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Placement and Treatment of Mentally Ill Offenders –

Legislation and Practice in EU Member States

Final Report – February 15, 2005

Hans Joachim Salize & Harald Dreßing
Central Institute of Mental Health
J5
D-68159 Mannheim
Germany

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Hans Joachim Salize & Harald Dreßing
J5
D-68159 Mannheim
Germany
Tel: ++49 621 1703 6401
Fax: ++49 621 1703 6405

Contents

		page
	Contents	3
1	**Introduction**	6
	Forensic Psychiatry	9
	Mental Disorder and Criminal Behaviour	12
	Criminal Responsibility	15
	Background Factors and Underlying Influences	19
	The European and International Policy Context	23
2	**Study**	31
3	**Results**	35
	Legal Frameworks and Key Concepts	36
	Pre-Trial and Trial Procedures	43
	Forensic Psychiatric Assessment	48
	Reassessment and Discharge Procedures	56
	Patients' Rights	61
	Service Provision	67
	Epidemiology	78
4	**Concepts and Procedures in the Member States**	90
	Austria	91
	Belgium	99
	Denmark	105
	England & Wales	122
	Finland	136
	France	145
	Germany	152
	Greece	160
	Ireland	167
	Italy	176
	Luxembourg	184
	The Netherlands	189
	Portugal	197
	Spain	207
	Sweden	215
5	**Summary and Conclusions**	225
6	**Appendix**	239
	List of Tables and Figures	239
	List of Experts and Collaborators	243

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With the exception of the specific national chapters, whose authors are separately indicated, this report has been written by the above listed study team.

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Austria	Hans Schanda, Göllersdorf
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Luxembourg	Jean-Marc Cloos, Luxembourg
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Portugal	Miguel Xavier, Lisbon
Spain	Francisco Torres Gonzalez, Granada
Sweden	Helena Silfverhielm, Stockholm
United Kingdom	David James, London

1 Introduction

The placement and treatment of mentally disordered offenders is a controversial issue within the criminal justice systems of western societies.
The matter draws in the field of mental health care and is the subject of regular mass media coverage, with enormous public interest in high-profile cases (as the Anna Lindh case in Sweden has recently shown). The handling of mentally ill offenders by a criminal justice systems is an indicator of the ability of a society to balance public safety interests with the achievements of modern psychiatry and of its ability to incorporate basic human rights principles into penal and mental health practice.

Central societal or human values are involved in judicial and detention procedures concerning persons who have committed a crime and been found to suffer from a mental disorder. Many of these values are to a certain degree contradictory, rather than complementary. In order to address and regulate these complex problems on a legal level, a detailed body of rules and regulations is required. To provide such legal frameworks for regulating the numerous aspects of detaining and treating mentally ill offenders is a major and constant challenge for all European Union Member States, as it is for any other country. Moreover, acts and codes need to be updated regularly to take account of new achievements in forensic psychiatry and the constant evolution of mental health care systems.

Although this field is almost permanently on the public and political agenda, there is a surprising shortage of basic information and evidence about the major characteristics of the legal approaches and their effectiveness. Most national health or judicial reporting systems provide only rudimentary estimates (e.g., on the number of court trials of mentally ill offenders, forensic service bed provision or major characteristics of the clientele). Cross-border comparisons and the identification of good models of provision or practice are greatly hindered in consequence. Internationally agreed or standardised indicators are non-existent.

The exact costs of judicial procedures or of forensic care are generally unknown, but there is no doubt that the size of the problem imposes a heavy burden on modern societies, affecting to varying degrees the criminal justice system, as well as the mental health care system and the prison system.
Without even the most basic information it is impossible to quantify the financial losses arising out of ineffective judicial or care concepts, or to start a debate on models of best practice.

Moreover, even among experts, there is no common agreement as to the nature and role of forensic psychiatry, nor how appropriately to integrate the care of mentally ill offenders into general mental health care provision.
There are debates as to whether community-based mental health care, which is a widely accepted approach in general psychiatry in Europe, might incorporate as an undercurrent a tendency to neglect the difficult to treat, i.e., violent or aggressive patients, who then consume the resources of forensic psychiatry, which has to face increasing numbers of referrals of non-compliant and violent severely mentally ill patients (Schanda, 1999). Some experts point out in general mental health care providers a limited knowledge of risk assessment and an underestimation of the future violent or criminal behaviour of schizophrenic patients (Müller-Isberner & Hodgins, 2000), although the proportion of violent or non-compliant patients with severe mental disorders and co-morbid substance abuse is constantly rising (Röder Wanner & Priebe, 1998; Kovasznay, 1991).
As a result, a growth in the number of forensic patients is reported in some European countries (Kramp, 2003), and overcrowded forensic hospitals are a common phenomenon (Müller-Isberner & Hodgins, 2000).

The limited integration and unclear position of forensic psychiatry may be due to its specific two-headed role to do justice to the individual needs of mentally disordered offenders on the one hand and to meet the expectations of the society and guarantee public safety on the other.

It is obvious that providing adequate treatment and reintegration into society of patients who are doubly stigmatised (as being offenders and being mentally ill) requires good services, sophisticated treatments, appropriate training and high quality standards, which is a long way from the reality of the position in many European Union Member States.

In the past, there has been only limited international research conducted on the various complex and interdependent issues and systems for the placement and treatment of mentally disordered offenders (Blaauw et al., 2002). An internationally standardised description and systematic analysis of legal instruments regulating the disposal of mentally disordered offenders and the different pathways into the various penal and health care systems is overdue.

In recognising this gap, the European Commission has recently increased its efforts to provide a basic overview of the current situation in the European Union Member States. This study which has been funded by the Health and Consumer Protection Directorate General of the European Commission is part of this effort.

Scope of this Study

In the complex field sketched above, this study tries to provide a structured description and cross-boundary comparison of

- legal frameworks
- underlying key concepts
- assessment, court and discharge procedures
- routine practices in placing and treating mentally ill offenders
- human rights and patients' rights
- forensic service provision
- outcome of legal procedures and forensic care (epidemiology)

in the fifteen Member States of the European Union before the extension in May 2004 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom).

All background information was gathered in a survey of experts from all included Member States. It relies to a large extent on administrative data as provided by national Ministries of Health or Justice or various other national authorities, to keep a nationwide focus. Research data was only used when no other sources were available.

This report starts with a general overview of the field. This is followed by a structured comparison of the above mentioned issues (results of the survey), which makes extensive use of flow charts, tables and figures.
Any inevitable simplification in the comparative section is compensated for by a section providing a separate chapter for each Member State, detailing and describing the specific situation and specific circumstances for each country separately.
The balance between public safety interests and the protection of individual rights is such a sensitive matter that can only be outlined in very general terms. In English-speaking, German and Scandinavian countries, it is broadly perceived as a formal process which requires a very detailed legal framework under the supervision of the judicial authority. In Latin countries health care professionals tend to be given more discretionary powers, according to the parens patriae principle, by establishing some general principles of guarantorship and assessing retrospectively how these powers were used.

The report concludes with a section summarising the major findings and drawing conclusions relevant to a future European harmonisation in this field. This section may also be used as an executive summary.

The approach of this study and the choice of topics may be considered selective, but this is inevitable, given the complexity of the issues and problems concerned.
Limited time and resources determined that the study rely completely on contributions from the Member States and the collaborating experts. As such, the results reflect the quality of data as currently provided by official sources throughout the European Union.
Although trying to harmonise items and data as well as possible, it must be acknowledged that all tables, figures and overviews in this study are at risk of comparing data that is not entirely equivalent. This reflects the general problem of the absence of European definitions or standardisations in the field and is the main reason why such overviews have rarely been attempted in the past.

Nevertheless, the authors believe that any inconsistencies in the results are more than offset by the comprehensiveness of the information provided here and the chance to draw conclusions as to the current state of judicial procedures and forensic care for mentally disordered offenders in fifteen European Union Member States.

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Forensic Psychiatry

In some, but not all western industrialised countries, forensic psychiatry today has been established as a professional specialty within psychiatry. The philosophical and theoretical foundations of forensic psychiatry can be traced back to the Greek and Roman writings of antiquity, but it was not until the 20th century that the forensic field developed into a specific discipline in itself.

However, the idea that a mentally ill offender should not be punished because of a lack of criminal responsibility seems to have been a standard doctrine in European countries for a long time. In early times, it was common practice to acquit mentally disordered or ill persons of having violated the law rather than confining them to mental hospitals. This resulted in high recidivism rates of mentally ill offenders (Rylander, 1961).

During the 18th century, mentally ill offenders often were placed together with the non-criminal mentally ill in asylums or workhouses, only some of which provided hospital services.
Legal reforms during the second half of the 19th century gradually permitted the compulsory admission of mentally ill offenders to psychiatric hospitals for an indefinite period (Slater, 1954). As a part of the expansion of mental hospitals during the 19th century all over Europe, some places offered early examples of what could be characterised as specialised services for mentally ill or disordered offenders.

Developments in the United Kingdom may illustrate this. Early in the 19th century, after a mentally ill person had tried to assassinate King George III, Parliament passed a statute aiming at the safe custody of insane persons charged with offences. In 1815, a hospital opened that provided specialised wards for “criminal lunatics” (Gunn & Taylor, 1999). The Home Secretary was responsible for its supervision and for taking care that the new forensic facilities were secure and strictly separated from general psychiatric wards.
These ancient forensic wards in the UK quickly suffered from overcrowding and new secure units had to be built, so that services for “criminal lunatics” very soon encountered the side-effects of segregation and specialisation that still challenge modern forensic psychiatry (Allderige, 1979).

Even today, it is still a matter of debate amongst experts as to whether forensic psychiatric services should be integrated into general psychiatric hospitals or separated into secure facilities of their own. Whereas large secure hospitals may be advantageous in that they can provide a variety of specialised treatment programmes and in that they probably offer better safety for the public, they also may serve as an example of what Erving Goffman has labelled the “total institution”. According to this concept, a total institution is characterised by a basic split between large managed groups, conveniently known as “inmates”, and a small supervisory staff. Inmates typically live in the institution and their contacts with the world outside the walls are severely restricted (Goffman, 1961).

While in the first half of the 20th century there was no basic change in psychiatric treatment approaches, new anti-psychotic and antidepressant drugs were developed and became available during the 1950s and ‘60s. As a consequence of these new opportunities for treating the mentally ill, community-based mental health care developed and the number of psychiatric hospital beds declined substantially.

However, the major psychiatric reforms that have changed the face of mental health care profoundly in most industrialised countries during the last few decades by-passed forensic care, where large security hospitals still dominate. A scientific evaluation of forensic hospitals from the 1980s still concluded: “Today, treatment programmes in secure psychiatric institutions are noteworthy

primarily by their absence, poor implementation, unevaluated status, lack of conceptual sophistication and incomplete description and documentation" (Quinsey, 1988).

Nevertheless, forensic psychiatry is able to provide treatment programmes that are effective both for the improvement or recovery of the mental state of the person concerned and his reintegration into society, as well as for the enhancement of public safety. There is no scientific evidence that psychiatric treatment and the requirement for secure conditions are incompatible. On the contrary, effective psychiatric and forensic treatment requires that both staff and patients feel secure.

Nevertheless, many components of psychiatric treatment that have been shown to be effective for mentally disordered patients must be modified before being applied to patients who have broken the law. Caring for the latter requires simultaneous consideration of:
a) the needs for treatment resulting from specific elements of the mental disorder, and
b) the needs for treatment with respect to factors promoting criminal behaviour.

To this end, treatment programmes developed in the framework of general psychiatry have been adapted to reduce criminal and violent behaviour, which is a specific aim of correctional treatment programmes.
Additionally, conceptual models concerning the Psychology of Criminal Conduct (PCC) have been developed to gain an understanding of underlying mechanisms. These models are used to evaluate correctional treatment programmes (Andrews & Bonta, 1998).

Growing theoretical and empirical research such as this has promoted forensic psychiatry to a professional specialty in a few countries. In the US, forensic psychiatry became an independent section as early as 1934 (Bluglass, 2000). But contrary to an increasing awareness by general psychiatrists of the specific requirements for treating mentally disordered offenders, forensic psychiatry in many western countries still does not have the status of an independent speciality. Formalised professional training is often lacking, so that some experts consider the empirical foundation for treating mentally disordered offenders still to be in its infancy (Hodgins, 2000).
Thus, there is a need for extended research in the field as well as for a consensual basic definition of forensic psychiatry, which might be characterised as a sub-speciality of general psychiatry that applies scientific and clinical expertise to legal issues embracing civil, criminal, correctional and legislative matters (Rosner, 1998).

Mental health professionals providing care to persons presenting both mental disorders and a history of criminal offending should be competent in the following areas (Gunn & Taylor, 1993):

- the assessment of mentally ill offenders,
- the preparation of written reports for the courts,
- expert testimony in court,
- the treatment of chronic disorders that lead to behavioural problems (especially chronic psychoses and personality disorders), and
- the knowledge of mental health law.

During the past decade, the focus in forensic psychiatry has shifted from the concept of responsibility towards the concept of dangerousness (Barras & Bernheim, 1990). Thus, the evaluation of future risks of recidivism has become a central issue, supporting the development of standardised risk assessments (Webster et al., 1995). Although research is still in its early stages, there is already some evidence that conditional release programmes for mentally disordered acquittals might be effective in reducing dangerous behaviour. Conditional release and monitored community treatment programmes seem to be promising approaches to balancing public safety interests and individual rights (Bloom & Wilson, 2000). According to several meta-analyses, therapeutic intervention programmes are positively correlated to decreasing criminal recidivism among the mentally ill. Effect sizes of certain appropriate treatment programmes were as great as 50% (Lösel, 1995; Andrews et al., 1990).
According to these analyses, effective treatment programmes may be characterised as being highly structured, cognitive-behaviourally orientated and multi-modal. Community-based pro-

grammes offering assertive forensic treatment also proved to be effective in symptom reduction and crime prevention (Bloom et al., 1991; Müller-Isberner & Hodgins, 2000).

These findings seem to support a new enthusiasm for therapeutic approaches that are based on empirical research. They are likely to render forensic care a therapeutically orientated sub-specialty of psychiatry that focuses both on rehabilitation and long-term community care as well as on the provision of inpatient care in high security facilities.
If risk assessment procedures turn out to be effective in routine care, prevention might become an additional central mission for forensic mental health care in the future (Mullen & Lindqvist, 2000).

