the correctional system, in the framework of specific sanctions formulated by the court. But the Herstedvester institution is still run by psychiatrists; the goal is by now, in principle, to offer psychiatric service or assistance to those prisoners who ask for it or who, on account of psychiatric symptoms, cannot remain in an ordinary prison. The number of prisoners seen by psychiatrists per year has increased since the change in the penal law, and the psychiatrist now simply provides a service where it is requested. Some 10 psychiatrists out of 500 work full-time in forensic psychiatry.

Elsewhere in Scandinavia, the importance of the forensic psychiatrist has also declined somewhat, although in Sweden, a number of special institutions have been established and forensic psychiatry as a specialty is on a par with general psychiatry and child psychiatry. In Sweden there is a considerable shortage of forensic psychiatrists. Criminal psychopaths are supposed to be sent to ordinary civil mental hospitals for treatment but even after many years of endeavour the difficulties associated with this idea have not yet been overcome.

By comparison with Denmark, in Finland and Norway fewer reports are made for the court and fewer psychiatrists are concerned with the treatment of offenders after the trial.

3.3 Federal Republic of Germany

The main task for the forensic psychiatrist in the Federal Republic is to testify on the mental state of the accused. He is primarily employed to give his opinion on the legal responsibility of the accused and, in cases of juveniles, to evaluate their degree of maturity. In addition, in trials of sexual offenders, he has to assess the capability of a juvenile witness to give accurate testimony. All such questions are legal ones and the expert is merely supposed to give his opinion, the final evaluation residing with the judge. The psychiatric expert is appointed by the prosecution or by the court. Since the school to which an expert belongs, and his degree of liberality are usually well known, the result of psychiatric examination can be influenced by selection of a particular psychiatrist.

After the Second World War efforts were made to reform the 1871 Criminal Code, and the narrow somatic approach to mental illness was removed. A new law was brought into effect from 1 January 1975. It is now possible to be found lacking in responsibility or suffering from diminished

responsibility because of "pathological psychic disturbance", "profound disturbance of consciousness", "feeble-mindedness", or "severe mental abnormality". The legal concepts, however, are not identical with medical or psycholigical ones and there are therefore still difficulties of communication between lawyers and doctors. Scientific evidence, however, is being increasingly used in court; for example, feeble-mindedness is now quite frequently determined by the results of standardized tests instead of rough clinical estimates.

It is noteworthy that psychiatrists in the Federal Republic were opposed to the use of the concept of profound disturbance of consciousness (which refers to states of strong mental agitation not caused by illness) as a ground for diminished responsibility. They saw it as leading to a future situation where every offender could claim to have acted in a state of extreme excitement. This has led to an interesting consequence, for psychiatrists frequently decline to give evidence on this issue, and courts are increasingly employing psychologists instead. There has, in fact, been a general increase in the use of the psychologist in court as an expert, much to the dismay of psychiatrists and in spite of their opposition.

Most forensic examinations are carried out by public health agencies or institutes. If observation of a defendant is considered to be necessary he can be detained in a psychiatric hospital for up to six weeks, but most examinations are carried out under outpatient conditions or in a prison. A psychiatric expert is supposed to be present during the whole court proceedings. He is entitled to put questions to the accused and to the witnesses. Though he has supplied the court with a written report before the trial, only his verbal report counts. He can introduce as evidence only facts stated during the trial and findings of his own medical examination. The psychiatrist normally questions both the defendant and the witnesses, and after he has given his findings, he in turn is questioned by the court and other participants of the trial.

In the past, forensic psychiatry has been little involved in therapeutic work in the Federal Republic of Germany. Offenders found guilty but insane were handed over to the custody of a psychiatric hospital. Therapeutic measures were usually only applied when one of the classic psychiatric diseases was present. The new law should introduce more therapeutic potential. However, whether this is realized or not will largely depend on whether adequate State finances are forthcoming. The omens are not encouraging. It was decided two years ago to set up social therapeutic institutions for the treatment of offenders. The development of these had been postponed and the new date for their introduction is 1978. They should admit recidivists with severe personality disorders, sexual delinquents, etc. Each of the new institutions is to be headed by a physician.

The fashionable anti-therapeutic wave in criminology will not cause many changes in the Federal Republic of Germany since the so-called treatment ideology never gained much influence there.

3.4 Ireland

In the Irish Republic certain models of service have been developed or fostered since the inception of specific programmes in 1971:

(1) *The comprehensive forensic psychiatric programme.* The services are developed independently within the health/social services. The clientele are treated and moved within the spectrum of services according to their perceived clinical needs.

(2) *The supplementary programme.* An example of this is after-care in the community after release. Certain prisoners who have been treated for psychiatric disturbances during their prison sentence may, on completing their sentence, be referred by the visiting psychiatrist to the prison (a member of the forensic psychiatric team) to an outpatient clinic of their local psychiatric hospital.

(3) *Isolated services,* usually in community hospitals for specific forensic problems: e.g., drug abuse, family violence.

(4) *Therapeutic communities.* Examples of this are a therapeutic community for drug abusers at Coolemine run on the Synanon model by ex-addicts. A similar institution exists for the treatment of alcoholics in the southern part of the country.

(5) *Education programmes in residential centres for disturbed juvenile offenders.* The staff nucleus in such centres is provided by religious orders. Psychiatric services to such centres are provided by the child psychiatry service. It is a matter of immediate concern that the age of criminal responsibility in the Republic is 7. Between this age and the age of 17, children may be charged with criminal offences but are normally tried in a juvenile court. There are no maximum security psychiatric facilities for children in the country.

Forensic services include:

(1) a central mental hospital,

(2) a day hospital outpatient clinic and assessment service for offenders,

(3) coordinated services for drug abusers.

The five psychiatrists, out of the nine physicians working in the forensic service, provide weekly treatment sessions in the prisons in the Dublin area.

Forensic psychiatric work in the medical/social environment does not provide a milieu for therapeutic miracles. It does, however, enable the health professional to work in a situation over which he has more control and therefore greater ability to establish an alliance of hope with his client.

3.5 Italy

Imputability (akin to responsibility) is a basic concept in Italian law. To be imputable an offender has to have the capacity of knowing and of willing. Before the age of 14 an offender is never imputable. However, if he has committed a crime which is considered dangerous he can be taken to a reformatory or placed under control within the community. From 14 to 18 years an offender is imputable, but the degree of his mental development has to be evaluated in a psychiatric report; at any age older than 18 years he is fully imputable.

Italian forensic services include prisons for juvenile delinquents. Juvenile courts have to have laymen qualified in social work, psychology, or other relevant disciplines sitting among the judges. The Italian penal system also includes special prisons run by physicians who are not necessarily psychiatrists, although these prisons are intended for mentally unstable offenders. The mentally abnormal offender may be found non-imputable or partially imputable according to the nature and severity of his disorder.

The forensic services in Italy still face a number of problems. For example, a judge can, without recourse to a psychiatric report, determine dangerousness. There are very few centres for the treatment of alcohol dependency. Previously, there was no distinction in Italian law between a drug pusher and a drug taker.[a]

For adults, under new legislation, there will be preventive detention institutions, prisons, security institutions such as farms, colonies and clinics, and observation centres for the scientific investigation of an offender's personality. It will be possible to send socially dangerous individuals to a security institution even if they are not imputable. Obviously the forensic psychiatrist will have to take a special interest in such institutions.

Even allowing for the new law, however, there will still be considerable defects in the Italian system. The basic problem is that psychiatrists are allowed to comment only on the mental state of the accused. They are not allowed to make any psychological assessment of personality. Furthermore, psychological and social work reports are only allowed in juvenile courts. Italian psychiatrists, criminologists, and other experts feel strongly that the Italian judicial system should move much more quickly towards accepting evidence from a wide range of experts at several different points in the court process. They feel it is wrong to confine the expertise to psychiatry and to

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[a] Since the Working Group, a new law has been adopted (Law No. 685 of 22 December 1975) that modifies such a situation by the introduction of more severe punishments for the drug pusher and the enforcement of recovery measures for the drug taker.

the question of imputable or not imputable. Ideally they would want observational studies to be allowed during the preliminary proceedings and for evidence of these to be introduced into the court. There should also be a real capacity to carry out psychological or psychiatric treatment within the community rather than necessarily within an institution.