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Mental Disorder and Criminal Behaviour

The majority of people suffering from mental disorders do not pose a risk of criminal behaviour or violence. However, large sections of the general public are unaware of this fact and there is a widespread misconception that those with mental disorders or illnesses are a danger to other people. This persistent prejudice is a major source of the stigma attached to the mentally ill who are seen as being potentially dangerous people for whom detention seems a most appropriate measure. Therefore, in order to do justice to the mentally ill, the issue requires more thorough and detailed exploration than it generally receives.

In principle, three principal research approaches can be adopted to explore the association between mental disorders and violent or criminal behaviour (Eronen et al., 1998):

- analyse the prevalence of violent behaviour among mentally disordered persons who are integrated into the mental health care system and/or receive treatment,
- determine the prevalence of mental disorders among persons who have committed violent acts and thus come into contact with the criminal justice system,
- conduct epidemiological studies to explore the prevalence of both psychiatric disorders and violent behaviour among the general population (thus covering both those persons who are in contact with the mental health care or the legal justice system and those who are not).

Some studies that have adopted the first approach estimate the risk that violent acts will be committed by schizophrenic patients as up to seven times greater than that for persons not diagnosed with a mental disorder, as was found in Northern Finland (e.g., Tiihonen et al., 1997). Other studies (e.g., Wessely et al., 1994) identified male patients with schizophrenia as 3.8 times more likely to acquire a criminal record than persons suffering from non-psychotic mental disorders. There are other findings, for which Eronen et al. (1998) or Angermeyer & Schulze (1998) have provided a more detailed overview.

A higher prevalence of severe mental illness or psychosis also is reported from findings among offenders (second approach). A study from the mid-eighties analysing homicides and cases of manslaughter from a 25-year period identified 20% of male and 44% of female offenders as suffering from a psychosis (Gottlieb et al., 1987). Similarly, 53% of people found guilty of homicide or manslaughter in Northern Sweden had a lifetime diagnosis of a severe mental disorder (Lindquist & Allebeck, 1990). Co-morbidity of addiction disorders or substance abuse appears common (Gottlieb et al., 1987; Lindquist, 1986; Côte & Hodgins, 1992).

Comparisons between randomly sampled male prison inmates and general population samples resulted in an up to two to three times greater prevalence of schizophrenia and major affective disorders in the prison sample (Teplin, 1994). In a more recent study, Steadman and co-workers (1998) determined the prevalence of community violence in a sample of patients discharged from acute psychiatric treatment during the twelve month period subsequent to discharge and compared it to the violent behaviour of residents from the same neighbourhood. Data was assessed from patient self-reports, reports from collateral informants or police, and from hospital records. Substance abuse symptoms turned out to be the most important risk factor, raising significantly the rate of violence in both patients and controls. However, substance abuse symptoms were found more frequently in patients than in persons from the community sample. When substance abuse played no role, the rate of violent behaviour was similar in both samples. The authors concluded that discharged mentally ill persons do not form a homogenous group regarding violent behaviour, thus specific disorders have to be considered.

Results from other epidemiological studies have produced similar findings indicating that psychiatric patients have a two or three times greater prevalence of violent behaviour than community residents who had never been in contact with the mental health care system (e.g., Link et al., 1992). The probability of having committed a violent act might be ten times greater in substance abusers (Swanson et al., 1990).

Although more specific analyses are needed, findings like these - although not consistent in rates or figures - do contribute empirical evidence to a century-long but controversial debate on the relationship between mental disorder and violent or criminal behaviour (e.g., Raine, 1993). Current research agrees that interdependencies are complex. Three major and divergent hypotheses might be formulated for explaining a possible link:

- Violent or criminal behaviour is a direct symptom of a mental disorder (causal hypothesis).
- Violent or criminal behaviour is one of several consequences of a mental disorder, as the disorder may affect cognitive or other mental capacities and support social deviant behaviour (intermediated association hypothesis).
- Violent or criminal behaviour and mental disorder are independent phenomena (non-linkage hypothesis).

It is not difficult to find arguments or data in support of each of the above-mentioned hypotheses. So the scientific discussion of how criminal behaviour and mental disorders are linked is far from being decided. The debate suffers from unclear definitions of the concepts of violent or criminal behaviour, which from time to time are even used as synonyms. Other methodological problems may also contribute to biased study results.

However, the scientific community currently favours the hypothesis of an intermediated association between the two phenomena. A closer look into the various sub-types of mental disorders supports this assumption.
People suffering from organic mental disorders pose no increased risk for criminality compared to the general population (Böker & Häfner, 1973), although aggressive and impulsive behaviour is connected to certain types of brain damage (Nedopil, 2000).

Substance abuse seems to be a most significant risk factor for offending behaviour. Apart from that, persons with paranoid schizophrenia or some types of personality disorders are at greater risk of offending (Hart, 1997; Hare, 1990; Webster et al., 1994). The same applies to certain types of affective disorders (Modestin et al., 1997).

For most other mental disorders or illnesses, no increased risk of violence or higher rate of offending can be confirmed, although self-destructive or suicidal behaviour – which could be categorised as violent although not being offending - is associated with most depressive disorders to an alarming degree.

Against all evidence of a positive correlation between certain mental disorders and criminal behaviour, it should be kept in mind that the contribution by mentally ill persons to overall levels of criminality is rather small - much lower than those of many other social groups.
Thus, there is a strong need to distinguish clearly when analysing or discussing the issue - for the public as well as for professionals, decision-makers or anyone else involved in criminal proceedings against mentally ill people.

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Criminal Responsibility

The idea that offenders suffering from a mental disorder must primarily be considered as ill and should therefore be exempted from punishment is of considerable antiquity, dating back to ancient Greek and Roman sources.
It is grounded in the concept that human beings have free will and are able to differentiate and choose intentionally between right and wrong or good and evil.

According to this concept, a person who commits a crime has chosen to transgress the law and is therefore subject to a punishment. The philosophical basis of this concept might be labelled as non-deterministic. However, a mental disorder may impair an individual's ability to differentiate between right and wrong and seriously affect their free will. Moral categories or any judgement of guilt are not strictly applicable in this case, which in turn diminishes the right or duty of society to take punitive sanctions against a person who has been affected by such a state, for having committed a crime.

Many societies have adopted the concept of "criminal responsibility" to describe these interdependencies. While "criminal responsibility" primarily stresses the judicial aspects of the problem, the term "accountability", which is often used synonymously, adds a medical connotation to it.
Medical and judicial viewpoints delineate a major area of discussion which gives cause for reflection upon the specific situation of mentally disordered offenders and the treatment of forensic cases. In the past, the complexity of the problem fed an intensive scientific and legal debate about how to define, specify and apply the concept of criminal behaviour in routine judicial and psychiatric practice. This debate is still continuing.

Aristotle considered a person to be morally responsible who, in full knowledge of the circumstances and consequences, deliberately chooses to commit a specific act without being forced or coerced to do so by third parties. However, Aristotle opted also for reduced punishment for criminal behaviour committed in extreme affective states.
Historically, the concept of responsibility became fundamental for the view of man as an intentional and free being, and gained recognition as such in Roman Law. Already at that time lunatics or mad people were considered to have no will of their own and therefore to be incapable of criminal intent. Today's fundamental forensic doctrine that offenders suffering from mental disorders are not eligible for criminal punishment dates back to these early roots.

In mediaeval times, the old Hippocratic concept of considering mentally abnormal states as illnesses gave way to the idea that these were signs or consequences of sinful behaviour on the part of the afflicted person. Expiation and penance were consequently introduced as basic principles to deal with mentally disordered people.
During the 13th century, while working on the issue of insanity and its legal consequences, the English writer on law, Henry de Bracton, developed the concept of "mens rea" to characterise a state of mind indicating culpability (Rosner, 1998).
According to this concept, a person lacking "mens rea" is insane and does not have available a free will. No such person can be considered to be morally responsible and - as a consequence of this lack of responsibility – should be exempted from punishment.

These are the origins and basic ideas behind the so-called insanity defence. "Insanity tests" were first performed by lawyers and philosophers long before mental health care or the development of forensic psychiatry as a medical discipline. The term "insanity" as used in this context was clearly seen as a judicial term with only minor medical connotations, indicating a defendant's lack of ability to understand the nature of his criminal behaviour.

The McNaughton Rules from 1843 are considered to be a cornerstone of the further development of the concept of criminal responsibility. In England during the 1830s, Daniel McNaughton stood trial for killing the secretary to Prime Minister Robert Peel at Downing Street, after being convinced that the Prime Minister was leading a conspiracy to kill him. When during the trial it became evident that McNaughton was mentally disturbed, the jury – rather unusually for that time – ordered him committed to a mental asylum rather than hanging an obviously ill person. The uproar over McNaughton's acquittal prompted the creation of the McNaughton's Rules by the House of Lords: to establish a defence on the grounds of insanity, it must be clearly proved that. At the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to kinow the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong".
The assessment as established according to McNaughton´s Rules of whether a defendant knew about the wrongfulness of his action was also known as the "right-wrong-test" (Andoh, 1993).
The purpose of the rules was to restrict the circumstances in which an insanity defence could be used, rather than to facilitate the procedure. The rules are so strictly drawn that most floridly psychotic defendants do not fall within them. Medically, they largely restrict the defence to people with organic disorders. The insanity defence itself had been introduced much earlier into British law (Rylander, 1961; Andoh, 1993).

The concepts incorporated into the McNaughton Rules have been criticised (e.g., Menzies, 2002; Smith, 1982; Ward, 2002) for their exclusive definition of accountability - which was considered as uncertain regarding the nature and quality of the act or ambiguous regarding the wrongness of the act (Andoh, 1993). Furthermore, the McNaughton Rules defined insanity as intellectual incapacity while excluding emotional and volitional aspects. Thus, the Rules may not cover the eventuality where an offender may be intellectually able to conceive that society considers his act to be criminal behaviour but at the same time may lack the power to prevent himself from committing the act.

In 1953, a report of the British Royal Commission on Capital Punishment therefore proposed an amendment to the Mc Naughton's rules, adding to them an "irresistible impulse test". The Royal Commission also specified the term "wrongfulness", under which the persons concerned are not held responsible for their actions, to include:

- *illegality standards* (applicable to defendants lacking the capacity to know or appreciate that their acts violated the law),
- *subjective moral standards* (applicable to persons suffering from a disease of the mind that results in their belief that they were morally justified to carry out their actions),
- *objective moral standards* (applicable to persons lacking the capacity to understand that society considers their actions to be morally wrong).

In the event, the law was changed by the Homicide Act of 1957, which introduced the concept of diminished responsibility into English law, the standard for which is very low within the Act. This enabled the substitution of a manslaughter conviction for a murder conviction in cases of mental illness (non-psychotic as well as psychotic), so allowing a range of possible disposal options. The concept of degrees of criminal responsibility is limited in the United Kingdom to cases of homicide.

The Old Germanic Law as well as the Ancient Laws of Ireland or the Ancient Dutch Law are reported to already have included certain features of the concept of reduced criminal responsibility for criminal acts, and thus reduced punishment (Zeegers, 1981). Scientists and legal experts from continental Europe have also contributed to this debate. Far from being exhaustive, the following overview gives a general impression of some of the major and often controversial positions.

Influential contributions came from Italy and were made by Beccaria (1738-1794) and Lombrosso (1836-1909). Beccaria, the founder of the classical school of criminology, considered criminal acts to be a result of free will and thus to require punishment or penal sanction (Ciccone & Ferracuti, 1995). In contrast, Lombroso (1876) as a representative of the positive school of criminology, identified physical features assumed to be characteristic for criminal males and discussed criminal behaviour as deterministic. As a consequence of crimes resulting from genetic predisposition, offend-

ers should be treated rather than punished. However, Lombroso's prognosis for achieving remission of criminal behaviour was not optimistic.
Rocco´s Penal Code, as incorporated into Italian law in 1931, could be seen as a compromise incorporating the main features of both discrepant schools of criminology. Since the code went into effect, Italian courts have had to judge whether an offence was committed by free will (with punishment as a consequence) or to evaluate the extent to which it was affected by pre-determined disposition (requiring treatment) (Ciccone & Ferracuti, 1995).

At the end of the 19th century, German psychiatrist Kraepelin criticised the use of punishment as the sole available sanction since it neglects the individual disposition of an offender and the chance to treat certain kinds of misbehaviour (Hoff, 1998). Kraepelin emphasised the consideration of pathological sources of delinquent behaviour, applying the criteria for mentally ill patients also to offenders. Thus, acquittal from imprisonment should depend on psychopathological status. As a consequence, the responsibility for a discharge decision should be shifted from judges or courts to the psychiatrist. Convinced that recidivism or repeated delinquency was closely linked to a mental disorder, Kraepelin favoured the integration of the concept of diminished criminal responsibility into the Penal Code. However, there were also contrary positions. Karl Wilmanns, another influential German psychiatrist of the time, argued that forensic and judicial practice would become unpredictable and unjust, were there to be a compromise between being either fully or completely lacking in criminal responsibility (Wilmanns, 1927).

In the Netherlands, the first statute referring to criminal responsibility of varying degrees appeared in 1809, to be applied to cases of insanity, varying madness, organic diseases affecting the mental state and to severe mental retardation (Zeegers, 1981). Punishment or acquittal would be decided on the basis of the degree of criminal responsibility. However, this progressive law has never been applied in practice (Zeegers, 1981), due to the French annexation of the Netherlands in 1810, after which French Penal Law stayed in effect in until Dutch Penal Law was initiated in 1886.
Although the Dutch Penal Law does not explicitly mention diminished criminal responsibility, the concept was implicitly introduced into the Dutch judicial context in 1928. From this time on, punishment for mentally disordered offenders has been able to be combined with specific restrictive measures ("Terbeschikkingstelling") in the Netherlands (Zeegers, 1981).

Modern neurobiological research in our day has reinforced the century-old debate on criminal responsibility. Today, some experts even reject the concept that human beings dispose of a free will and consider findings from functional brain imaging or neuro-psychology to be supportive of this theory. Some conclude that human actions can only be deterministic (Libet, 1983). At least in Germany, the consequence has been a demand for a reform of the penal system (Roth, 2001; Singer, 2003). These positions more or less resemble Lombroso's or Kraepelin's medical models of delinquency. As is always the case with extreme theories, there are also many experts who argue strongly for a non-deterministic concept of human existence.

Although far from being decided, time will tell how this philosophical debate can relate to the daily routine of dealing adequately with mentally disordered offenders. There is still a great need for pragmatic solutions that balance the needs of society and of the persons concerned.

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Background Factors and Underlying Influences [1]

European Union Member States, despite being increasingly politically integrated, still have different cultures, legal systems and welfare systems. Each country's regulations on the treatment and placement of mentally disordered offenders incorporate these elements in a dynamic process, usually with a trend towards slow but continuous change. The purpose of this chapter is to provide a general, at-a-glance framework of such background factors and underlying influences.

Legal Systems and Traditions

The principles and practices of each national legal system are deeply rooted in the history and the identity of a country. The legal system can be seen as a means of representing and preserving from rapid change different visions of the individual and of human relationships, even within politically homogenous areas like the European Union.

Roman Law

Roman law underpins most legal systems in continental Europe. From its origins in ancient Roman and Greco-Roman tradition, its current forms reflect the evolutions it experienced during the Middle Ages in Central Europe under the Holy Roman Empire and at the beginning of the Modern Era with the French Revolution.
In their many different forms and varieties, what all Roman Law systems have in common is their prescriptive nature. Codes state what is an offence and what is not, and lay down procedures and punishments which must be applied by magistrates and judges with little discretionary power. Interpretation is limited, codes and doctrines are the sources of judgement, and jurisprudence plays a minor role. A consequence of such systems is that processes of change in specific areas are very slow (taking decades or centuries) and that there is little flexibility in adapting legal outcomes to circumstances and individual situations.

Roman Law systems can be quite different. German laws may be considered the prototype of Roman Law, while Mediterranean countries seem to have simpler systems, with fewer options and wider discretionary powers accorded to judges in difficult cases. France, Belgium and Holland (nations with many legal aspects in common) seem to have more detailed laws, in which many exceptions are regulated for, as well as Scandinavian countries in which civil law seems to regulate more matters.

With regards to mentally disordered offenders Roman Law tends to emphasise the psychological element of an offence: the basic concept is responsibility, which in cases of insanity at the time of an offence is considered to be diminished or lacking. In other words, mentally disordered offenders are deemed not responsible in a similar manner to children and therefore avoid judicial sanction. Usually, for reasons of public safety, a security measure can be applied in case of persistent dangerousness. This is one of the reasons for the development of separate psychiatric forensic systems.

Common Law

Common Law is practised in all countries whose legal systems developed from the Anglo-Saxon. Its roots lie in the more informal way of managing justice adopted in the early Anglo-Saxon Kingdoms and it is much less prescriptive in nature. It has a pragmatic approach and emphasises behaviour rather than psychological elements. The judge has wider discretionary powers and the trial is aimed at ascertaining

[1] The editors of this report would like to thank Angelo Fioritti, Rimini, for writing down this chapter after a discussion among all experts during a study-meeting, and Miguel Xavier, Lisbon, for his comments during the preparation of the manuscript.

whether the offence was committed or not (verdict of guilt). Once the verdict has been reached, a decision is taken as regards the sentence or disposal of the case, which in cases of mental illness entails a placement in hospital for treatment. This disposal is a pragmatic decision arising from issues of justice, equality, effectiveness and the right to psychiatric treatment. There is no concept of responsibility, but a series of empirical acts and decisions which are taken in the best interests of the individual and of society.
The implications of this system are that each case can be flexibly managed as to procedures and to placement, that changes are much more rapid, allowing for radical reforms and different practice, based simply on the decisions of one or a few judges, when new needs are felt. The forensic psychiatry system can undergo more rapid development and change.

It is readily understandable, given the above, that procedures and practices may be very different in these systems and that concepts and terminology may vary.

Health Care and Welfare Systems

As with their legal systems, European countries have adopted very different welfare and health care systems, in which variations are particularly great where mental health care is concerned.
Italy, the UK and most Scandinavian countries have adopted a radical public health approach and run National Health Services (NHS) with an objective of universal and comprehensive coverage . Under this approach, the UK has promoted a major reform, integrating within the NHS all forensic psychiatric treatment facilities, leaving to the judicial system only the role of reaching a verdict and of disposing of mentally ill cases by transferring them into the health care system.
Most European countries run mixed systems, where some basic services are provided by the State and most services are provided on private or public insurance schemes. The development of the forensic psychiatric system is always a State task, but it can be accomplished either by the Ministry of Justice or by the Ministry of Health. It is clear that, in these countries, integration with general psychiatric services can be more difficult given the different administrative arrangements governing different sectors.

All in all, there is considerable variation in regulations which determine the integration of forensic psychiatry into the judicial or general health care systems of the respective country. These regulations may additionally be influenced by the overall philosophy or direction of national health policies (e.g., NHS or insurance based, see tab.1).

General Psychiatric Policy

A broad consensus to move towards de-institutionalisation has taken place across most of western Europe for more than 20 years. This change is still underway in Central and Eastern Europe. Despite this, the rate of change has varied markedly, and support service models vary substantially. For instance, a survey of European psychiatrists reported that community mental health services existed in fewer than half of localities in Spain, Portugal, Greece and Ireland, and only as pilot schemes in Eastern Europe (Goldberg, 1997). In the last two decades of the 20th century, there has been a debate between those who were in favour of the provision of mental health treatment and care in hospital and those who preferred treatment and care in community settings, where the two were seen as mutually exclusive. This dichotomy is increasingly replaced by a new agenda, in which *balanced care* includes *both* modern community-based *and* modern hospital-based care (Thornicroft & Tansella, 2003).

Nevertheless, wide differences are still present within the member states of the European Union, with different levels of implementation of the principles of community psychiatry. The total number of psychiatric beds available in each country ranges from 1.7 per 10,000 population in Italy to 20 per 10,000 in Belgium (in 1998 according to an official figure from the Ministry of Health).

Seven countries have more than ten beds per 10,000 population: Belgium, Denmark, France, Ireland, Luxembourg, the Netherlands and Finland. Only four countries (Spain, Italy, Austria and United Kingdom) have less than six beds per 10,000 population. Excluding Italy and Finland, all the other countries

still have psychiatric beds in mental hospitals. Moreover, although the majority of the EU countries have a national mental health programme (absent in Austria, Spain and Sweden), regional and local variations are present in most countries (Becker & Vasquez-Barquero, 2001). Other studies have confirmed this variation, although national figures or rates might differ due to varying algorithms, definitions or underlying sources (Salize et al., 2002).
Many countries which have already chosen to switch to a community-based mental health system (e.g., UK) or have incorporated substantial community services in a hospital-based system (e.g., the Netherlands, Portugal, some German Federal States), still provide a high number of psychiatric beds.

Tab. 1 Comparative Classification of Legal and Health Care Systems in EU Member States

Member State	Legal System	Health Care and Welfare System
Austria	Roman Law	National and private insurance
Belgium	Roman Law	National and private insurance
Denmark	Roman Law +	NHS
England & Wales	Common Law	NHS
Finland	Roman Law +	NHS
France	Roman Law	National and private insurance
Germany	Roman Law	National and private insurance
Greece	Roman Law	NHS
Ireland	Common Law	NHS
Italy	Roman Law	NHS
Luxembourg	Roman Law	National insurance
Netherlands	Roman Law	National and private insurance
Portugal	Roman Law	NHS
Spain	Roman Law	NHS
Sweden	Roman Law +	NHS

Information for this table was partly taken from the WHO-website on European Health Systems (http://www.euro.who.int/observatory)
Roman law +: primarily Roman law tradition with certain Common law features,
NHS: National Health System

Mental health legislation has focussed the interests of most countries during the '90s. Two recent comparisons of the legal frameworks in European Union Member States have delineated models for regulating this complex issue: these may also influence legislation and care routines for mentally disordered offenders (Fioritti, 2002; Salize et al., 2002).

Cultural Attitudes

There is no doubt that cultural attitudes have a strong influence in determining the shape of regulations, practices and innovations, both in judicial and health care systems. These cultural attitudes vary perceptibly and result from multiple social sources.
Educational models and shared values emphasise respect of the social norms in most Central European, Scandinavian and English-speaking countries. Failure to comply with social norms results in involvement of criminal justice agencies and processing by a court. In Latin countries, informal diversion schemes are more routinely practiced and major violations of the law are perceived as a matter for the courts. Detention is practiced only in the case of major offences and alternative measures are often pro-

posed. This may contribute to the low figures for detained mentally disordered people in prisons and forensic care in Latin countries.

But also attitudes towards care may also help explain the low figures. In Latin countries, informal support from family, the community or non-professional agencies is traditionally stronger than in other countries. In Italy and Spain, for example, children usually live with their parents until they marry and, if they need support for mental health problems, they usually receive help from familial or informal resources before utilising mental health care facilities. Only recently, with rapid and dramatic demographic changes (low birth rate, increasing immigration, the aging population), do these traditional informal supports seem to be becoming weaker, with more requests for public assistance from the NHS or social services becoming apparent. In general, in Latin countries, it is still perceived as the responsibility of the family to take care of a person with mental disorder, and this might explain the lower rates of institutionalisation.

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The European and International Policy Context

The placement and treatment of mentally ill persons who have committed a crime is an issue that does not fall within a single policy area, but cuts across a number of fields such as health, legal affairs and human rights in a variety of ways and to differing degrees. The fact that a mentally ill person who has committed a crime must be viewed as both a patient and as an offender encapsulates the complexity of the issue. Consequently, for the European Community, the issue of the placement and treatment of mentally ill offenders incorporates concerns both from the field of public health and from those of legal affairs and human rights.

The European Union and Mental Health

The emergence of health issues as a concern at the European Union level originates from health and safety provisions laid down in the Treaties establishing the European Coal and Steel Community (ECSC) and the European Atomic Energy Community (EURATOM). These were then followed by internal market considerations, with the free movement of people and goods making a certain degree of co-ordination in public health an essential requirement. With the Maastricht Treaty, public health for the first time became an official EU area of competence, although on the basis of the principle of subsidiary. Article 3(o) of the Maastricht Treaty highlights the responsibility of Community Institutions to ensure the Community's contribution to health protection. Additionally, it states that health protection requirements form an important part of the Community's other policies. In November 1993, the Commission published its communication on the Framework for Action in the Field of Public Health as a response to the new health provisions of the Maastricht Treaty. Drug dependency constituted one of the eight areas for action identified and in 1995, the European Monitoring Centre for Drugs and Addiction was set up in Lisbon.
Although a common European Union health policy was not introduced, Article 152 of the Treaty of Amsterdam provided the EU with a wider competence to act in the public health area. The Commission's activities remained within the general context of prevention and health promotion, emphasising also the promotion of mental health. Community measures have concentrated on supporting co-operation and networking initiatives among the Member States through the provision of information, education and training, as well as reports on the state of health and the integration of health protection requirements in the European Community.

With the development of public health as an area of competence for the Community, mental health issues were integrated step-by-step into this new competence. The Council Resolution of June 2, 1994 on the Framework for Community action in the Field of Public Health called for the issue of mental illness to be explored and actions at Community level to be identified in order to assist Member States in this area. The Commission communication of April 16, 1998 on the Development of a Public Health Policy also identified mental health as a field that has to be taken into account in future Community action.
The Council Resolution of 18 November 1999 on the Promotion of Mental Health called for Member States to give attention to mental health, to promote the exchange of good practice and joint projects, as well as to support research activities, including using the support of the Fifth and Sixth Framework Programmes of the European Community for Research, Technological development and Demonstration Activities.

These developments have been accompanied by an intense process in recent years to promote a European Mental Health Agenda so as to provide a visible platform of mental health issues in a European context. One of the first steps towards realising this goal was the founding of the European Network on Mental Health Policy in 1995, which included all of the Member States plus Norway.

The next step taken was a research project in 1997 on the Development of Key Concepts for European Mental Health Promotion.[1] In April 1999, a Joint WHO and European Commission Meeting on Balancing Mental Health Promotion and Mental Health Care was held in Brussels, Belgium, followed by a European Conference on Promotion of Mental Health and Social Inclusion in October 1999, in Tampere, Finland.

As mental health was identified as an issue of concern for the Community within the area of public health, relevant projects and research activities were supported under the Public Health Community Action Programmes by the DG XXIV Health and Consumer Protection, such as

- Mental Health Promotion for Children up to six years of age (1997)[2]
- Comparative Study on The Support of People with Mental Health Problems in ten European Capital Cities[3]
- Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU Member States (1999-2001)[4]
- Mental Health Promotion of Adolescents and Young People (2000)[5]
- Mental Health Promotion and Prevention Strategies for Coping with Anxiety and Depression in Europe (2001)[6]
- Mental Health Economics to Assess The Economic Dimensions Relevant to Mental Health Systems in the Member States (2002)[7]
- Mental Health in Europe, European Mental Health Conference (2002)[8]
- Integration of Mental Health Promotion Interventions into Countries' Policies and Practice and the Health Care Systems (2002)[9].

Relevant research was also supported through the DG V Employment and Social Affairs:

- Harassment and Discrimination faced by People with Psycho-social Disability in Health Services (2001)[10]
- Promoting Social Inclusion of People with Mental Health Problems: a Challenge for the European Union, A Review of Good Practices in Four Countries (2000)[11].

The European Union and Legal Affairs

The issue of mentally ill offenders is also of concern with regard to the Community's policy area of legal affairs. Here, the Community is pursuing a policy to encourage legal cooperation in criminal matters and to slowly harmonise substantive and procedural criminal law with regard to those crimes that are of a cross-border nature. Although the Treaty of Maastricht identified various areas of the Directorate General (DG) of Justice and Home Affairs as matters of common interest, there

[1] Implementing Organisation: Finnish National Research and Development Centre for Welfare and Health (STAKES), Helsinki
[2] Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[3] Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[4] Implementing Organisation: Central Institute of Mental Health, Mannheim.
[5] Participation:14 Member States, Iceland, Norway. Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[6] Consortium-led project/Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[7] Participation: All Member States, Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[8] Participation: All Member States and candidate countries, Implementing Organisation: National Research and Development Centre for Welfare and Health (STAKES), Helsinki.
[9] Participation: All Member States and five candidate countries, Implementing Organisation: Academic Centre of Social Sciences, University of Nijmegen.
[10] Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.
[11] Implementing Organisation: Mental Health Europe – Santé Mentale Europe, Brussels.

was still no legal basis for a convergence of substantive criminal law.[12] The Treaty of Amsterdam laid the ground-work for a convergence of substantive but not procedural criminal law.[13] The 1998 Vienna Action Plan laid down provisions as to how best to implement the Amsterdam Treaty with regard to the area of freedom, security and justice. In 1999, the Tampere European Council set further goals: the convergence of criminal law in specific sectors identified as areas of common interest, the co-ordination and the mutual recognition of judicial proceedings, and the protection of individual human rights.