3.6 Netherlands

A court can ask for a mental report on an offender in order to ascertain the degree of mental responsibility for his offence.

There is a shortage of observational facilities and only in serious criminal cases or when serious mental disorder is obvious can the offender be taken, for observation, for six weeks to the special psychiatric observation clinic in Utrecht.

Offenders found to be completely lacking in responsibility can be sentenced in one of four ways:

(1) Discharged.

(2) Discharged and committed to a mental hospital for a maximum of one year, although this can, if necessary, be extended yearly.

(3) Discharged with detention at the Government's pleasure (TBR) in order to undergo treatment at a special TBR institution. This detention order is for a period of two years but may be extended any number of times for one or two years by a court. It can also be a suspended sentence. In the near future this type of detention order will be limited to a maximum of four years and if further detention is needed it will have to be ordered under the civil insanity laws. Some psychiatrists are unhappy about the new proposal, believing that unlimited sentences are necessary for effective treatment.

(4) Discharge, committal to a mental hospital for one year, and detention at the Government's pleasure.

If an offender is found to have diminished responsibility he must be given a penal sentence, although the judge may order TBR as well (for instance two years' prison plus TBR). A proposal for the future is that an offender should receive a prison sentence or the detention order, but not both. Already offenders are usually admitted to the TBR institution during their imprisonment, in order to start treatment as soon as possible.

It is possible for offenders deemed completely responsible to be sentenced to TBR, but usually only if they are recidivists and only if a psychiatrist has diagnosed a mild disorder.

TBR institutions are a specialized type of mental hospital dealing with offenders. They are controlled by the Ministry of Justice, although of the

eight in current use, only three are actually owned by the State. These TBR institutions are a special form of mental hospital for offenders and are run as therapeutic communities. Most of the patients sent there are poorly motivated and would rather be sentenced to prison. In practice, resistance to treatment usually fades away when the offenders understand the regime. They always, however, have a right to appeal against a TBR placement, to a special board.

3.7 United Kingdom

(a) *England and Wales*

Forensic psychiatry is at a critical and interesting phase of development in the United Kingdom. The British National Health Service has just undergone reorganization and this is affecting all areas of medicine, including forensic psychiatry. Much more importantly, however, a government working party, the Butler Committee *(8)*, charged specifically with examining forensic psychiatry and its problems, has just completed three years' work and has proposed a number of major changes both in the law and in facilities for the mentally abnormal offender. Time will tell whether or not these proposals will be carried out but in any case the Report has established a new wave of understanding and interest in forensic psychiatry.

Under the new arrangements England and Wales is divided into a number of Regional Health Areas, charged with providing all medical and nursing facilities required, including mental hospital facilities, except maximum security arrangements. However, forensic services are still rudimentary and the first major recommendation of the Butler Committee was that there should be more effective regional forensic services, including some medium security services. There is a centralized national health service maximum security hospital service, largely for the patient offender, run independently of the regional structure, consisting of four hospitals. The Prison Department also has an independent Prison Medical Service which is entirely separate from the National Health Service and which looks after the health of all prisoners in custody. This service provides the bulk of psychiatric court reports and runs specialized forensic psychiatry facilities such as Grendon Underwood Prison and other therapeutic communities.

All aspects of psychiatry have been profoundly affected in Britain by the trends which took place after the Second World War and have been enshrined in England and Wales in the 1959 Mental Health Act. In essence these trends were a liberalization of hospital care, a determination to regard a psychiatric patient as no different from any other kind of patient, and a community care philosophy which sees the bulk of psychiatric treatment being provided by outpatient and community arrangements. Most mental hospital doors are now fully open for the patient to leave and

indeed most psychiatric practice is being transferred to district general hospitals and it is intended to pull down as many as possible of the old large mental hospitals on the basis that chronic care will be provided by the community social services.

In practice this has led to a number of difficulties. Hospitals are now very reluctant to accept troublesome patients. Many hospital staff now believe it is wrong and retrograde to control psychiatric patients or to nurse them behind closed doors. It follows that, if such an ethic is applied to the whole of the mental health system, a significant minority of patients will not be catered for. Not all patients can be dealt with in an entirely open liberal system. Currently, many disturbed and disturbing patients are either living at home or being treated in prisons. Chronic care is far from satisfactory in the community and patients who have chronic disorders are frequently readmitted to psychiatric services. Aftercare and community facilities of all kinds are greatly overstretched.

The special hospitals providing maximum security are full to capacity and are frequently dealing with patients who do not require maximum security but who are simply too troublesome for an open ward in a general hospital. Most patients who commit an offence are sent to prison for psychiatric examination, and many such patients are imprisoned because the only facility which will offer them inpatient medical treatment is a prison.

In England and Wales, the lack of resources for forensic psychiatry is a severe problem. There is remarkably little interest in special hospitals, prison medicine, and the chronic care of troublesome patients. Very little research money has hitherto been allocated, although the Department of Health and Social Security is now setting up a special research budget especially for forensic psychiatry. There is no established university department of forensic psychiatry anywhere in England and Wales, and there is consequently very little formal teaching of this discipline to medical students or postgraduate students.

It was the growing crisis in forensic psychiatry, including a number of patients who offended in a dangerous way, that led to the setting up of the Butler Committee, whose main recommendations included the following. Every region should establish a forensic psychiatry service including a medium security service. Courts should be able to remand patients to hospital for medical and psychiatric examination. Psychopathic patients should be dealt with largely by the Prison Medical Service, leaving the National Health Service to deal with the mentally ill and the subnormal. The Prison Department should establish special units within prisons for the treatment of psychopaths, and courts should be able to impose a reviewable sentence on imprisonment for highly dangerous patients who might otherwise receive life imprisonment.

(b) *Scotland*

While Scotland has been affected by many of the attitudinal and resource problems affecting England and Wales, there are some differences in the forensic services. Firstly there is no separate Prison Medical Service; prisoners requiring psychiatric and other medical advice obtain consultation from national health service doctors. Unlike England and Wales, Scotland has a Department of Forensic Psychiatry at Edinburgh University. Scotland has only one special hospital, at Carstairs, but approximately half of its patients have never been through the court process. In Scotland crime is still perceived as individual wickedness. Psychopathy is not recognized as a syndrome and the psychiatrist has not been as welcome as a therapeutic agent as he has been elsewhere.

3.8 Union of Soviet Socialist Republics

In the USSR, the tasks of the forensic psychiatrist include the evaluation of the mental state, and degree of responsibility of an accused person, recommendations as to treatment of the mentally ill or those considered lacking responsibility, evaluation of the mental state of those who show signs of psychiatric illness whilst serving a sentence and recommendations regarding appropriate medical measures, the examination of the mental state of victims and witnesses and the evaluation of the capacity of subjects to give evidence in a civil court.

As a rule a forensic psychiatric examination is carried out by a commission of public health psychiatrists who are independent of the prosecution and the defence in the trial. The examination may be required at the time of the preliminary investigation, during the hearing of the case, or while serving a sentence. Although only the investigating and judicial authorities can appoint the psychiatrist, an application for such an examination may come from the accused, his relatives, guardians or lawyers.

Examinations are carried out for a variety of reasons. For example, the accused may be known to have a psychiatric history, he may have had a brain lesion or he may have been described as mentally retarded in childhood. Witnesses may give evidence about abnormalities in his behaviour, or court members themselves may be concerned about his behaviour, even the very nature of the offence (for example, unmotivated action or excessive cruelty) may persuade the court to ask for a psychiatric examination.