Certain cross-border crimes that were identified by the Tampere European Council as a primary field of action, such as the sexual exploitation of children, touch upon the issue of the placement and treatment of mentally ill offenders. Therefore, the respective programmes that have been launched with the aim of combating these crimes Community-wide also include mentally ill offenders as a target group.

The DAPHNE programme was adopted in 1997 as a preventive action programme to fight violence against children, young people and women, and to protect victims and groups at-risk. The programme has been continued, with DAPHNE II running from 2004 to 2008. It funds research, training, networking, the exchange of best practice, and awareness-raising campaigns, as well as treatment programmes. Organisations eligible to apply for funding comprise non-profit organisations and public institutions in the 25 Member States, the EFTA/EEA countries, as well as in Bulgaria, Romania and Turkey. In a wide-ranging approach, the DAPHNE programme does not only target the victims of violence, but has also identified perpetrators as a target group that needs attention. Examples of DAPHNE-funded projects that directly target offenders are:

- Research Study to Measure The Effectiveness of Programmes to Prevent Recidivism of Sex Offenders[14]
- Training on Treatment of Young Perpetrators of Sexual Child Abuse[15]
- Development of a Cognitive Behavioural Therapy Module for People with A Sexual Interest in Children Who Also Exhibit Problematic Internet Use.[16]
- Creation of a Europe-wide Telephone Hotline for Offenders Seeking to Opt out of The Cycle of Violence.[17]

The STOP programme, which ran from 1997 to 2000, sought to improve co-operation between people working in the judicial field, such as judges, prosecutors, civil servants and police, with the aims of establishing respective networks, fostering knowledge of other Members States' legal systems, encouraging the exchange of experience and encouraging further research, especially on sex offenders.
The follow-up programme, STOP II, came to an end in 2002. Since 2003, a Framework Programme on Police and Judicial Cooperation in Criminal Matters, AGIS, has merged STOP and five other programmes. Various projects funded by the STOP and STOP II programmes had identified sex offenders as a target group for their activities:

- Seminar and Networking Activities to Combat Sexual Exploitation of Children: Comparison of Risk Management Methods across Member States; Improvement and Best Practice in the Field of Risk Management[18]

[12] See Art. K 1 TEU Maastricht
[13] See Art. 29, 31(e), 34(2) TEU Amsterdam: As for the developments of EU standards in procedural criminal law see the JHA Consultation Paper on Procedural safeguards for suspects and defendants in criminal proceedings.
[14] 97/120/WC: Participation: France, The Netherlands, United Kingdom. Implementing Organisation: Centre Recherche Action et de Consultations en Sexocriminologie, France.
[15] 99/19/C
[16] 01/42/YC
[17] 02/234/W
[18] 99/016. Participation: Ireland, Belgium, United Kingdom; Implementing Organisation: West Midlands Probation Service, UK.

- Study to Examine Policies and Practices of Supervision of Child Sex Offenders in The Community to Reduce Offending and Provide Help for Offenders[19]
- Operational Project to Improve Working Methods in Order to Identify and Arrest Sex Child Offenders[20]
- Research on Predicting Methods on Dangerousness of Paedophiles Collecting Child Pornography[21]
- Study on Training Methodologies and Training Needs for Persons Dealing with Child Sex Abusers[22]
- Research on Existing Alternative Penalties and Sanctions Targeting Sexual Offenders, Evaluation of Modifications of National Legislation Applied to Sexual Offenders during the Last Ten Years[23]
- Comparative Study on Techniques and Methods for Assessing Dangerousness and Risk of Re-offending of Presumed and Convicted Sexual Offenders[24]
- Training Seminar on Intervention Risk Assessment and Other Skills for Professionals Working with Sex Offenders.[25]

Although much relevant research has been undertaken by both the Directorate General (DG) of Health and Consumer Protection and the DG of Justice and Home Affairs, a comprehensive and systematic comparative study on the placement and treatment of mentally ill people who have committed criminal offences has hitherto been lacking. With the current study, the DG of Health and Consumer Protection aims to close this gap.

Mentally Ill Offenders and Human Rights – The Council of Europe

The placement and treatment of mentally ill people who have committed criminal offences must be considered in the context of human rights. Human rights are inseparably linked to mental health as both are complementary approaches to the improvement of the human condition. Human rights also are the only source of law that legitimises international scrutiny of mental health policies and practices within a sovereign country (Gostin 2000).

The fundamental document in the protection of Human Rights in Europe is the *European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR*) of the Council of Europe, which was signed in 1950 and took effect in 1953. The European Convention is not statutory; it owes its legal existence simply to the expression of the will of those states that are parties to it, from which it therefore takes its legal effect. As an instrument of the Convention, the European Court of Human Rights (ECHR) investigates alleged violations of the Conventions' Human Rights standards, involving both inter-state cases as well as individual claims. However, the Court is only able to consider those cases that have already exhausted all domestic remedies. There have been several judgements by the Court concerning national mental health laws and practices. The resulting case law has dealt mainly with issues of compulsory detention, conditions of confinement and civil rights, for example the case *Aerts vs. Belgium*. It contains implications for the provision of services.[26]

[19] 99/017. Participation: Sweden, Ireland, United Kingdom. Implementing Organisation: University of Leeds, UK.
[20] 99/020. Participation: EU Member States, non-EU member states of the G8, Interpol, Europol, WCO, NGOs engaged in child protection. Implementing Organisation: HM Customs and Excise, UK.
[21] 99/021. Participation: Ireland, United Kingdom, Interpol. Implementing Organisation: University of Cork, Ireland.
[22] 99/046. Participation: Italy, Belgium, United Kingdom. Implementing Organisation: Ministry of Justice, Italy.
[23] 99/026. Participation: Belgium, Germany, Spain, France, Italy, Portugal. Implementing Organisation: INCC, Criminology Department (public body), Belgium.
[24] 99/028. Participation: all EU Member States. Implementing Organisation: University of Liege, Belgium.
[25] 2000/STOP/110. Participation: All EU Member States. Implementing Organisation: Probation and Welfare Services, Ireland.
[26] As no hospital bed was available for him, a mentally disordered patients was kept in prison. Aerts vs Belgium, ECHR Reports of Judgements and Decisions 1998.

Article 5.1 of the Convention states that *"Everyone has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law"* which subsumes under (e) *"the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."* The primary impact on persons suffering from a mental illness has been in relation to protection against arbitrary detention under this article (Fennell, 1999). Additional articles of importance to people with mental illness, including those who have committed an offence, concern the obligation to respect human rights (Article 1), the right to life (Article 2), the prohibition of torture (Article 3), the right to a fair trial (Article 6), the prohibition of punishment without law (Article 7), and the prohibition of discrimination (Article 14).

How can the impact of rulings by the European Court of Human Rights on the protection of human rights of the mentally ill be evaluated? Bindman et al. (2003) argue that ECHR rulings have not set a high standard for modern mental health services, as the European Convention has tended to preserve old stereotypes and prejudices against people suffering from mental illness, apparent in the phrasing of the respective articles of the Convention, especially Article 5. It is the interpretation of the Convention on Human Rights by the European Court of Human Rights that is seen as the actual mechanism of protection of human rights of the mentally ill. The crux, however, is that human rights can only be secured by challenges brought before the Court. People with mental illness for the most part have fewer means and less capacity to undertake this step and are thus at a disadvantage (Findlay, 2003). The rights as set out in this Convention have also been brought into the domestic law of those States which have ratified the Convention. France was one of the first to do so; Great Britain's Human Rights Act of 1998 took effect in 2000. Conclusions about the impact of this act differ. It was initially suggested that the Human Rights Act would be likely to result in "a flood of legal cases", particularly those of patients admitted on a compulsory basis under the Mental Health Act. This would necessitate the re-determination of the balance between the rights of the individual patient and those of the Community (Macgregor-Morris et al., 2001). However, Bindman et al. (2003) noted that during the first year after the Human Rights Act had taken effect, the number of cases dropped rather than increased.

Special attention was given to the mentally ill in 1983, when the Committee of Ministers of the Council of Europe adopted a *Recommendation Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients.* The Recommendation also covers questions of treatment, legal capacity and dignity of those patients who were placed following criminal proceedings. The 1994 Parliamentary Assembly *Recommendation 1235 on Psychiatry and Human Rights* refers to compulsory admission in general, and no special distinction is made between mentally ill persons admitted under civil law and those admitted following criminal proceedings. Nevertheless, the Recommendation gives special attention to the situation of detained persons, stating that the recommendations set out should also apply to them. The Recommendation also applies to social therapy programmes, which should be set up for persons suffering from personality disorders.
In 2000, the Council of Europe published a *White Paper on the Protection of Human Rights and Dignity of People Suffering from Mental Disorder Especially Those Placed as Involuntary Patients in A Psychiatric Establishment,* the scope of which encompassed civil detention as well as detention in the context of offending. The White Paper defines the roles and certain standards regarding the various agencies involved in the placement and treatment of mentally ill offenders, such as the police, courts, prisons and medical experts. It further emphasises that Member States should ensure sufficient provision of a range of hospital accommodation with the appropriate levels of security and community-based forensic psychiatric services. The European Prison Rules (1987) also stipulate an obligation to treat mentally ill detainees, not in prison, but in appropriate establishments.

Mentally Ill Offenders and Human Rights – The European Union

From the mid-1970s on, human rights in the Community became an increasingly visible issue for the European Commission and the European Parliament, which resulted in a joint declaration by

the EC institutions on human rights in 1977. In 1993, the Maastricht Treaty incorporated a limited reference to human rights, also referring to the European Convention on Human Rights by stating that *"The Union shall respect fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms (…)".*[27] However, at the same time it was ensured that the European Court of Justice would have no jurisdiction to enforce these commitments in the context of Justice and Home Affairs (Pillar III of the EU).
In 1997, the Amsterdam Treaty incorporated provisions relating to human rights in the context of the access of new Member States. In December 2000, the EU proclaimed the *Charter of Fundamental Rights of the European Union.* The legal status of this catalogue of basic rights laid out in 54 articles is still unclear and is presently under intense debate as to the extent to which the Charter does have an effect (McCrudden, 2001). The scope of application of the Charter is limited to Union institutions and bodies and does not extend to Member States.[28] As for the relationship between the Charter of Fundamental Rights and the European Convention on Human Rights, the Charter builds upon but does not intend to replace the Convention (Menéndez, 2001).

The Charter itself provides standards of health care in Article 35, stating that *"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national law and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."* The principles set out in this article are based on Article 152 of the EC Treaty and on Article 11 of the European Social Charter (the right to protection of health). Chapter VI on Justice includes the right to an effective remedy and fair trial (Art. 47), the presumption of innocence and right to defence (Art. 48), the principles of legality and proportionality of criminal offences and penalties (Art. 49) and the right not be tried or punished twice in criminal proceedings for the same offence (Art. 50). Despite its non-finalised legal status, it is argued that the Charter represents a step forward in the protection of human rights and articulates a new normative basis and a new ethic for the European Union (De Búrca, 2001).

Mentally Ill Offenders and Human Rights – The United Nations

As one of the main sources of law within the United Nations system, the Universal Declaration of Human Rights attempts to achieve common standards of human rights. It contains several articles that protect human rights concerning the placement and treatment of mentally ill persons, including those who are placed on the basis of criminal proceedings. Article 5 states that "…no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment". Article 12 of the Declaration states that "…no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation.", an article which is put forward by critics against the granting of wider access to the medical data of mentally ill offenders or the introduction of offender registration laws. The Declaration is not legally binding. Nevertheless, as its key provisions have gained greater acceptance and been applied more often over the past decades, they are now considered to be customary international law and have inspired the development of legally-binding human rights instruments (Gostin, 2000).

In the early 1970s, the United Nations began intense debates on issues of mental health, and the years 1983 to 1992 were designated as the "Decade for Disabled Persons". In 1989, the General Assembly adopted the Principles for The Protection of Persons with Mental Illnesses and The Improvement of Mental Health Care, which formulate detailed statements on the rights of people with mental illness. The Principles state that all people have the right to the best available mental health care and that treatment should be undertaken with humanity and respect (Principle 1). Specific reference is made to the fact that these principles shall also apply to criminal offenders suspected of suffering from a mental illness (Principle 20). The principles also determine standards of surgical procedures, stating that sterilisation should never be carried out as a treatment for mental illness.

[27] Treaty of the European Union (The Maastricht Treaty), 1992 O.J. (C191): Art. F(2). However, the Union is no party to the European Convention for the Protection of Human Rights and Fundamental Freedoms.
[28] The exception to this rule concerns those instances in which Member States are "implementing union law" (see Article 49 of the Charter).

Any major surgical procedure should only be carried out on the basis of a formal domestic law and with the patient's informed consent. Any irreversible treatment should not be carried out on an involuntary patient. In addition, the principles determine that clinical trials and experimental treatment should never be carried out on a patient without the patient's consent. If a patient is unable to give this consent, an independent body has to give its approval (Principle 11).
The Standard Minimum Rules for the Treatment of Prisoners states that persons found to be insane are not to be detained in prisons. It also states that prisoners suffering from other mental abnormalities shall be observed and treated in specialised institutions under medical management and steps shall be taken to ensure the continuation of care after release.
The United Nations Standard Minimum Rules for Non-Custodial Measures (The Tokyo Rules) aim for the rehabilitation of offenders as well as their integration into the community and call for the development of non-custodial measures. The Rules reject the controversial practice of community access to the personal data of an offender, stating that the offender's personal records should be kept strictly confidential with access limited to persons directly concerned with the case. Furthermore, the Rules call for the avoidance of pre-trial detention as a means of last resort only for investigation or protection of society, and for post-sentencing alternatives to assist the offender with his/her reintegration into society. The UN Resolutions as such are not legally-binding documents. However, they are of practical importance as they help to establish international human rights norms by creating a baseline for fair treatment of mentally ill persons and therefore also enable objective monitoring of psychiatric abuses. In addition, they can also be used as an interpretive guide to international treaty obligations (Gostin, 2000).

Human Rights - An Issue That Matters

Passmore et al. (2003) assessed psychiatrists' knowledge of the UK Human Rights Act and their ability to apply it to clinical scenarios. They concluded that the overall level of knowledge of the Human Rights Act was good, given that it had been implemented only shortly prior to the assessment. A thorough knowledge of human rights issues as well as of the respective international and national legal instruments is essential for both researchers and forensic practitioners in view of their implications for managing mentally ill patients, including those admitted under criminal law. This is particularly important with an eye towards the process of integrating the Eastern and South-Eastern European countries into the EU.

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2 Study

The study was aimed at gathering and analysing information about the differences and/or similarities in legislation on the placement and treatment of mentally ill offenders across fifteen European Union Member States.
The study was funded by a grant from the health promotion programme of the European Commission (Grant Agreement SPC.2002448) and conducted from January 1st 2003 to September 30th 2004. The study centre was located at the Central Institute of Mental Health (CIMH) in Mannheim, Germany and co-headed by Hans Joachim Salize and Harald Dreßing from the CIMH.

The study relates in part to the previous EC-funded study "Compulsory admission and involuntary treatment of mentally ill patients – Legislation and practice in European Union Member States" which was conducted by the leaders of this study between October 1st 2000 and January 1st 2002 (EU grant agreement no. SI2.254882/2000CVF3-407).

While in the above-mentioned study legislation for placing or treating mentally ill patients involuntarily was analysed, this second phase study has focussed on the issue of legal frameworks for mentally disordered offenders. This specific group is to be seen as different from non-offending mentally ill patients detained involuntarily under public or civil law. Judicial procedures and care for mentally ill offenders require a specific legislation regulating the varied and complex aspects of their placement and treatment. Standardised overviews of the various legal frameworks across the European Union are lacking. This study aims at bridging this gap by contributing essential information on the current situation in the Member States.

This study document consists of

- a general outline of the issue,
- fifteen chapters (each of them dedicated to a Member State) reporting in a standardised way the national forensic systems and legal frameworks for mentally ill offenders,
- a synopsis of the current legislation and practice in the EU Member States,
- an analysis of similarities or differences across the Member States,
- a concluding chapter which summarises conclusions drawn from the analyses.

Work Plan

The implementation of the project involved the following tasks:

1. The setting up of a network of experts and collaborators (specialists in forensic psychiatry) from each EU Member State (prior to the extension of the European Union in May 2004).
2. Inclusion of contact persons from the ministries of justice and the ministries of health of the Member States in the network.
3. Development of a questionnaire for gathering structured information about legislation for the treatment of mentally ill offenders and current practice in each Member State (filled in by the specialists in forensic psychiatry), as well as information about the national forensic psychiatric service provision (facilities, number of beds etc). Essential information for the latter part was to be provided by the responsible National Ministries or other key agencies.
4. Development of guidelines for writing a chapter describing specific characteristics of each Member State. The chapters were to be written by the national experts.

5. Assessment of the current situation in each Member State (by means of the questionnaire).
6. Analysis and comparison of the results of the assessment and compilation of a synopsis of the current situation in the European Union.
7. Organisation of a meeting to discuss the results and their consequences attended by at least one expert or collaborator from each Member State.
8. Analysis and aggregation of the discussion, results and conclusions from the meeting.
9. Report on the results (study document).

Network of Experts

At the beginning of the project, experts from all fifteen EU Member States prior to the extension in May 2004 were selected. About a third of all experts had already worked on the previous study referred to above, and were therefore familiar with the study design. On a subcontractual basis,, all the experts agreed to fill in the study questionnaire, to write a national chapter on mentally ill offenders and to attend an experts' meeting to discuss preliminary results. The experts were also obliged to inform their responsible ministries of their collaboration in this study. The board of experts comprised:

- Austria — Prof. Dr. Hans Schanda, Göllersdorf
- Belgium — Prof. Dr. Paul Cosyns, Edegem
- Denmark — Dr. Peter Kramp, Copenhagen
- England & Wales — Dr. David James, London
- Finland — Dr. Riittakerttu Kaltialla-Heino, Tampere
- France — Dr. Pierre Lamothe, Dr. Munier, Lyon
- Germany — Dr. Michael Osterheider, Bernd Dimmek, Lippstadt
- Greece — Dr. Giorgius Alevizopoulos, Athens
- Ireland — Dr. Dermot Walsh, Dublin
- Italy — Dr. Angelo Fioritti, Rimini
- Luxembourg — Dr. Jean-Marc Cloos, Luxembourg
- The Netherlands — Dr. Catharina H. de Kogel, Den Haag
- Portugal — Prof. Dr. Miguel Xavier, Lisbon
- Spain — Prof. Dr. Francisco Torres Gonzalez, Granada
- Sweden — Dr. Helena Silfverhielm, Stockholm

Assessment Tools and Methods

Information on legislation and practice concerning the placement and treatment of mentally ill offenders in the Member States was gathered by means of a detailed, structured questionnaire, which comprised the major assessment tool in this study.

Following an exhaustive review of research literature and based on the knowledge and expertise of the project staff, a detailed questionnaire was developed. The questionnaire consisted of more than 100 specific items including both structured and unstructured questions covering the following topics:

- Legislation (laws, acts or legal instruments) on the placement and treatment of mentally ill offenders,
- Key concepts (mental disorder, criminal responsibility),
- Pre-trial procedures,
- Psychiatric assessments,
- Trial procedures and relevant court structures,
- Verdict (factors leading to a court decision),
- Placement and treatment facilities,
- Re-assessment procedures,
- Specific therapeutic procedures,

- Patients' rights,
- Discharge procedures and aftercare,
- Epidemiological data (outcome).

Because of the complexity of the issues concerned, the questionnaire had to strike a balance between questions on empirical data and open questions about specific national characteristics that are hard to describe in a structured way. A major part of the work of the first study phase was devoted to the development of this questionnaire.

Additionally, guidelines for the composition of the country-specific chapters were developed. The national chapters were supposed to focus on issues and national particularities that cannot adequately be explored by means of a questionnaire, such as the advantages and the limitations of the current legal system, practical problems of placement and treatment of mentally ill offenders, as well as public opinion and media coverage of issues related to mentally ill offenders. Both the questionnaire and the guidelines on the national chapters were forwarded to all experts.

Expert Meeting

A two-day meeting with partner experts was held in Mannheim, Germany, from 13th - 14th February 2004.
After a short introduction on major issues concerning the placement of mentally disordered offenders and forensic care, a summary was presented of preliminary results derived from the study questionnaire which had been filled in and returned by the attendees during the preceding months. This covered the following issues:

- Legal frameworks for mentally ill offenders in the Member States,
- Key concepts of mental illness and criminal responsibility,
- Assessment issues,
- Placement and treatment facilities for mentally disordered offenders in the Member States,
- Pre-trial and trial procedures, issues of verdict and sentence,
- Re-assessment and discharge arrangements,
- Epidemiology of mentally disordered offenders (prevalence and incidence data from the Member States),
- Treatments and therapeutic interventions.

The presentations were followed by the completion of missing information from the Member States, a clarification of queries and an extensive discussion of preliminary results. Among other points, the discussion focussed on key criteria for grouping the legal frameworks of the Member States in such a way as to identify similarities or major differences in approaches across the European Union. There was overall agreement on the complexity of the major issues covered by the study, requiring clear definitions for key concepts (e.g. criminal responsibility), procedures or responsibilities for assessment and decision-making (court procedures) and the patient groups included. It was agreed that the comparison of epidemiological data, i.e. time-series on forensic prevalence or incidence, requires unambiguous descriptions of included patient groups and diagnoses, which is seriously affected by the rather heterogeneous health-reporting standards in the Member States.

The attendants stressed the great need for a description of the current situation in the Member States and an evaluation of the legal frameworks and their impact on the routine practice of forensic care across the European Union.

Dissemination of Research Results

Dissemination of (preliminary) research results started during the study period and has been continued to be an integral part of the group's activities.

At the 8th Annual Meeting of German-Speaking Social Psychiatrists (Austria, Switzerland, Germany) in Palma de Mallorca in March 2004, a presentation was given on "Legislation and Practice

of Civil and Forensic Detention of Mentally Ill in the European Union". The presentation included both results from the previous study on civilly committed persons as well as preliminary results from the current study.

Results were also presented at the 12th Symposium of the AEP-Section of Epidemiology and Social Psychiatry (Association of European Psychiatrists) in Mannheim in June 2004. In the session "Recent European Studies and Networks", an overview of results was given with a particular focus on epidemiological data. In the session on "Coercion in mental health care: legal frameworks and routine practice in Europe", a second presentation of the study focused more specifically on conceptual and judicial aspects of criminal responsibility. An additional presentation concerned the results of the first study on involuntary placement and treatment of mentally ill patients.

Additionally, study results were presented at the 6th ENMESH Conference (European Network for Mental Health Service Evaluation) "Inclusion and Mental Health in the new Europe" in London, UK in September 2004, and at the International WPA Conference (World Psychiatric Association) "Treatments in Psychiatry – an Update" in Florence, Italy, November 10th -13th 2004.

Further dissemination is planned through participation in conferences and the publication of articles in relevant journals.

Communication with the European Commission and Report Writing

Two meetings with the Health and Consumer Protection Directorate-General were held in Luxembourg on February 3rd 2003. In addition to these meetings, communication by e-mail and phone took place when required. The interim activity report, as well as a financial interim report, were submitted to the Directorate-General by August 2003.

This final study document was forwarded after the ending of the funding period.

3 Results

The following section presents the results from the survey which was conducted as a central part of this study.
The section describes separately the results for each of the following topics:

- Legal Frameworks and Key Concepts
- Pre-Trial and Trial Procedures
- Forensic Psychiatric Assessment
- Reassessment and Discharge Procedures
- Patients' Rights
- Service Provision
- Epidemiology.

By summarising and comparing country–specific information in a standardised way, it provides an overview of the current situation in the Member States.

The chapter relies almost completely on data from the study questionnaire which was filled in by the experts from the Member States. When necessary, additional non-standardised information contributed by the experts was also included. In a few cases, information form other sources was added.

Legal Frameworks and Key Concepts

Legal Frameworks

This section summarises the various legal regulations relevant for decisions on mentally ill or disordered offenders in the Member States participating in this study.

Tab. 2: Most relevant Laws regulating Forensic Cases, Year of most recent Modification

	type and name of law	most recent revision or modification
Austria	Penal Law ("Strafgesetzbuch")	1975
Belgium	Social Protection Act	1964
Denmark	Penal Code ("Straffeloven") Mental Health Act ("Lov om Frihedsberøvelse og anden tvang / psykiatrien")	2000 1998
England & Wales	Mental Health Act Insanity and Unfitness to Plead Act (CPP) Homicide Act	1983 1991 1957
Finland	Mental Health Act	2002
France	Penal Code Health Act ("Code de la Santé Publique", "HDT - Hospitalisation à la demande d'un tiers" "HDD - Hospitalisation d'office danger")	1994 2000
Germany	Penal Law ("Strafgesetzbuch") State Laws on Enforcement ('Maßregelvollzugsgesetz", „Unterbringungsgesetz")	1975 various
Greece	Penal Law	1983
Ireland	Penal Law ("Insanity Bill")	prepared
Italy	Penal Law (CP) Civil Law (CC) Civil Procedural Law (CPP) Criminal Procedural Law (CPC)	1930 (revision prepared) 1988
Luxembourg	Mental Health Law Penal Code Criminal Investigation Code Law of Penitentiary Administration	2000 2000 2000 2000
the Netherlands	Criminal Code Principles Act TBS („Beginselenwet Verpleging Terbeschikkingstellinggestelden ")	1997
Portugal	Penal Code (CP) Code of Criminal Procedure (CPP)	1995 1987
Spain	Penal Law (Organic Penitentiary Law) Mental Health Act	1995/1996 2000
Sweden	Forensic Care Act Mental Health Act	1992 2000

As expected, all Member States provide specific laws, codes or other legal instruments for regulating judicial procedures concerning mentally disordered offenders. In the majority of Member States, these regulations apply nationwide. In some Member States, however, forensic legislation may be wholly regional or split between the national and regional. Belgian forensic law is applicable nationwide, although there are specific regulations for the regions of Brussels, Flanders and Wallonia. Denmark has common legislation for the mainland, whereas there are separate regulations for Greenland.
German Penal Law regulating criminal responsibility and the disposal of mentally disordered offenders applies nationwide, whereas federal law regulates procedural aspects.
In case of the United Kingdom, England and Wales share the same forensic legislation, which is different from that in Scotland and that in Northern Ireland.
In the case of split forensic legislation, the results and conclusions presented below refer to legal frameworks covering the largest jurisdiction in a given state (e.g. the mainland without Greenland for Denmark; England and Wales in the case of the UK) unless otherwise indicated.

No Member States provide all-embracing forensic legislation in a clearly demarcated code or statute, but rather Member States provide a variety of codes, laws or acts regulating different of the many aspects of forensic cases (criminal responsibility, rules for detention or treatment, penal aspects, trial or discharge procedures etc.). In consequence, the following overview does not cover all possible regulations, but describes the most significant forensic laws or codes as selected by the contributing national experts.

The most recent year of revision as listed in table 2 suggests forensic legislation in the Member States is an issue under constant change and review. However, old codes are still in effect as well as newer ones. This may serve as an indication of the complexity of the issues or of the diversity of judicial approaches.
This interpretation is supported by the varied distribution of relevant regulations into penal codes and health or mental health laws, which follows no obvious pattern and does not allow conclusions to be drawn as to whether medical or punitive aspects are to the fore in the judicial management of forensic cases.

Legal Terms Defining Mental State

Similarly to the wide variation in legal frameworks, the basic terminology for addressing the mental condition of the persons concerned varies widely in the laws of Member States. Table 3 lists significant terms or wordings as used in national codes or acts. Please note that these terms are translated from the original language into English by collaborating experts for the purpose of this study, and therefore cannot be considered as official.

The terms or descriptions are particularly non-specific, widely varied and, from a professional psychiatric point of view, in large part antiquated. They have little relation to the classification systems established in international mental health care (e.g. Diagnostic and Statistical Manual of Mental Disorders DSM-IV, International Classification of Diseases ICD-10). This non-specific terminology embraces all kinds of mental disorders and allows broad scope in their construction.

It remains debatable to what degree specific diagnostic categories should be included in the basic legal regulations, taking into account the fact that these categories and the defining classification systems are subject to change and refinement over time. Thus, the concepts as employed by the law reflect the difficulty in determining the relationship that nosological entities as defined by the current classification systems might have to a person's intellectual capacity and volition. However, definitional uncertainties or the use of particularly broad concepts of disordered mental state lay themselves open to wide interpretation by experts engaged in assessments or court procedures and provide a constant source of inequality in their application and outcome.
In addition, vague definitions of mental disorder are a serious obstacle to comparing forensic mental health legislation between the Member States and to reaching any conclusions as to differences between them as to which conditions are covered or explicitly included, or as to the conceptual differences which may lie behind any such differences.