The examination can be carried out in a mental hospital, at an outpatient clinic, at the investigator's chambers, or sometimes in the absence of the subject concerned, if there are case documents available. Special forensic psychiatric departments in mental hospitals have been set up by the public health authorities; these have both inpatient and outpatient facilities. In the USSR only an accredited specialist can practise as a forensic psychiatrist.

Inpatient observation cannot, as a rule, exceed 30 days. If a psychiatrist requires more time than this he has to show due cause to the court for prolonging his period of observation.

The forensic psychiatrist has a right to request any previous documents, and case histories which might throw light upon the subject's personality and previous behaviour. This is particularly important when it is suspected that the subject has suffered from temporary mental disorder at the time of the offence. The psychiatrist has a right to be present at court hearing, to ask questions during the interrogation, and to consult other experts. If at any point, the expert finds that the problem facing him lies outside his competence or the available evidence he can, after explaining his reasons, refuse to submit a report.

The results of the forensic psychiatric examination are submitted in the form of a report signed by all members of the public health committee, who share equally in the responsibility for its content. If one of the experts disagrees with the opinion of the others he has a right to refuse to sign the report and state his personal view in a minority report. The report is, of course, not necessarily conclusive, and is treated in court as one piece of evidence before the court makes a final decision on responsibility, etc. If the expert committee does not satisfy the court, a second examination may be sought. This second examination will be carried out by other experts, and is usually entrusted to the Serbsky Institute of Forensic Psychiatry.

Although the Serbsky Institute of Forensic Psychiatry is entrusted with most of these second examinations, it should be emphasized that there is no procedural hierarchy in forensic psychiatry in the USSR. In law, the conclusions of the Serbsky Institute are considered of equal value to other experts and are evaluated on their merits.

The Serbsky Institute was established to protect the rights of mental patients who have committed socially dangerous acts and is now the scientific and methodological centre for forensic psychiatry. It is run by the USSR Ministry of Health. In addition to the examination of complicated and controversial cases it carries out extensive research and trains specialists in forensic psychiatry. Regular postgraduate training courses in forensic psychiatry are held for psychiatrists from all the Soviet Republics. It also teaches law students, for whom forensic psychiatry is a compulsory subject.

In the Soviet Union, forensic examinations are not the basis of a contest of experts, each appointed by interested parties. The main forensic aim is to protect the rights of mental patients and provide them with a maximum of help. The great importance attached to forensic psychiatry in the USSR is indicative of the attention given by Soviet justice to the personality of the accused, witnesses, victims of crimes, plaintiffs and defendants in a trial.

3.9 Discussion

Everybody was impressed with the diversity of systems operating in Europe. This makes generalization extremely difficult. A plea was made for European comparative studies to be conducted.

Some participants felt that there was much too much emphasis on diagnosis, which is only the beginning of events, so far as the fate of an offender is concerned. In some systems the offender might actually prefer to go to prison rather than to hospital, and a properly organized system should allow him that choice.

Others agreed that the psychopathic individual is particularly unfortunate in many systems because he is under two restraints: he receives both punishment and treatment. Some believed that the concept of psychopathy serves no useful purpose and could be abolished. So-called concern for the safety of the community may in fact hide a punitive element.

One participant emphasized that doctors who work for ministries of justice are never entirely free agents. They cannot make discharge decisions on clinical grounds alone because "security" always has to be considered.

It was pointed out that in some forensic situations, nurses become little more than guards working to a form of military discipline.

A number of participants stressed that forensic psychiatry is an ordinary part of medical practice and its skills are not confined to diagnosis. Prevention, treatment, prognosis, rehabilitation, and follow-up are also part of the business of forensic psychiatry. Good forensic psychiatry is practised in an open nondisciplinary manner, in collaboration with nurses, social workers, probation officers, psychologists and the like. A good service to the client will depend upon free communication between these various disciplines, and the various stages in the diagnosis, treatment and rehabilitation process.

A further plea was heard for the patient's views to be taken into account when disposal recommendations are being made.

4. FUTURE POLICY

4.1 Forensic work in different settings

Most participants believed that crime is not often related to mental disease, but some criminals are mentally abnormal. On the other hand, long-term imprisonment (say over 4-6 years) can damage mental health. Any civilized system will have to find ways of coping with the two problems. For example, if the mentally abnormal criminal is not treated in prison

then he has to be treated in a security hospital. Many participants believed that the main obstacle to effective institutional treatment for offenders is the total institution. Almost everybody agreed that all total institutions are mentally harmful, and that prisons are especially harmful, because they stigmatize the prisoner and are universities of crime. Nevertheless it would be unrealistic to expect that in the near future all total institutions and prisons will be abolished.

It seems reasonable to assume that something of the order of 10% to 20% of the general population needs psychiatric help at least once in a lifetime. Therefore, at least a substantial part of the criminal population also can be considered as in need of psychiatric help. Prisons were designed as punishment and as correctional institutions. If they correct at all, they only correct the well-balanced, fully integrated person.

Psychiatry must defend itself today against the charge that it is an instrument of individual or collective repression. Psychiatry has always stood close to coercion and compulsion. Modern laws should protect the individual from the possible abuse of psychiatry. Psychiatry has a connexion with total institutions and we know from history that psychiatric asylums and prisons were not always separate. It was felt that the fact that we separate the two types of institution today is more due to progress in psychiatry than to progress in the administration of justice. The view was expressed that modern psychiatry should aim at giving responsibility to the mentally sick.

Any system needs doctors; the question for debate is the point in that system at which the doctor operates and how he deploys his skills. Nobody believes that prisoners should be excluded from medical and scientific help.

There was general agreement that we should begin to look for a new approach to forensic psychiatry. Traditional forensic psychiatry limits itself to court work and treatment on an institutional model. A move could now be made into aftercare, crisis intervention, and outpatient treatment in collaboration with probation officers.

Several disadvantages to the penal system as a therapeutic agent were outlined. Firstly most prisons are total institutions and have poor accommodation. Next psychiatrists, counsellors and the like make poor prison governors because of the conflict of their interests. Thirdly, it is unlikely that prison regimes can be altered sufficiently to allow for flexible home leave, or for early discharge arrangements if required. One participant outlined his view that all delinquency is a form of personal illness, in that it is a symptom of maldevelopment. He therefore felt that there was no case for retaining prisons at all; all delinquents should be sent to therapeutic institutions.

There was general agreement that as general psychiatry moves more toward community psychiatry so forensic psychiatry should move more into the community. Recent developments in the Republic of Ireland were taken to illustrate the changes that are needed as this happens. Firstly, modernized

maximum security psychiatric hospitals with acceptable staff/patient ratios and the introduction of proper therapeutic programmes are required. This may cause difficulties in itself as it is possible that nursing unions will not allow their members to be employed in such hospitals. Coordinated services for drug abusers are required, and expanded and modified day-hospital programmes are needed. Patients can be referred to the forensic services on a voluntary basis, on probation, during parole, during a suspended sentence, or whilst on remand.

When we consider the complete separation of the health care and penal system we should also consider its advantages and disadvantages:

Advantages

(a) The clientele do not confuse psychiatry with punishment.

(b) Doctors have few role conflicts.

(c) Doctors have more clinical freedom.

(d) Cross referral between the systems is possible.

(e) Voluntary agencies can be used to the full.

Disadvantages

(a) The health care system tends to reject the troublesome offender.

(b) There are legal delays in getting offender patients into the civil health system.

(c) Doctors get anxious about their potentially violent patients.

(d) Most justice systems will keep the right of veto over important clinical decisions such as discharge.

One of the biggest problems of separating the health care and penal systems as far as possible is the stigmatization of the forensic services. Offender patients are readily rejected and in some situations find it very difficult to receive psychiatric treatment at all. It is as well to keep in mind two well-described phenomena. Penrose's Law suggests that there is an inverse relationship between mental hospitals and prison population figures *(9)*. Rollin has drawn attention to the revolving mental hospital door for the offender patient treated in a health care system which is completely open and liberal *(10)*.

The Danish experience is also worth noting. At one time, mentally retarded offenders were always transferred to the civil system, but subsequently the hospitals improved, retrained many of the retarded patients and

returned them to the community. If they re-offend, nowadays they often ask to be treated as criminals rather than as patients.

There are in general only four types of institution for the mentally abnormal offender in current use: (1) prisons with visiting doctors; (2) special psychiatric prisons; (3) special security hospitals; (4) ordinary psychiatric hospitals. There are special dangers in relation to the special psychiatric prisons and special security hospitals because the nurses and doctors easily become part of the law enforcement system and thus compromise their ethics. On the other hand, some believe that only by possessing formal status within the justice system will the doctor have sufficient influence to act in a really reforming way.

There are special problems in treating the offender patient in an ordinary psychiatric hospital. A crucial point is whether the case is closed, from a legal point of view, at the transfer from the justice system to the health system. In other words it has to be established whether it will be necessary for the non-correctional institution to obtain permission from the justice department, perhaps through a new court procedure, to transfer the patient, give him permission to leave the hospital, or to discharge him. The participants discussed one example of the problems resulting from a justice department veto, outlined in Greenland's article on treatment under compulsion *(11)*. The example, which raises the problem of preventing courts from using mental hospitals as an extension of the prison system, goes back to 1938, when a man, during a psychotic episode, killed his small son and a niece and was found unfit to stand trial. Seven years later his doctor reported that he had recovered sufficiently to stand trial. He was then tried, acquitted on the ground of insanity and sent to gaol to "await the pleasure of the Lieutenant Governor"; although at this point he was no longer mentally ill he was transferred back to hospital where he remained for another 22 years until his release was arranged by Canada's Ombudsman. In the early years of his confinement vigorous but unsuccessful efforts were made by the hospital superintendent and the patient's mother to have the case reviewed. Participants felt that if, as in this case, the justice authorities have the right to veto discharge, then the institution outside the justice system acts as a branch of the justice system.

The most satisfactory approach from the doctor's viewpoint is when the criminal case is settled in court with a transfer or referral to a non-penal institution, which then treats the patient according to its own rules. This institution can treat him as an outpatient, an inpatient or discharge him if he is not motivated to treatment.

Public opinion will not allow restrictive security conditions to be removed in all cases. Some participants felt that it is part of the forensic psychiatrist's task to campaign for these to be as few as possible and to see that there are appeal possibilities to ministries of justice and courts. They also believe that doctors should be clear that specialized forensic institutions are

in many respects branches of the criminal justice system. Four major difficulties were delineated as standing in the way of using forensic services as part of the ordinary health service setting. Firstly there is already a shortage of the appropriate facilities such as community accommodation, alcoholic clinics and the like. Secondly, doctors, in an ordinary setting are very likely to ignore the criminal and antisocial side of their patients' characters. Thirdly, only selected offenders will be sent by the courts, as public opinion would not tolerate the management of every mentally abnormal individual in an ordinary hospital. Finally, since it is extremely difficult to treat an unwilling patient in an ordinary hospital, antagonism between the institution and the offender is bound to occur.

Some participants were at pains to point out that the prevention of illness and the prevention of crime are not the same and that they should always be carefully distinguished. One participant suggested that the basic but rarely asked research question underlying many of the issues being discussed is what distinguishes the offending mentally ill from the non-offending mentally ill?

The idea of *primary* prevention, i.e., preventing the first offence, found favour. Thought could well be given to setting up walk-in clinics or crisis centres where people in distress could turn at moments of great need. Homicide prevention (when a patient asks for help) is surely as much of a psychiatrist's job as is suicide prevention.

The meeting was warned not to confuse needs with demands. New hospitals, new services are often demanded but they are not always needed. Conversely, patients may need things but not demand them. In addition, they were reminded too of the importance of other professionals in primary health care such as psychologists, social workers and nurses *(1, 2, 3)*.

The message from the participant sociologists was loud and clear. Prisoners have human rights. One of them should be the ability to obtain psychiatric treatment if they want it. This is quite different from the establishment of psychiatric institutions to treat prisoners for criminality.

4.2 The proportion of offenders to be examined and treated psychiatrically

The previous discussion had already indicated a clash of views. Some participants felt that as many offenders as possible should be de-criminalized by understanding their neurotic impulses, whilst others felt that as many as possible should be normalized by allowing them the right to be treated as criminals rather than as patients.

All were agreed that not all offenders can even be *examined* psychiatrically. A suggestion by a participant from France was that, soon after arrest it might be possible to screen all offenders coming into custody by means of questionnaires. Those showing indications of pathology could then be examined in more detail by interview and multidisciplinary observations.

However, this is illegal in some countries. If a good relationship can be established during the initial stages, it may form the basis of successful treatment later.

Using this system in a French prison, it has been found that 20%-25% of admissions to custody need psychiatric care. Of these, less than 1% are psychotic, while almost 10%-12% have neurotic symptoms, 10% are alcoholics and 2% drug addicts. Almost half of all the new prisoners are psychopathic but they usually want no help at this time. This group may overlap with those who need care.

In a recent British study *(12)*, a three-way formula has been used to evaluate the number of "psychiatric cases" in English prisons. Men were scored in terms of their symptomatology, their previous non-penal psychiatric history, and their desire for treatment. About one-third were found to be "cases" by this system.

It was once again strongly reaffirmed by most participants that case identification should not mean compulsory treatment. Prisoners' wishes are of the utmost importance. Furthermore, professional secrecy should be respected at all levels.

4.3 The psychiatrist's contribution towards humanizing prison conditions

The forensic psychiatrist is sometimes subject to an ambiguity in his profession. On the one hand he has the professional duty of any doctor which is to treat individuals, and this means that the patient is free to accept or refuse any treatment advised; but on the other hand any doctor is to some extent an agent responsible for public health. It is part of a forensic psychiatrist's duty to ensure that he maintains the correct balance between these interests. He will be helped in this difficult task if he fully understands that the "medical model" is a modest one. Medicine is rarely concerned with dramatic changes in the human condition and frequently produces best results by helping to reduce physical and mental suffering. For example, the psychiatrist is very unlikely to be able to contribute much to the reduction of crime itself.

The doctor working within the penal system has a special opportunity to challenge and improve it. Some would argue that for a psychiatrist to work in a prison at all helps perpetuate an unpleasant and inhuman situation. Others would hold that this is an unrealistic view and in fact medicine has been one of the humanizing forces which has helped penal reform over the last century or so. A doctor may have to work in any institution established by society, however unpleasant that institution might be; for example he might work for a coal mine as an occupational health physician even although it could be argued that it is not a good thing to have coal mines. In the same way that an industrial medical officer may advise on the detrimental aspects of a worker's environment, a medical officer in a prison can

likewise point to harmful effects, such as those resulting from severe disciplinary measures, incarceration for long periods of time, and so forth.

There are four basic ways in which a psychiatrist can contribute towards humanizing a prison. Firstly, he can provide appropriate treatment for psychiatric disturbances which arise or are present among the inmates. Secondly, he can protect prisoners against unwanted or controversial treatment. He can, for example, advise that irreversible treatment such as psychosurgery and castration should not be given in detention when freedom of choice is extremely limited. He can also advise against forced feeding, when somebody is taking a rational stand on a moral or political issue. To help him in these respects the World Medical Association has issued an *International Code of Medical Ethics (13).*

Thirdly, he can make a positive contribution to the prevention of ill treatment by a maintenance of proper sanitary and environmental conditions. Difficulties will inevitably arise because most disciplinary measures are in fact a form of ill-treatment but he can advise against the use of severe measures such as solitary confinement, reduced diet, physical violence, and drugs, as it is clear that these will have a significantly detrimental effect on a prisoner's health *(14).*

Fourthly, he is in a position to notice deliberate torture, and can protest in the way he thinks most effective. Some participants felt that withdrawal from an institution where torture was practised was the only ethical course open to a doctor; others felt that to remain while persistently complaining to the appropriate authorities might prove more effective.[a]

Under the law, the forensic psychiatrist may also be able to make a humanizing contribution. One way is for him to act in a purely civil capacity to give evidence that ill-treatment has taken place, or that certain compensation is appropriate for injuries and so on. In other words he can act as a purely personal medicolegal adviser. Another, and more common approach is for him to give expert opinion before a court in such matters as capacity to stand trial, degree of responsibility and so on. The concept of responsibility is a difficult, almost impossible one for the doctor, but it does enable the psychiatrist to present medical evidence about the mental state of a patient to a court. It is true that a medical report of this kind can sometimes be damaging to a patient, but this is a feature of a bad report rather than a good one. A report may in fact be the beginning of a therapeutic relationship where, for the first time, an offender is able to discuss the possibility of treatment.