Tab. 3: Legal Terminology for describing the Mental State in relevant Legislation within the Member States

Austria	- mental illness - mental deficiency - profound impairment of consciousness - other abnormal mental conditions - mental abnormality of higher degree
Belgium	- mental deficiency or mental retardation - severe mental unbalance - insanity
Denmark	- mental illness - state equal to mental illness - moderate to profound mental retardation - mild mental retardation - inadequate development, impairment or disturbance of mental abilities
England & Wales	- Mental disorder , which is defined as any of the following:- - mental illness (not defined), - mental impairment (when treatment is likely to alleviate or prevent deterioration) - severe mental impairment (when treatment is likely to alleviate or prevent deterioration) - psychopathic disorder (when treatment is likely to alleviate or prevent deterioration) - other disability of mind
Finland	- state of lunacy, senile lack of understanding, similar condition (penal law) - mentally ill (mental health act)
France	- mental disorder suppressing discernment or control of action
Germany	- mental disorder - severe disorder of consciousness - severe mental abnormality - intellectual disability
Greece	- morbid perturbation of intellectual functions or perturbation of consciousness
Ireland	- mental illness - mental handicap - dementia or any disease of the mind
Italy	- mental flaw - mental inferiority - insanity
Luxembourg	- mental disorder suppressing discernment or control of one´s actions - mental disorder impairing discernment or control of one´s actions - power or irresistible restraint - severe psychiatric disorder endangering oneself or others
the Netherlands	- developmental deficiencies - pathological mental disturbance
Portugal	- psychic abnormality
Spain	- anomaly - psychological alteration - intoxication - perceptual disturbance
Sweden	- serious mental disorder - mental disorder - severe personality disorders

Excluding Mental Conditions

Most national laws provide no clear definition as to which mental states automatically exclude a person from legal mental health provisions. In those laws which incorporate more precise descriptions, these usually concern only substance abuse disorders, personality disorders or disorders of sexual preferences.
It is only England & Wales which incorporate sophisticated medical terminology into mental health law in defining sexual deviancy and alcohol or drug dependence as being excluded from the provisions of the legislation. There are other Member States which exclude some or all of these disorders when deciding on the mental condition of suspects having committed an offence (e.g. Finland, France, Ireland, Italy etc.), but these arrangements lack legal definition and have been established as a common guideline in routine practice instead.

The relevant legal frameworks of the Member States do not function as practical guidelines for handling problems occurring during routine procedures (e.g. forensic assessment). Additionally, on a more political level, the lack of clear definitions prevents moves towards the harmonisation of legal frameworks or of routine practices within or across the Member States.

The above mentioned syndromes comprise mental conditions which some professionals and the broader public might consider as being more modifiable by volition than most mental disorders. Thus, forensic legislation across the European Union partly reflects a debate as to whether or not some specific conditions (e.g. addictive behaviour) belong to a more narrowly conceived concept of psychiatric disorder.

Although this debate might be considered outgrown and resolved in professional mental health care circles, there are some serious conceptual problems in unambiguously incorporating offences committed under the influence of alcohol or illicit drugs into forensic legislation. The mental state of a person who was intoxicated at the time of an offence might be affected by

- a singular pathological drug or alcohol intoxication
- a chronic state of intoxication due to addiction disorder
- dementia due to alcohol
- paranoid or hallucinatory states induced by drugs or alcohol.

These states form different syndromes from a medical point of view, and thus require different and complex judicial consideration (e.g. when judging the degree of individual responsibility). Not surprisingly, Member States have developed rather individual approaches. There is a group of Member States (including England & Wales, France and Ireland) where a suspect is not considered mentally ill or disordered within the terms of the relevant legislation, even in severe cases of addiction. Such individuals are subject to being tried in the same manner as “healthy” offenders. In some other countries (e.g. Luxembourg, Portugal), each case is decided on its merits, and a number of penal or forensic consequences may follow.
Article 92/93 of the Italian Penal Code admits no specific judicial procedure or insanity claim for persons who commit crimes whilst intoxicated. Frequent states of intoxication may even lead to more severe penalties (art. 94 Penal Code). However, chronic states of intoxication severe enough to cause physical damage may be admitted as a legal criterion for diminished criminal responsibility.
The Italian approach, although allowing cases to be considered in court trials according to their individual merits, provides an example of how medically defined terms such as “intoxication” might be widened in their interpretation when transformed into legal concepts.

Inclusion Criteria

Although omitting clear concepts and medical definitions of mental conditions on a legal level, in routine practice in most Member States a core set of mental disorders has been established which qualify for inclusion under mental health legislation. These disorders were transformed into ICD-10 terminology for the purposes of this study and are described in table 4.

The highest level of agreement across the Member States concerns schizophrenia and other psychotic disorders (F2). Most varied is the inclusion or otherwise of addiction (F1), neurotic disorders (F4) and personality disorders (F6).
Due to the absence of binding definitions, it may be the responsibility of psychiatrists, judges, courts or other authorities involved in trials against mentally disordered offenders to follow the common practices of the respective Member State or to apply individual criteria. Therefore, the overview presented here lacks official status.

Tab. 4: Mental Disorders covered by Forensic Legislation (as established in Routine Care)

	F0 Organic mental disorders	F1 Substance abuse disorders	F2 Schizophrenia	F3 Affective, mood disorders	F4 Neurotic, stress related & somatoform disorders	F6 Personality disorders	F7 Mental retardation
Austria	x	x	x	x	x*	x*	x
Belgium	x	x	x	x	x	x	x
Denmark	x	x	x	x	x	x	x*
England & Wales	x	In part*	x	x	In part*	In part*	x *
Finland	x	x	x	x			x
France	x		x				
Germany	x	x	x	x	x	x	x
Greece	x	x*	x	x	x	x*	x
Ireland	x*	x*	x*	x*	x	x	x*
Italy	x		x	x			x
Luxembourg	x	x	x	x	x	x	x
the Netherlands	x	x	x	x	x	x	x
Portugal	x	x	x	x	x	x	x
Spain	x	x	x	x	x	x*	x
Sweden	x	x	x	x	x	x*	

** Austria:* *F4, F6 only in severe cases, status for F60.2 (dissocial personality) unknown*
England & Wales: *F1.3, F1.4, F1.5, F1.6, parts of F1.7 are included; F1.2 are specifically excluded amongst F4: F42 and other items are covered, although very rarely encountered F6 covered explicitly by law, although including only F60, F61, F62 and F69, all other items of the F6-block are not. F7 covered explicitly by law*
Denmark: *F7 explicitly covered by law*
France: *F1, F4, F6 specifically excluded by law, status for F3 and F7 unknown*
Greece: *F1 explicitly covered by law, status for F60.2 (dissocial personality disorder) and F65 (disorder of sexual preference) unknown*
Ireland: *F1: intoxication explicitly excluded by law, F0, F2, F3, F7 covered by law*
Italy: *F1 explicitly excluded by law*
Spain: *status for F60.2 (dissocial personality disorder) unknown*
Sweden: *F6 covered by law definition*

Age of Criminal Responsibility

Whether a person is considered as being responsible for a crime depends not only on the mental state of the person concerned but also on his or her age.
A generally low age-limit for criminal responsibility might be an indicator of a restrictive judicial system, attributing to young adolescents or even children full or only slightly diminished responsibility for offences committed.

There are considerable differences between the Member States in the age at which a child or adolescent is liable to prosecution and to stand trial. Whereas the majority of states define the minimum age of criminal responsibility at between 14 and 16 years of age, England & Wales, France, Greece and Ireland remain below this figure. Belgium, Luxembourg and Spain consider 18 years as a specific threshold (see table 5)
However, even when prosecuting and judging a juvenile offender as an adult, that does not necessarily mean the application of the adult penal framework. Most countries provide a complex educational and correctional system for juvenile delinquents.

Tab. 5 Minimum Age of Criminal Responsibility in the Member States

8-13 years	14-16 years	18 years
England & Wales (10 y.) France (13 y.) Greece (8 -13 y.)* Ireland (12 y.)	Austria (14 y.) Denmark (15 y.) Germany (14 y.) Finland (15 y.) Italy (14 y.) the Netherlands (16 y.) Portugal (16 y.) Sweden (15 y.)	Belgium (18 y.)* Luxembourg (18 y.)* Spain (18 y.)

** Belgium:* *In certain cases 16 years.*
Luxembourg: *In certain cases 16 years.*
Greece: *Although the penal law of 1983 is in effect (7-12 years), juvenile regulatory laws anticipate that an offender between 8-13 years of age can be prosecuted but only for therapeutic and only rarely for penal purposes. Below 8 years of age a child is considered as not accountable.*

However, low age limits for prosecution in general do not necessarily mean similarly restrictive thresholds for criminal responsibility in mentally disordered persons, no matter what age they might be.
One touchstone for this might be the manner in which cases are processed which concern suspects suffering from mental disorders that affect cognitive abilities or volition to a lesser degree than most severe mental disorders. This includes especially personality disorders, and alcohol and drug addiction.

As shown in table 4, there are several Member States with low age limits for criminal responsibility, where addiction disorders (France, England & Wales, Ireland) or some personality disorders (France, England & Wales) are excluded from the scope of forensic mental health law. However, Member States with higher age-thresholds do likewise. So the minimum age of criminal responsibility does not provide a reliable indicator of restrictive forensic mental health laws.

Criminal Responsibility as a Key Concept

To assess mentally disturbed offenders differently from suspects whose mental abilities are not disturbed is a practice based on the assumption that mental disorders significantly affect a person's ability to exercise free will and to control their actions (see chapter "Criminal Responsibility").
So the forensic laws of the Member States may be characterised by the extent to which they incorporate the concept of criminal responsibility, or by whether different degrees of diminished responsibility are distinguished in their systems..

As shown in table 6, the basic concept is applied in most, but not all Member States when judging mentally disordered offenders. Countries with an Anglo-Saxon or Common Law tradition, or those that adopt significant features thereof, usually exclude any assessment of a mentally ill suspects' criminal responsibility from pre-trial or trial procedures.
Thus, in England & Wales and Ireland, the criminal responsibility of a suspect is considered only in cases of homicide, where the charge will be reduced to one of manslaughter, if the defendant's responsibility can be shown to have been diminished. As a consequence, in these Member States, the disorder of the person concerned is the decisive criterion, which usually means that a treatment or hospital order is made as a sentence.

Tab. 6 Concepts of Criminal Responsibility in Mentally Disordered Offenders incorporated into the Legal Frameworks of Member States

Criminal responsibility either full or absent (dichotomous concept)	Lacking, diminished or full criminal responsibility (graded concept)	Criminal responsibility not applied as a legal concept
Austria	Finland	England and Wales *
Belgium	France	Ireland *
Denmark	Germany	Sweden
	Greece	
	Italy	
	Luxembourg	
	the Netherlands	
	Portugal	
	Spain	

** England & Wales, Ireland Diminished responsibility is only an issue in cases of homicide*

Although these results fit into the patterns of legal tradition that have grown up in the different Member States, it remains questionable as to whether differences in concepts of criminal responsibility result in any significant consequences in routine forensic practice.
There may be differences in legal or medical responsibilities during the post-trial phases (as shown in chapters below). However, whether or not the concept of criminal responsibility is applied, all Member States separate mentally ill offenders from mentally non-disturbed offenders and from non-offending psychiatric patients according to their individual needs for treatment and/or the degree of danger that they constitute to the public.
So the degree to which the concept of criminal responsibility is incorporated into the legal frameworks of the Member States may not by itself comprise as a useful criterion for their evaluation.

Pre-Trial and Trial Procedures

Placement Options Prior to Trial

The type of facility in which a mentally disordered suspect is detained before trial depends largely on when mental disturbance in the accused was first suspected. In many cases, doubts about the mental functioning of a suspect are not raised until the subject is on remand, suspicion then being raised by disturbed behaviour on the part of the suspect, by the contents of witness statements or by the specific circumstances surrounding the case. In consequence, mentally disordered suspects are commonly found in remand prisons throughout the European Union.
Nevertheless, it is standard practice in all EU Member States to attempt to ensure adequate treatment of remand prisoners where a serious mental disorder is detected. However, the actual place or institution where such treatment is provided varies and the site of treatment can be crucial in determining the quality of care and its outcome.

Placement options in the pre-trial phase are similar in the various Member States (see table 7). When a suspect is thought mentally ill before trial, placement in a general psychiatric facility is possible in twelve Member States, the exceptions being Belgium, Luxembourg and Portugal.
All Member States other than Belgium provide for placements in a specialised forensic facility before a trial has started. In eleven Member States, a mentally ill suspect may also be placed in a remand prison, the exceptions being England & Wales, Ireland, Portugal and Sweden. In the case of minor offences, suspects can also be bailed to their home address for outpatient treatment in almost all Member States.

Tab. 7: Placement Options Prior to Trial

General psychiatric facility	Specialised forensic facility	Prison
Austria	Austria	Austria
		Belgium
Denmark	Denmark	Denmark
England & Wales	England & Wales	England & Wales*
Finland	Finland	Finland
France	France	France
Germany	Germany	Germany
Greece	Greece	Greece
Italy	Italy	Italy
Ireland	Ireland	
	Luxembourg	Luxembourg
Netherlands	Netherlands	Netherlands
	Portugal	
Spain*	Spain	Spain
Sweden	Sweden	

** Spain:* *only in rare cases and on a temporary basis*
England & Wales: *prison placement only in the short term whilst awaiting hospital placement*

However, the criteria concerning pre-trial placement and the attendant procedures differ from country to country and vary according to local regulations and practice. For example, in England & Wales, the mentally disordered person will initially be remanded in custody until the formalities of

transfer orders have been completed and will then only remain in prison until a bed becomes available in the health service. The court cannot determine the hospital, but only sanction a transfer into a general psychiatric or forensic institution, based on the recommendation of the psychiatrist responsible for the patient's area of domicile.

Maximum Period for Pre-trial Placement

The maximum length of pre-trial placement is specified by law in only five Member States (table 8), this ranging from a legally-defined maximum of 28 days in Ireland to twelve months in Germany or Portugal.
The question of importance here is whether the absence of legally defined time-limits constitutes a legal loophole or indicates an emphasis on the treatment needs of the suspect. In Finland, for example, the treatment periods of mentally disordered suspects during the pre-trial phase vary according to rules set out in the Mental Health Act and according to the need for treatment (although the relevant legal regulations are under discussion).
Where mental health care provision within the prison system is poor, a failure to meet legal limits on pre-trial placement is likely to result in unmet needs for treatment amongst remand prisoners suffering from mental disorders.