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[a] The foregoing represents the views of participants actually working in a forensic psychiatry situation; it is to be clearly understood that neither the participants nor WHO can in any way condone the practice of torture or any form of maltreatment of prisoners and detainees.

Once again there were divergent views about the value of the psychiatric report for prediction. Prediction was conceded to be a difficult art by most participants and some felt it should be given up, although courts press psychiatrists to make comments about the future dangerousness of a detainee, simply because the predictive processes go against the spirit of justice. A justice system says that it is better for ten guilty men to go free than for one innocent man to be convicted, whereas a predictive system says that ten non-dangerous men should be kept in prison rather than allow one dangerous man out.

Two further important points were stressed as far as the legal systems of the European Region are concerned. Firstly, the label that is attached to an institution is less important than the attitudes within that institution. Some prisons are better than some hospitals and it is not always the case that the most humane outcome for a particular offender is to send him to an inadequate hospital which has no proper facilities for him. Secondly, while it is true that valid comparisons cannot be made between countries because of vast differences in their systems, there is no real justification for ethical differences in medical practice existing between those countries.

Some differences of opinion which could not be resolved in discussion at the meeting were related to the issue of a doctor being employed by the penal system. Some felt quite strongly that the doctor should only join in with institutional work as a visitor whereas others felt that such an approach would be an ineffective way of modifying a system and would only serve to placate the doctor's conscience.

A note of warning was also sounded from the United Kingdom indicating that where medical pressure (as has recently happened in Scotland) leads to the setting up of a special humane unit for abnormal offenders, it can be counter-productive for other abnormal offenders who are not lucky enough to get into it, as a deterioration of conditions in the other services can result from staffing shortages, budgetary considerations, etc.

Finally, most participants emphasized an important point raised again and again at the meeting, that treatment should almost always be a voluntary activity, undertaken at the request of a potential patient and that it is part of the doctor's duty to see that the voluntary nature of treatment is upheld.

5. RESEARCH

This topic sparked off a lengthy discussion ranging from the specific problems needing enquiry to the political factors involved in a penal system. Once again the question of the need for a separate sub-specialty of forensic

psychiatry was raised, but the consensus was that the name is less important than the practice. Some participants pointed out that the criminal justice system is not primarily concerned with health, but if the term forensic psychiatry is retained for a separate sub-specialty, then its practitioners cannot escape the criminal justice component. In that event, forensic psychiatry is bound to be concerned with both mental illness prevention and crime prevention. Many forensic psychiatry practitioners do not agree with this assessment but accept that criminological research into the effectiveness of forensic psychiatry as a crime prevention activity is a legitimate pursuit.

Dangers were enumerated by the Working Group in respect of action research because the researcher is frequently forced to take the decisions himself. It was generally agreed that at the present stage of development of forensic psychiatry the first priority should be for descriptive studies. Insufficient is known about criteria for accepting patients, for managing them, and for discharging them. Not enough is known about the details of our treatment programmes and our institutions. In such descriptive studies, legal, psychological and social factors cannot, of course, be overlooked. Nevertheless it was pointed out that teamwork is not necessarily appropriate for research. The concept of teamwork is often used when its advocate is talking of leading a team rather than participating in it.

Leading on from descriptive studies, the next natural step is evaluation studies. Crime prevention is really behaviour modification. The researcher and the forensic psychiatrist should be specific about what type of behaviour it is desired to modify; evaluative studies would thereby become possible.

A neglected but important area of research is to find out what offenders want and how they see the system in which they have to live. During the meeting it became clear that there is a general need for comparative studies of various kinds, and for the evaluation not only of treatment methods but of the processes of forensic psychiatry itself. It was pointed out that sociologists want to understand the self concepts of forensic psychiatry, the goals of forensic psychiatry, and the criteria by which forensic psychiatrists wish to be evaluated.

It was emphasized that good medical research can have a humanizing effect, for example, by introducing scientific standards of assessment, by studying behaviour disorders in an objective rather than a moralistic way, by describing and attempting to measure value systems, by bringing different disciplines together, and by disseminating information through publications.

When the inevitable discussion on prediction studies was raised, one participant stressed that biologists should remember the uncertainty principle and that prediction can only be valid for a group. Even if it were possible to predict group behaviour exactly, it would never be possible to predict individual behaviour and it would be possible only to attach probability scores to the individual's future behaviour.

In a discussion of the relationship between crime and mental health, it was pointed out that there are now a number of studies showing that health and criminality are separate phenomena. For example, in a recent British project *(12)* it has been found that a psychiatric prison regime may improve the health of inmates but does not necessarily change their criminality. In any case, institutions cannot influence what happens after a man has been released. Much more information is needed about the relationship between crime and mental illness. We need to know why some mentally ill offend and others do not. It is even possible that psychotic episodes may prevent crime in some individuals. A study in the USSR is currently being undertaken into the differences between schizophrenics who offend and those who do not.

6. ORGANIZATIONAL PATTERNS AND INITIATIVES

Twenty years ago, forensic psychiatrists were mostly the servants of the court. The discussion at the Working Group made it clear that their position has changed radically. However, there is still an evident danger that the forensic psychiatrist may too easily fall in with the system in which he works. Doctors are conservative by nature and may become agents of social control by default. It is possible for the psychiatrist to assume the part of a second prosecutor, his statements sounding like condemnations rather than evaluations. We have to remember that institutions are often stronger than individuals. It is not always the psychiatrist, the psychologist, or the social worker who changes the institution; it is sometimes the institution which changes the professional.

Perhaps wider training programmes should be offered in forensic psychiatry. Furthermore, the court should not rely on a limited well-organized group of experts, but the judge should appoint as an expert any professional he thinks qualified.

Most agreed with the view that the forensic psychiatrist who remains a real physician will not confine himself to the preparation of reports but will always be striving to provide his potential clients with medical treatment. It is not compatible with the ethics of the medical profession for a case to be closed after giving a court report. This does not mean that the doctor should try to revolutionize the legal system, but at no point should he ignore the individual's appeal for help.

No participant believed that treatment should be precluded by the fact that crime is more often socially rather than psychologically determined. Deviant behaviour is not often the cause of therapeutic intervention but it can well be the occasion for it. The main error of forensic psychiatry has

been to aim at the prevention of recidivism. It is not criminality which is the legitimate object of therapy, but the individual with his difficulties and sufferings. If an offender is suffering from a mental disturbance that usually receives treatment, therapy must not be refused because the patient is also labelled criminal. Many felt that it is preferable to treat the psychotic criminal in a psychiatric hospital like any other patient. Some urged strongly that if the psychotic criminal is detained because of his criminal behaviour and propensities he should not stay longer than if he were well, simply because he is ill.

Once more it was reiterated that an important precondition for the treatment of offenders is not only the presence of a psychotic, neurotic or personality disturbance but also the offender's desire for help. Except in cases where the freedom of decision is destroyed altogether, no patient should be treated on a compulsory basis. Nevertheless, it must be remembered that many recidivists suffer a great deal because of their neurosis. A recent study from the Federal Republic of Germany *(15)* showed that, as a group, recidivists suffer excessively from psychosomatic complaints as well as from depression, anxiety, and feelings of inferiority. They also showed irritability, impulsiveness, low frustration tolerance and social inhibitions. In spite of this high degree of individual suffering many of these individuals found it difficult to translate their needs into an explicit desire for treatment. Most of them had been labelled as bad from childhood onwards.

It was proposed that, in order to distinguish between penal control and psychiatric treatment, forensic psychiatrists should refuse to become entangled in treatment experiments which are not primarily established for therapeutic purposes. Treatment-oriented institutions should be strictly separated from those pursuing the goal of punishment. Furthermore, considering the limited degree to which the harmful effects of total institutions can be modified, much more effort should be made to build up forensic outpatient facilities.

Perhaps more than any other psychiatrist, the forensic psychiatrist needs to adapt his treatment to the needs of his clients. Expectations of delinquents are sometimes quite different from those of the professionals. For example in one centre it has been found necessary to begin group treatment with excursions, picnics and the like and to include friends, partners and parents in the regime before effective understanding could be gained. Similarly, new forms of cooperation between forensic psychiatrists and other related professionals need to be worked out. Probation officers, social workers, psychologists, often have greater experience in coping with the troubles of offenders, but on the other hand, well developed methods of social psychiatry can usefully be injected into probation work. The biggest problems arise in the collaboration required between lawyers, especially the judiciary, and psychiatrists. There is room for more intensified training of law students in behavioural sciences.

7. CONCLUSIONS

At the concluding session the Rapporteur summarized his view of the consensus of the meeting as six main conclusions, although, on every point there were divergent opinions, preventing the participants from reaching unanimity.

These conclusions were:

(1) Although there was fundamental disagreement between the sociologists and psychiatrists at the meeting about retaining the prefix "forensic" there was broad general agreement that forensic psychiatry should remain part of general psychiatry.

(2) General medical ethics apply to forensic psychiatry in exactly the same way as they apply to other parts of the medical profession, and, in particular, a forensic psychiatrist should see his first duty as to his patient, and should *not* operate as a part of the State control systems.

(3) A "new forensic psychiatry" is developing, with less emphasis on diagnosis and more on treatment. In future, particular attention should be paid to community treatment, primary prevention, and crisis intervention.

(4) Forensic psychiatry can only contribute to the prevention of crime insofar as an individual potential offender seeks help and receives effective treatment for a mental disorder which, if untreated, would lead to a behaviour disturbance.

(5) The academic and research status of forensic psychiatry is at an early stage of development. Interdisciplinary teaching, research, and communication are urgently required.

(6) Finally, a further working group on forensic psychiatry should be convened, likewise on an interdisciplinary basis.

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Annex I

THE QUESTIONS FOR FORENSIC PSYCHIATRY TODAY

Dr B. Borup Svendsen[a]

Forensic psychiatry as a discipline has existed from the beginning of the nineteenth century, from the time psychiatry was established - and it has always worked together with the older discipline of *forensic medicine*. The ways of cooperation and dominance or subordination between these two disciplines is, however, not our topic at this occasion.

The present meeting is one of the very few international meetings where we concentrate on forensic psychiatry as such. Elsewhere forensic psychiatrists participate in discussions on crime, or social defence, or penal law, or general or social psychiatry. This meeting was intended to be an internal discussion on the functions of forensic psychiatry, a reappraisal of whether the discipline was useful or not, and whether it was justified to work for its development or not. This meeting is not meant to proclaim the importance of forensic psychiatry as was done by such figures as Stumpfl *(1)* who, in 1958, wrote, "we have said that psychiatry and especially forensic psychiatry is the central core ("Kernstück") of criminology as science, and can add that in future research it will appear as its *via regia*." On the contrary, it was intended to question whether forensic psychiatry was important or not, by listening with open minds to able and outstanding critics.

It was felt worthwhile discussing the roles of the mental health professions in the prevention and control of crime and this discussion was considered timely on account of the development both within general psychiatry and within criminology. The demand for forensic psychiatry has been on the decline in some countries where forensic psychiatrists have been used for quite a number of years. Why has this been so?

Forensic psychiatry is defined as a subspecialty of psychiatry. It deals with the aid which psychiatry can provide for the juridical system, and with the aid which the juridical system can provide for psychiatry.

The application of forensic psychiatry within the juridical system is mainly in the fields of penal law, administrative or civil law, and social law. Here it is considered appropriate to concentrate on the functions within the penal law.

One main function in penal law is the psychiatric evaluation of offenders, generally before trial, to assist the court in its decision on the offenders' responsibility. The other main psychiatric function within penal law

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is participation in post-trial administration, in particular with regard to security and treatment aspects of dealing with mentally abnormal offenders.

Stable organizational arrangements seem to have been made in most European countries, whereby psychiatrists or other physicians elucidate in each case the questions found pertinent according to the national penal law. Recently, some sociologists have attacked this traditional examinatory arrangement, saying that it distracts attention from the injustices of the present sentencing and correctional system. Much more discussion has, however, focused on forensic psychiatrists' contributions after trial.

Three main phases of forensic psychiatry may be described. A first phase developed a hundred years ago by the Italian positive school, originally dominated by a pessimistic evaluation of offenders, underlining the security of society. It was the right of society to take measures against the danger represented by offenders. Security measures should take the place of punishment.

A second and more optimistic tradition, aiming at the therapy of offenders, especially developed by psychiatrists and others of a psychoanalytical or dynamic observation, evolved from about the First World War, primarily in the Anglo-Saxon countries, and it worked within the prison and probational services; the work in the Danish Herstedvester centre, the Dutch Van der Hoove Clinic and the British Grendon Underwood prison belong to this phase.

While these two schools (we have to apply principles of both in our work today) both underlined medicine's contributions to a study of the genesis of crime, in the third, present-day, sceptical phase, non-psychiatrists have underlined the great extent of the hidden criminality, that crime, especially in young offenders, can often be interpreted as normal adaptational phenomena and that sociological hypotheses are most relevant in the analysis of many crimes. Many, including some forensic psychiatrists, now find it meaningless to use a medical model alone in dealing with offenders.

We now have to discuss whether the forensic psychiatrist should define for himself a specific role with certain functions, or whether he should give up his identity and join the corps of criminologists and penologists.

If a definite role for the forensic psychiatrist is to be defined, which offenders should then be dealt with? All offenders? Mentally abnormal offenders? Some mentally abnormal offenders? *Where* are the tasks of forensic psychiatry to be performed? Within the civil systems for non-criminal mentally abnormals or within the correctional system? And within both of these possibilities, should it be in special institutions for offenders or in ordinary institutions for non-offenders? *What* should be the aims of treatment? Should the psychiatrist be responsible for the treatment?

What should be the position of forensic psychiatry in relation to general psychiatry, to forensic medicine and to public health? Are forensic psychiatrists able to contribute to the prevention of crime?

As forensic psychiatry is an auxiliary discipline, it is essential that the legal administrators' expectations from the forensic psychiatrist as employers are outlined.

As crimes are obligatory phenomena in our patients or clients, we must hear whether new conceptions within criminology are thought to alter our scope of work.

As we are dealing with individuals, it must be of interest to learn whether new perspectives can be given to our work by the recently created organizations of offenders, as representatives of the people we treat.

This approach is somewhat different from the approach of the WHO seminar on forensic psychiatry in 1958 *(2)* and from joint consultations between WHO and UNSDRI in 1969 and 1970 *(3)*, but it has been felt necessary to discuss things anew in view of developments within and outside psychiatry since then.

Some may feel that the scope and purposes of this meeting are all too vague, that WHO ought to have given much more specific recommendations on the prevention of delinquency and crime and on the control of crime (the expression "treatment of crime" has been deleted from the official UN vocabulary to a certain extent, as far as I understand). If detailed plans of the programme of forensic psychiatry had been put forth much more benefit might be achieved from the discussions. I agree completely that such criticism was justified, provided that the present goals of forensic psychiatry were clearly defined; in that case we only have to discuss the strategy of forensic psychiatry. But I don't think that the goals of forensic psychiatry are sufficiently clearly defined and analysed. Therefore, forensic psychiatrists first have to make sure that today they generally share similar viewpoints in different countries on such crucial questions as how many or how few of the offenders should be covered? Are we able to make a valuable contribution in dealing with all or only a few of offenders? Are we able to give advice on the prevention of crime if crime is to a high degree a sociologically determined phenomenon inherent in any society?