Tab. 8: Limits on Pre-trial Placement Specified by Law

Up to one month	Two to six months	Six to twelve months	Not specified
Ireland (28 days)	Greece (6 months) Netherlands (106 days)	Germany (12 months) Portugal (12 months)	Austria Belgium Denmark England & Wales Finland France Italy Luxembourg Spain* Sweden

** Spain: there are no general limits regarding the length of a pre-trial placement, maximum length being specified by law according to the severity of the crime (usually from one to four years).*

The Defence Counsel

In the pre-trial and trial procedures, arrangements for acquiring defence counsel are of particular importance in the mentally ill, although none of the Member States' criminal laws include particular reference to mentally ill defendants. In all Member States, suspects have the legal right to an assigned counsel, with the exception of Luxembourg where this right is only current practice. The assignment of a defence counsel against the defendant's wishes is possible in ten Member States, namely Austria, Belgium, Denmark, England & Wales, France, Germany, Italy, the Netherlands, Portugal and Spain. Yet conditions for the assignment of a defence counsel against the defendant's wishes vary between Member States. For instance, in France it is mandatory for the defence counsel to be physically present at court, but the suspect does not need to collaborate with a counsel assigned against his or her wishes.

Only in England & Wales, Germany, the Netherlands and Portugal is it possible for the trial to be held of a mentally ill defendant without a defence counsel being allotted (see chapter "Patients' rights"). Again, England & Wales does not specify such matters in its legislation regarding the mentally ill. If a person chooses to defend himself, he may do so. Nevertheless, in practice courts are very cautious about letting mentally disordered defendants defend themselves.

In most Member States, the costs of an assigned counsel are covered by the Ministry of Justice. Only in Ireland does the social security system reimburse an assigned counsel. In Luxembourg, the defendant himself has to pay, and only where he is unable to do so will the state reimburse the costs.

Defendants' Attendance at Court

Similarities between states are also evident in trial procedures. In most Member States other than Denmark, Greece, Portugal and Spain, mentally ill or disordered defendants do not have to attend for every session of the trial. However, there are differences between those Member States in which full attendance is not obligatory. In Finland, it is part of the psychiatric assessment to determine whether a mentally disordered or ill defendant should attend. In England & Wales, the defendant's attendance is obligatory for plea and for sentencing.
Finally, one should note that, in Denmark, an offender may be remanded without being present in the court, where he suffers from severe psychotic symptoms, has been admitted to hospital and the psychiatrist considers the offender unfit to attend. Nevertheless, the offender has to be present for sentencing.

Tab. 9: Consequences of Being Unfit to Plead

Suspension of trial	No suspension of trial
Austria	Denmark
Belgium	Finland
England & Wales*	Greece
France	Portugal
Germany	
Greece	
Italy	
Ireland	
Netherlands	
Portugal	
Spain	
Sweden	

** England and Wales: the trial may be suspended whilst the defendant is treated in order that he become fit to plead, or a finding of unfitness may be made, in which case the defendant is sent to a psychiatric hospital for treatment and the matter may never come to trial*

In cases where the defendant is unfit to plead, the trial will be suspended in most Member States (table 9). Only in Denmark (see above), Finland, Greece and Portugal will the trial not be formally suspended, but the judgement may include a suspension of the sentence and the convicted person is sent to a psychiatric institution for treatment instead.

Period when Mental Illness Present as a Decisive Factor in Disposal

The issue as to the period when the defendant's mental illness was present is of particular importance in terms of the consequences that follow.
If the defendant was ill at the time of the offence as well as at the time of the psychiatric assessment following arrest, the consequences are clear and are along the same lines in all EU Member States: disposal is by way of hospital placement and treatment instead of a prison sentence.
If the offender was mentally disordered at the time of the offence but not at the time of the assessment, the potential danger for the public becomes a decisive factor. If the offender constitutes no further illness-related threat and if no relapse and no re-offending is to be expected, the offender is

acquitted in most Member States, e.g. in Austria, France, Germany or Italy. Criminal charges will be dismissed in the Netherlands in this case.
If the offender is considered to be a danger to the public, in some Member States this would usually result in a referral to psychiatric care (e.g. in Denmark, Italy, Ireland or Luxembourg) whereas in others it would result in prison (e.g. in Greece or the Netherlands). In Member States such as England & Wales and France, both forensic care or prison are possible options.
There are country–specific and sometimes rather complex pathways to either psychiatric care or punishment when a defendant was not suffering from a mental illness at the time of the offence but is ill at the time of the assessment.

Obligatory Psychiatric Treatment in Case of Specific Offences

Obligatory psychiatric placement or treatment in the case of certain types of crime, whether or not related to a mental disorder, is an uncommon option in the EU Member States.
Treatment programs for sex offenders are available in some Member States in varying quality or quantity; only in France, Belgium (since 1998) and Germany are these programs required by law. However, in these States, these laws are relatively new and therefore sufficient numbers of specialised facilities to provide such treatment are still lacking.
Furthermore, in Belgium, it is routine practice to provide treatment for drug offenders, although not obligatory by law. Similarly, most Member States provide treatment programs for substance-addicted offenders in prison or in other settings. However, concepts, capacities and inclusion-criteria differ even more than with sex-offenders treatment programs.

Sequence of Psychiatric Placement and Sentence

A controversial question in forensic psychiatry concerns the sequence of forensic placement or treatment orders and prison sentence in cases where both are imposed.
In Member States which do not exempt mentally disordered persons from prison placement, the sequence is legally regulated only in seven (Austria, Belgium, Germany, Italy, the Netherlands, Portugal and Spain, see table 10).
In all others states where joint disposals can be imposed, the sequence is determined in each individual case at sentence. In routine practice, the availability of forensic hospital beds may have an influence on the matter, according to the experts from Greece and Luxembourg collaborating with this study.

Tab. 10: Regulations for Sequence of Treatment and Prison Sentence

Regulated by law	Not regulated by law	Not applicable
Austria	France*	Denmark
Belgium	Greece	England & Wales
Germany	Ireland	Finland
Italy	Luxembourg	
Netherlands	Sweden	
Portugal		
Spain		

** France: sequence regulated by law only in sex offenders*

Thus, the sequence most frequently followed varies between EU Member States. In Belgium, France and the Netherlands, a prison sentence may be served before admission to a forensic facility. In Germany, Italy and Portugal, forensic psychiatric placements precede a prison sentence. However, there are exceptions to the general rule. In Germany, for instance, the expected treatment outcome is a decisive factor in determining the sequence. If a positive result from treatment does not appear realistic, a prison sentence may be served first. The option to serve a prison sen-

tence and forensic treatment at the same time is possible in Austria, Greece, Ireland, Luxembourg, Portugal and Spain. In Portugal, this latter option is the one most frequently adopted, and only in the case of a need for medical treatment might a sentence be postponed (see table 11).

Tab. 11: Most Common Sequence of Psychiatric Measures and Prison Sentence

Prison sentence before forensic treatment	Treatment before prison sentence	Both at the same time	Not applicable
France Netherlands	Germany Italy Portugal	Austria Greece Ireland Luxembourg Portugal Spain	England & Wales Denmark Finland

If both psychiatric treatment and a prison sentence are imposed on the mentally ill offender, seven Member States provide for the option to count the duration of psychiatric treatment towards the period of the sentence, namely Austria, Germany, Ireland, the Netherlands, Portugal and Spain (table 12).
In France, if a mentally ill offender is detained under a court order ("mandat de dépot") before trial or after sentence, and if he has to be placed in a psychiatric hospital during this period (because he needs care during the assessment or is unable to stay in prison under art. D 398 of penal procedure code), the duration of treatment is counted towards the duration of the final prison sentence

Tab. 12: Duration of the Treatment Counted Towards the Length of Prison Sentence, where Both are Imposed

Possible	Not possible	Not applicable
Austria* Germany Ireland Netherlands Portugal Spain Sweden*	Belgium France Greece Italy Luxembourg	Denmark England & Wales Finland

** Austria: obligatory*
Sweden: depending on type and severity of crime

In Austria, 100% of the time spent in treatment is counted towards the time to be served in prison. In the Netherlands, the offender needs to serve at least one third of the sentence. In Germany and Portugal, it depends on the treatment outcome. However, in Germany, a maximum of two-thirds of the treatment time can be counted towards the sentence. In Ireland, there are no relevant regulations.
In Belgium, Greece, Italy and Luxembourg, there is no option for treatment time to be deducted from the length of imprisonment. Here different rationales might apply. For example, in Belgium, treatment is not linked to the prison sentence and therefore cannot be counted towards it.

In England & Wales and Denmark, in cases where there is pre-sentence treatment in hospital but the sentence given is one of imprisonment, time on remand in hospital is counted towards the sentence, just as would be the case with time spent in a remand prison.

Forensic Psychiatric Assessment

Forensic psychiatric assessment is considered to be a crucial element in the judicial process, influencing all subsequent decisions on sentence, detention, placement or treatment of the person concerned.
Quite apart from determining the psychiatric treatment needs of the accused, the forensic psychiatric assessment of a suspect constitutes a major link between the criminal justice system and the mental health care system, requiring clear-cut procedures and clearly-defined responsibilities for both systems concerned. The size, content and detail of such procedural regulations may constitute a reflection of how important a thorough psychiatric examination is considered by the various legal frameworks and may speak to the state of collaboration between judicial authorities and psychiatric experts.

Legal Prerequisites for Forensic Assessment

It is perhaps surprising that not all Member States stipulate an examination of the mental state as a legal prerequisite for a trial against a suspect assumed to be mentally ill or disordered.

Tab. 13: Assessment of the Mental State as legally defined Prerequisite for a Trial

Legally defined	Not legally defined	Not applicable
Austria	Finland	Denmark
Belgium	Germany	England & Wales
France	Italy	
Greece	Luxembourg	
Ireland	Sweden	
The Netherlands		
Portugal		
Spain		

So, in Finland, Germany, Italy, Luxembourg or Sweden, judgements against mentally ill offenders can theoretically be issued without considering the opinion of an expert. However, this would happen only in rare and obvious cases where the court's or judge's knowledge or expertise might suffice.
In the Netherlands, an expert assessment is mandatory only in cases where a so-called "terbeschikkingstelling" (TBS)- or hospital-order is to be imposed[1]. However, although not being legally mandated, it is common practice in other situations to assess suspects presumed to suffer from mental problems.

[1] *For details on the terbeschikkingstelling-order see the chapter on the Netherlands in the section "Concepts and Procedures in the Member States".*

Denmark and England & Wales are classified here as 'not applicable', since their systems clearly separate the issue of reaching a verdict against a mentally disordered offender from the decision as regards disposal.
In both Member States, the responsibility of the court during the trial is to decide, whether or not the defendant has committed the offence which he is accused of. Due to the basic philosophy of the common-law tradition, the mental state of a defendant is not relevant to the decision as to guilt or innocence. So in England & Wales or Denmark, it is the task of an assessing expert to consider the issue of appropriate disposal, but not to form a view on guilt or other judicial concepts. Denmark additionally refrains from evaluating the mental state in cases of minor offences threatened with a fine.

Scope of Forensic Assessment

It is the basic task of any expert conducting a forensic assessment to examine and describe the overall medical condition and the mental state of a suspect or defendant. This might be extended to additional medico-legal aspects, among them the ability to control one's actions, the issue of insight, the degree of dangerousness to the public or the likelihood of recidivism, which it is common practice to consider in all Member States except Denmark and England & Wales (see tables 14 and 15). The examination of these aspects goes beyond the basic medical tasks of reaching a diagnosis and recommending appropriate treatment.

Tab. 14: Evaluation of additional Issues as Part of the Forensic Assessment

Yes	No
Austria	Denmark*
Belgium	England & Wales*
Finland	
France	
Germany	
Greece	
Ireland	
Italy	
Luxembourg	
Netherlands	
Portugal	
Spain	
Sweden	

** Denmark:* *The evaluating expert can be asked for a risk assessment, but it is not obligatory*
England & Wales: *Assessments have to contribute evidence for a treatment order, that requires the following: a) The person is suffering from a mental disorder "of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment, b) in the case of psychopathic disorder or mental impairment that "such treatment is likely to alleviate or prevent deterioration of his condition, c) It is the most suitable method of disposing the case.*

Criteria for the diagnosis of mental disorders are clearly defined, whereas those for deciding on the above-mentioned medico-legal concepts are ill-defined and lacking in standardisation. As a consequence, this increases the latitude available to anyone asked to assess these aspects, as well as their degree of responsibility for their opinions.
This may result in a broader disagreements among experts concerning such issues in a defendant than concerning his basic mental disorder, determined by well-established and internationally acknowledged diagnostic procedures.

Forensic Assessment of Specific Crimes

Without it being legally stipulated, the mental state of offenders having committed grave crimes (e.g. homicide, infanticide, sexual abuse of children, other sexual crimes, repeated arson) is routinely assessed. Similarly, this is done in case of spectacular, bizarre or extremely cruel crimes.
Only France provides for the mandatory psychiatric examination of persons having committed sex offences or other serious crimes listed in the penal code. These crimes are tried by special courts ("court d'assises")

Whereas legal frameworks do not do so, routine practice in the Member States commonly supports a so-called medical model of delinquency, suggesting a strong correlation between mental disorder and the probability of committing an offence.

Tab.: 15 Additional Conditions or Circumstances to be Assessed

Ability to control one's actions	Capacity for insight
Austria*	Austria
Belgium	Finland
Finland	France
France	Germany
Germany	Greece
Greece	Luxembourg
Ireland	the Netherlands
Luxembourg	Portugal
the Netherlands	
Portugal	
Spain	

** Austria: Whereas in theory, this is a legal criterion decided by the court or judge, for which the expert only has to provide evidence, in routine practice this decision is made by the expert*

Connection between Offence and Mental Disorder

To consider whether or how an offence relates to a mental disorder in the offender constitutes an essential part of the forensic assessment in many member states. In at least two thirds of Member States, the assessing expert has to evaluate the degree to which an offence was influenced by or committed as a direct consequence of a mental illness (see table 16).

To provide evidence for a causal correlation often exceeds medical expertise. Clear signs or any defined criteria as to how far a mental disorder might be connected to offending behaviour are missing. Only in clear-cut cases of severe psychotic symptoms (e.g. when an offence was committed under the influence of command auditory hallucinations), a psychiatric examination would be able to confirm a connection.