If there is no agreement on such main principles then we have to discuss them rather than details. However, we can illustrate the principles by certain examples. If major divergencies of opinion exist, we should define these as clearly as possible.

The first reports are devoted to criticism from our employers and customers, the lawyers - and from our patients, clients or objects for observation and treatment - and from research observers representing criminology and sociology.

Next, we forensic psychiatrists should ourselves discuss organization and trends in different countries, and after that different settings and problems. Further, we shall try to discuss how research could help develop forensic psychiatry - and how forensic psychiatry ought to be organized in the future.

We asked for criticism and we've got it. Going through the papers you may, however, be struck by the divergence and the distance of standpoints among our critics.

The forensic psychiatrists may, however, feel some consolation in the fact that the points of view of the participating forensic psychiatrists are much nearer to one another, and that here one can feel a common attitude of medical and social obligation. There is some prospect of establishing a trans-national identity for forensic psychiatry. And there still seem to exist such essential differences in outlook and organization that the present meeting is amply justified.

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Annex II

FUTURE RESEARCH NEEDED FOR DEVELOPMENTS OF FORENSIC PSYCHIATRY

Professor F.H. McClintock[a]

Abstract

Discussion on research requirements presupposes a fairly clear agreement as to the nature of forensic psychiatry and its scope in the future; but since these are problematic - as implied by the strong grounds for holding the Working Group - suggestions for useful research must at this stage be tentative and largely personal and will clearly need to be reconsidered in the light of the subsequent deliberations on our main subject.

Although the role of forensic psychiatry within the criminal justice system is under rigorous scrutiny in a number of industrial countries and the demand for it in some has actually declined, one may assume that in the foreseeable future the forensic psychiatrist will continue to fulfil important duties in a number of spheres, although they may become more restricted henceforward. It is suggested that his main services will include:

(1) diagnosis of mental abnormality in relation to criminal responsibility, as part of the trial process of offenders;

(2) assessment of mental abnormality and dangerousness in relation to the sentencing process of the courts (particularly where special medical facilities are provided for the mentally abnormal offender);

(3) the superintendence of psychiatric treatment programmes for convicted offenders who remain in the community under probation or allied services;

(4) as consultant within the penal institutional system;

(5) the running of special institutions for offenders within the medical and social services; and

(6) assessment of the suitability for release of offenders on parole or allied schemes.

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Within each of these six spheres of professional responsibility, it is necessary to apply evaluative research to assess the extent to which the aims of the service are achieved in terms of the medical and legal objectives laid down. In this context it is also suggested that shared comparative medico-legal studies could economize research efforts focused upon the work of forensic psychiatry and its achievements in different criminal justice systems, where the relationships between the forensic psychiatrist, the lawyer, the social worker and the penal administrator need to be carefully examined, not just in terms of membership of a formal organization but also as professional workers in a continuous interactive process. This calls for action research and descriptive research in relation to the present forensic psychiatric services and facilities in worldwide variations of criminal justice systems. In these spheres of treatment it is necessary to distinguish between purely mental problems and problems of criminality, and to evaluate through research the extent to which they are effectively dealt with psychiatrically and by other means of intervention through the criminal justice processes. For this purpose more sophisticated kinds of prediction studies will also be required. But where the research is related to offenders suffering from specific mental illnesses, the problems and methods follow very closely those existing in other kinds of medical investigation. The more difficult areas of research evaluation are related to the work of the forensic psychiatrist among offenders whose behaviour or attitudes are not accepted as normal but who are not mentally abnormal in strictly medical terms. Here it will be necessary to re-examine the meaning attached to abnormality and the theories of personality development according to which different schools of psychiatry operate. Moreover, it may be suggested that different kinds of psychiatric intervention or even non-psychiatric intervention may all have much the same results in behaviour modification, and if this is the case then the implications will need to be carefully considered.

Radical criminologists have criticized the forensic psychiatrist for attempting to deal solely with the mental abnormality of the offender when the basic question (as they suggest) is the wholly abnormal socio-economic structure of the community from which most of such offenders come. Within the context of that debate, one important future research area might be the socioeconomic conditions in relation to personality development in the various environments in which criminality and mental abnormality seem to be most prevalent. Such research might throw new light on the dynamic processes which lead to the association of mental abnormality with crime, and might indicate alternative strategies of intervention wherein the psychiatrist can play a more positive role at an early preventive stage, rather than at the stage in which serious acts of deviance have led to arrest and conviction.

Annex III

ORGANIZATIONAL PATTERNS AND INITIATIVES

Professor W. Rasch[a]

Some theses are tentatively postulated:

1. *Forensic psychiatry should not be maintained within a rigid organizational framework. Expert activities should not be limited only to physicians employed in governmental agencies.*

Forensic psychiatrists tend to overadapt to the rules of the legal system the longer they are involved in it, and readily become conservative agents of social control.

As an expert, the psychiatrist can sometimes assume the part of a second prosecutor, with his statements sounding like condemnations rather than evaluations. In the correctional field, psychiatrists often take up their job in prison with an illusion that they will effect some alterations. They are motivated by humanitarian principles without realizing the paradoxes inherent in the concept of humane punishment. In fact, the custodial system always proves to be stronger. It is not the psychiatrist, the psychologist, or the social worker who can change the institution, but the institution which changes him. The conversion of therapeutic roles into custodial ones is a well-known phenomenon. In a set-up where contempt and harshness towards prisoners are prime values, someone who tries to offer help finds himself in a hopeless position. A consequence of this change of attitude is the tendency of prison doctors to make erroneous denunciations of prisoners as malingering.

2. *In the field of forensic psychiatry, wider training programmes should be offered.*

Abandoning the idea that the court has to rely on a limited well-organized group of psychiatrists, the judge will be free to appoint as an expert any physician he thinks qualified. Prosecutor and defence should be entitled to make their suggestions.

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The objections against the employment of any doctor as an expert are that inexperienced physicians often lack the understanding of legal requirements. This is quite correct, but balanced by the fact that the evaluation of the legal issue anyway rests with the judge. On the other hand, some physicians who are esteemed as experienced experts often know little of modern psychology. By insisting that the expert's task is to diagnose diseases and not to disclose the psychological peculiarities of an offender, they try to make a virtue of their deficiency. Efforts should be made to improve and expand the educational level of forensic psychiatrists in order to secure certain standards.

3. *The forensic psychiatrist who preserves his self-concept as a physician will not confine himself to the preparation of expert reports, but will strive for therapeutic activities.*

It is incompatible with the ethics of the medical profession that a psychiatric expert should consider a case closed after giving his report or leave all further care of his patient to the prison authorities. This does not mean that he is expected to start a revolution against the legal system, but he should not ignore the individual's appeal for help. There is ample proof that a high percentage of offenders, particularly among recidivists, are severely disturbed personalities who are in urgent need of support.

4. *The fact that criminality is a social phenomenon does not preclude individual treatment. Deviant behaviour is not the cause but the occasion for therapeutic intervention.*

A popular argument against criminal therapeutic efforts is that criminality is socially determined and that individual treatment distracts the attention from the essential problems. This view, if correct in principle, should not induce the physician to abstain from therapy and await the beginning of utopia. Any social system will produce its casualties. Within a society there will always be a certain proportion of members who are not able to cope with its demands. This can already be derived from the normal distribution which applies to all biological phenomena.

The main error of criminal therapeutic efforts has been to aim at the prevention of recidivism. Criminality cannot be the legitimate object of therapy, but only the individual with his difficulties and sufferings. If an offender is suffering from a psychic disturbance that usually receives treatment, therapy cannot be refused simply because the patient is also labelled a criminal. The goal of treatment cannot be adaptation at all costs but growth and emancipation. Freedom from recidivism would constitute a fortunate side-effect. The limitation of treatment efforts to abnormalities of character should also take into account the fact that deviant behaviour is a

transitory phase for many individuals. The task of the forensic psychiatrist should be to sort out those persons who are likely to start a criminal career. Admittedly, it is not easy to make this diagnosis, let alone to arrive at a prognosis. One of the major gaps in forensic psychiatry is that it has failed to develop reliable prognostic criteria.

5. *Mentally sick persons who have committed a crime should be treated like any other mental patients.*

There is no disagreement that persons suffering from psychoses who committed a crime are not to be punished but submitted to adequate treatment. They only represent a small percentage among criminals. These offenders should be treated in a psychiatric hospital like any other patient. Within the field of hospital psychiatry, the tendency exists to consider mentally disturbed offenders as especially dangerous and to isolate them in separate institutions or separate wards. This procedure means to subject the offender to a double stigmatization.

Even in cases where the reason for the admission into the hospital was a minor offence, the duration of detainment is unduly long. For example, in the Federal Republic of Germany the average stay is approximately 10 years.

The reasons for this are lack of interest on the part of the doctors and lawyers, fears of hospital doctors that they will be heavily criticized by the public in case of a new offence by an ex-patient, the fact that doctors often do not know where to send the patients on release, and finally, the absence of adequate criteria for assessing a person's dangerousness. Reasons often used to prolong detention are disciplinary problems or attempts to escape.

6. *A precondition for the treatment of offenders is not only the presence of a personality disorder but also their desire for help. The suffering of a delinquent manifests itself differently to that of the ordinary patient.*

Except in cases where freedom of decision is destroyed altogether, no patient should be treated on a compulsory basis. In general, indication for treatment is deduced from his wish for therapy.

A familiar stereotype is that the criminal only suffers from the consequences of his failure but not from his mental disturbance. This view needs to be combated. The psychiatric expert knows that he is frequently confronted with despair and a wish to be cured on the part of the client, which does not result from a momentary desire to gain the doctor's sympathy. The suffering of the delinquent differs from that of the neurotic who consults the private practitioner and is able to verbalize his complaints. Informative in this context are the results of an examination of 89 recidivists selected at random from the prisons of North Rhine-Westphalia. In the Freiburg personality inventory, a factor-analytically constructed questionnaire, the mean

scores of the sample were statistically significantly higher on the scales of nervousness, aggressivity, depression, excitability, inhibition, and emotional lability. The scores on the masculinity/femininity scales were lowered. According to these results, the recidivists examined suffer considerably from psychosomatic complaints as well as from depressive dysphoria, anxieties and inferiority complexes. They are irritable, impulsive, show little tolerance of frustration and are socially inhibited.

The personality deviations described within this group of offenders make it obvious that there is a high degree of individual suffering. It is difficult to transform this suffering into an explicit desire for treatment. One has to consider that these people have been called bad or criminal from childhood onwards. One cannot expect them suddenly to conceive of themselves as being in need of treatment.

7. *The unsatisfactory results of treatment projects should not be used as an argument of principle against treatment philosophy.*

There seem to be three main aspects of the failure of treatment experiments.

The first is that the experiments were only half-heartedly supported by the authorities. Most institutions remained understaffed and did not have enough resources to attract qualified personnel. So-called security demands remained a high priority. The institutions not freed from their custodial character came to be poor mixtures of prison and hospital. Sometimes the treatment programmes were introduced in departments of large penitentiaries. This led to continuous conflicts with the main institution, usually ending with the defeat of the therapeutic unit. As a consequence of the weak position of the therapists in a prison setting, the antitherapeutic inmate culture is preserved which precludes the chance of any effective therapeutic work. From this experience two postulates can be derived:

– forensic psychiatry should refuse to be entangled in treatment experiments which are not based on a therapeutic set-up;

– treatment-oriented institutions should be strictly separated from those pursuing the goal of punishment.

The second aspect is that the programmes often were begun without a clear theoretical concept. The deficiencies of classical psychiatry were the lack of critical reflection of its methods and the neglect of its social dimensions.

The third aspect concerns the selection of the inmates for treatment. Valid criteria were not specified. The need for treatment was inferred from the symptom of recidivism, and the elimination of recidivism was established as the treatment goal. Here again can be seen the tendency of forensic

psychiatry to over-adapt to the legal system and to abstain from developing its own concepts.

8. *Treatment in open institutions or under outpatient conditions is to be preferred. In the initial phase, confinement will often be unavoidable.*

Considering the limited practicability of reducing the harmful influences of prison-like institutions, more endeavours should be made to build up outpatient treatment facilities. In therapeutically oriented half-way houses, therapy could be performed while the conditions there can be brought to match those of normal life. The well-known difficulty of offering work or adequate training to the inmates of prisons can be avoided. After discharge, the client should have the opportunity to return to the institution whenever he wants. In some cases the main goal of treatment may be to teach him to make use of this opportunity in critical situations.

When severe personality disorders are present, initial treatment in a closed institution is unavoidable. As long as the client has not conceived of himself as someone who needs treatment, he will show no readiness to cooperate and will stay away as soon as he has the chance. The aim of therapy during this phase is to eliminate identification as a criminal.

9. *The methods applied should be adapted to the needs of the clients and not arouse anxieties and resistance.*

A demand like this sounds rather commonplace, but is by no means easy to achieve. A team of psychologists and psychiatrists in our Institute had started group therapy with delinquents. The attempts failed until we found ways of close cooperation with probation officers and fitted the group meetings to the expectations of our clients. It proved best to begin with theme-centred group sessions, excursions, picnics, and similar activities, and to approach personal problems gradually. The treatment was expanded to the social environment of the client: friends, partners, parents were invited to participate.

At present, an interesting long-range project is under discussion in West Berlin. The point of departure is that delinquents often miss maternal care in the first years of their lives. Mothers participating in the scheme would receive a salary if they give up work and devote themselves totally to the care of their children. Participation in special child-rearing courses would be obligatory for them.

10. *New forms of cooperation between forensic psychiatrists and other professionals engaged in the field of correction should be worked out.*

The multitude and diversity of problems to be handled in the treatment

of offenders require interdisciplinary cooperation. Social workers and psychologists are often best at coping with the troubles of offenders. On the other hand well-developed methods of social psychiatry could usefully be integrated into the probational work.

Cooperation between the different professions has proved to be extremely difficult. This cannot only be explained by the lack of suitable models for cooperation. Of greater significance seem to be the emotional problems arising in the interactions between professionals in different disciplines. The management of these inevitable conflicts should be secured by the installation of regular team supervision.

Specific problems arise in cooperation with judges, who often lack the understanding of psychological and psychiatric problems. In order to improve communication between judges and professionals, the training of law students in the field of behaviour sciences should be intensified.

Annex IV

PROGRAMME

Monday, 13 October

Registration

Opening session

Introduction

Different attitudes towards forensic psychiatry, formulated by:

a legal administrator

a criminologist

a representative of an offenders' organization

Tuesday, 14 October

Present organizational status, with examples from different countries: Italy, Federal Republic of Germany, United Kingdom, Denmark, Netherlands, USSR

Wednesday, 15 October

Future policy

1. Forensic psychiatric work in different settings:

(a) prison or probational services

(b) special psychiatric services within the penal system

(c) special institutions for offenders within the medical and social services

(d) ordinary civil and medical institutions for offenders

2. The part played by psychiatrists in combating ordinary crime and their specific contribution to crime prevention

(a) What proportion of offenders should be examined psychiatrically and what is a realistic proportion?

(b) What proportion of offenders should be administered by psychiatrists?

(c) Psychiatrists' contribution towards humanizing conditions in prisons, prison camps and preventive institutions and abolishing torture

(d) Aspects of forensic psychiatry considered controversial

Thursday, 16 October

Future research

Organizational patterns and initiatives

General discussion

Friday, 17 October

Summary and conclusions

Presentation by Rapporteur

Closing session

Annex V

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