Most probably, in routine practice a variety of strategies have emerged to deal with this dilemma. When going strictly according to the psychiatric textbook, an assessing expert must often fail to provide evidence for a causal connection between disorder and offence, and by doing so overestimate the responsibility of the offender. As a consequence, a considerable proportion of mentally ill offenders might be considered to be mentally well.

Tab. 16: Correlation of Mental Disorder and Crime

Assessment of correlation required	Not required
Austria	Belgium
Finland	Denmark
France	England & Wales
Germany	Ireland
Greece	Luxembourg
Ireland	
Italy	
Netherlands	
Portugal	
Spain	

Thus, the varieties of interpretation of the connection between illness and offending may lead to a wide variation in outcomes in terms of sentence or placement decisions.
Member States, whose regulations do not require evidence of a connection between offending and mental disorder, allow for a much clearer medical approach. The most significant stance is adopted in Denmark and England & Wales, where the basic legal philosophy demands treatment for any ill person who is in need of it. Thus, if a defendant is mentally ill and found guilty of a criminal offence, he will be sent to hospital, in lieu of any other punishment. As a consequence, the court will surrender all power over the case. This is likely to occur, even where the defendant was not demonstrably ill at the time of the offence, but has become ill since. In this legal context, questions concerning a correlation between offence and mental disorder are redundant.

Expert Appointment

Differing qualifications, professional training, experience and specific skills may all influence the assessment procedure and its outcome. Thus, manner in which the expert is appointed and the selection criteria play an important role.

Tab. 17: Entitled Authority for Appointing the Forensic Expert

Court	National Agencies	Others
Austria	Finland*	Denmark*
Belgium	Portugal*	England & Wales*
France	Sweden*	
Germany		
Greece		
Ireland		
Italy		
Luxembourg		
The Netherlands		
Spain		

** Denmark:* *According to defendant's address, in most cases the assessment will take place at one of four regional centres covering most of the country*
England & Wales: *According to defendant's address*
Finland: *Authority for Medico-legal Affairs*
Portugal: *National Institute of Legal Medicine*
Sweden: *National Board of Forensic Psychiatry*

The court is authorised to select and appoint the assessing expert in more than two-thirds of the Member States (see table 17), whereas in Finland, Portugal and Sweden this is the responsibility of national agencies or authorities.

Denmark and England & Wales, however, adopt a community approach by appointing the expert according to the defendant's home address. In Denmark, most forensic assessments are conducted at four regional forensic centres, covering most of the country, whereas the home counties of the offenders are responsible for forensic care.

The community approach is even more to the fore in the case of England & Wales, where hospital admission by court order may only occur upon the recommendation of a psychiatrist who will be treating the person in hospital and only if the hospital agrees to supply a bed.

Number of Experts involved into the Assessment

Only one-third of the Member States legally define the number of experts having to contribute to a forensic assessment (see table 18). However, any regulation in this area does not encroach upon the right of the defendant to include additional independent experts into the procedure, credited (and often paid by) himself (see chapter Patients' Rights).

Tab. 18: Number of Experts Contributing to the Assessment

One expert	Two experts	More than two	Not defined
Austria France Ireland Sweden*	England & Wales The Netherlands Spain*	Sweden*	Belgium Denmark Finland Germany Greece Italy Luxembourg Portugal

** Sweden: one expert in case of "minor forensic assessments", more than two in case of "major forensic assessment"*
Spain: From a legal point of view, at least two experts must be designated by the court; in addition, the defendant may propose one or more experts paid for by himself

The inclusion of more than one expert may increase the quality of a forensic assessment. Flexible regulations in this regard are most clearly seen in Sweden, where a so-called "minor forensic assessment", which does not even require the participation of a psychiatrist, is distinguished from a "major forensic assessment", undertaken by a team of psychiatrists, psychologists, social workers and nurses. This required participation of four experts from different professional backgrounds is unique in the European Union.

Particular Professional Background of Experts

More than two-thirds of the Member States legally require that a trained psychiatrist assess the mental state of a suspect assumed to be mentally ill (see table 19). In Member States lacking a legal regulation for this, it is common practice for psychiatrists to conduct forensic assessments.

Tab. 19: Particular Professional Background required for Forensic Assessment

Psychiatrist	Any physician	Psychologist/ Behavioural scientist	Other	Not defined
Austria Denmark England & Wales* Finland France Greece Ireland Luxembourg The Netherlands* Portugal Sweden*	England & Wales*	France The Netherlands* Sweden*	Sweden*	Belgium Germany Italy Spain*

** The Netherlands:* *The participation of at least two experts with different professional backgrounds is mandatory. In most cases, this means a psychiatrist and a psychologist.*
England & Wales: *Two physicians contribute to the assessment, of which one has to be a psychiatrist.*
Sweden: *A minor and a major assessment are distinguished. Four experts contribute to a major assessment. A psychiatrist is directing, a psychologist, a social worker and a nurse are additionally involved.*
Spain: *Usually, one or two psychiatrists are the assessing experts, along with the court medical officer. However, other professionals might be involved additionally or instead of these.*

Due the complex requirements of a forensic assessment and to the far reaching consequences it might result in, it might be advantageous to have legally binding regulations requiring the inclusion of experts from different professional backgrounds in any assessment..
Sweden is the Member State providing the most refined procedure in this regard, by having a team of psychologists, social workers and nurses, headed by a psychiatrist, contributing to a so-called “major forensic assessment”. However, cost considerations might prevent such sophisticated approaches being adopted in other countries.

Certification of Experts / Quality Standards

Beyond specifying the professional background of assessing experts, the legal regulations of most Member States require little further certification or quality standards. However, in Finland, experts have to be licensed by the Authority of Medico-Legal Affairs (TEO).
Similarly, in Sweden, the National Board of Forensic Medicine provides certification, and in England & Wales, forensic experts have to be approved by the Secretary of State under a section of the Mental Health Act. Professional associations from several Member States (e.g. Denmark, Germany and the Netherlands) have defined quality standards for forensic psychiatric assessment.
A certificate for forensic psychiatric assessment has been proposed by the German Society of Psychiatry, but it is not yet a mandatory requirement to hold it.

Professional Training in Forensic Psychiatry

Professional training in forensic psychiatry is incorporated into the university curricula or medical schools of several Member States, but length and quality are rather variable (see table 20).

Tab. 20: Specialist Training in Forensic Psychiatry

Available	Not provided
England & Wales (3 years) Finland (6 years) Germany (1 year) Portugal (6 months)	Austria Belgium Denmark France Greece Italy Ireland Luxembourg The Netherlands Sweden Spain

The most elaborate forensic training is offered in Finland (6 years separately from general psychiatric training) and England & Wales (3 years after a 3 year education in general psychiatry).
Overall, experts from most Member States complain of an insufficiency or total lack of quality standards in forensic psychiatry. The formal construction and implementation of such standards is an important challenge for the future.

Reporting Procedures and Quality Standards

The responsibility and involvement of the assessing expert in trial procedures may be indicated by the format in which he or she has to deliver their report to the court. There are some Member States (Denmark, England & Wales, Finland or Sweden) requiring merely a written report of the assessment (see table 21). In the remaining Member States, the assessing expert has additionally to attend the trial and detail the results verbally.
Whereas a written report might restrict the contribution of the expert to his original professional expertise, giving evidence at court could result in the expert being drawn into a deeper involvement in the judicial procedure.

Tab. 21: Reporting Formats of the Assessment of the Mental State

Written but no verbal report at trial	Written *and* verbal report at trial
Denmark England & Wales Finland Sweden	Austria Belgium France Germany Greece Ireland Italy Luxembourg The Netherlands Portugal Spain

On a legal level, only Sweden defines quality standards for the expert report. However, in routine practice, medical associations from most of the Member States do provide guidelines or criteria for quality assurance. But these are far from being homogeneous, and international standardisation is missing.

Funding Procedures

The Ministry of Justice is the most common authority for reimbursing the cost of forensic assessments. Only in England & Wales and Finland is this the responsibility of the Ministry of Health. This might indicate that the forensic assessment is widely conceived of as a legal procedure, whereas the subsequent detainment is seen as a responsibility of national health authorities.

Reassessment and Discharge Procedures

Most mental disorders are characterised by rather variable courses, requiring regular re-assessment of the mental state in general mental health care, but even more so in forensic cases, where fundamental restrictions on personal liberty may be connected to a worsened or improved state of health.
Consequently, it is of major importance to understand how detailed national forensic laws regulate psychiatric re-assessment during forensic detentions, as well as their time-frames, comprehensiveness and scope or other crucial conditions.

Regular Reassessment of Placement Criteria

All Member States bar one stipulate periodic re-assessment in their relevant laws. The only exemption is Italy, which seems remarkable, considering the seven-day periods at which re-assessments have to be repeated in civil detention cases. Compared to this, the legal position of forensic patients in Italy seems to be remarkably undefined and much weaker, at least as far as this aspect is concerned.

Tab. 22: Responsibility for Psychiatric Reassessment

Psychiatrist from treating facility	Independent psychiatrist	Other
Austria	Austria*	Ireland (Mental Health Review Board)*
Denmark	Germany*	Belgium (Social Defence Commission)*
England & Wales	Greece	Luxembourg (Special Commission)*
Finland	Netherlands*	Sweden (County Administrative Court)*
France		
Germany		
Netherlands		
Portugal		
Spain*		
Sweden*		

** Austria:*	*in case of specific court order*
Belgium:	*the Social Defence Commission is composed of a presiding magistrate, a lawyer and a psychiatrist*
England & Wales:	*responsibility lies with the treating psychiatrists, but the patient can appeal to an independent panel which includes an outside psychiatrist*
Germany:	*in case of specific court order*
Ireland:	*the Mental Health Board comprises a senior lawyer or judge, a consultant psychiatrist and such other number of members as the Ministers of Health and Justice may appoint*
Luxembourg:	*decisions about maintaining placement are taken by a special commission including two magistrates and two persons suggested by the Ministry of Health. One has to be a psychiatrist*
The Netherlands:	*after six years and subsequently every six years*
Spain:	*reassessments are usually made by a psychiatrist from the treating facility together with a court medical officer*
Sweden:	*the County Administrative Court has to make a decision in cases ordered for special assessment for discharge (see national chapter for Sweden)*

Responsibility for Reassessment

Psychiatrists are commonly responsible for conducting re-assessments of the mental state during forensic placements. (see table 22). In some Member States, the re-assessment is the responsibility of the treating psychiatrist, thus allowing the closest knowledge of treatment progress

responsibility of the treating psychiatrist, thus allowing the closest knowledge of treatment progress and the broadest back ground of information to be incorporated in the evaluation of the mental state or the prediction of future progress.
However, in the case of lengthy detentions and long-lasting patient-therapist relationships, the risk of under-estimating important aspects (e.g. dangerousness of the patient) might increase. This is one of the reasons why some Member States entrust third parties or independent psychiatrists with the responsibility for re-assessing the mental state of forensic patients.
This is the case in Greece, Luxembourg, Sweden, Ireland (Mental Health Review Board) and Belgium (Social Defence Commission). Austria, Germany and the Netherlands provide mixed regulations, allowing for the involvement of independent psychiatrists in the routine procedures (by the treating psychiatrist) in the case of a specific court order. In the Netherlands, an independent psychiatrist is mandatory in a TBS-detention lasting longer than six years.

In most Member States, standardised risk assessment scales (e.g. PCL-R or HCR-20) are used routinely in forensic practice, although not a legal requirement. Their use appears to be on the increase, as most experts collaborating in this study confirmed.

Tab. 23: Time-frames for Post-trial Reassessment of Mental State

Every six months	Every one to two years	Every five to six years
Belgium*	Austria*	Netherlands*
Finland	Denmark*	Denmark*
France	Germany	
Ireland	Greece*	
Spain	Luxembourg*	
Sweden	Netherlands*	
England & Wales*	Portugal	

** Austria:*	*once each year and at any time on request of the offender*
Belgium:	*reassessment every six months on request of the detained person or his lawyer*
England & Wales:	*treatment orders last for six months and can be extended for a further six months and then annually by the treating psychiatrist. The court is not involved*
Denmark:	*for patients with a placement-order a re-assessment (and court hearing) has to take place at least five years after sentence and afterwards every second year (again together with a court hearing). For patients sentenced to inpatient or outpatient treatment, an instruction from the Prosecutor General orders the Regional Departments to ask for a re-assessment each year. Every six months, each forensic patient has the right to ask the prosecution to bring his case before the court*
Greece:	*every second year after the expiration of the minimum length of placement laid down at sentence for the category of diminished responsibility (article 39 §1): every third year for the category of lack of criminal responsibility (article 70)*
Luxembourg:	*two months after admission, a report on the mental state has to be written by the psychiatrist in charge and must be forwarded to the Special Commission. Where the placement continues, a re-examination is scheduled annually*
The Netherlands:	*psychiatrist from the treatment facility every year, independent psychiatrist after six years. TBS (see chapter "The Netherlands") has to be imposed for two years. Afterwards the court can extend TBS for a further one or two years each time*

Time-frames for Reassessment

Time frames for regular re-assessments of the mental state of a person in forensic care vary considerably between Member States, reflecting differing concepts of forensic care within Europe. Clusters of Member States which might indicate common medical or criminological criteria for upper limits cannot be detected (see table 23). However, from the human rights point of view, a common definition of time-frames for regular re-assessment of the mental state would appear desirable.

Obligatory Assessment Prior to Discharge

It might seem somewhat surprising that three Member States (England & Wales, Italy and Spain) do not legally stipulate an assessment of the mental state of a forensic patient prior to imminent discharge (see table 24). This is particularly so, when one considers the public sensitivity to the potential threat from discharged mentally ill or disordered offenders.
However, these legal omissions do not necessarily indicate that careless discharges happen in practice in these Member States, where formal assessments most probably take place even when legal stipulations are absent.
However, this finding suggests at least that conditions or criteria for the termination of forensic placements are much less formalised in some Member States than are the criteria for initiating placement or treatment.

Tab. 24: Obligatory Assessment of Mental State Prior to Discharge

Stipulated by law	Not stipulated by law
Austria*	England & Wales
Belgium	Italy
Denmark*	Spain
Finland	
France*	
Germany	
Ireland	
Greece	
Luxembourg	
The Netherlands	
Portugal	
Sweden*	

** Austria:*	*independent expert when ordered by court, routine practice in case of discharge recommendation ("discharge suggested") by treatment facility*
Denmark:	*only for patients with placement order*
France:	*discharge only when two experts in separate assessments agree*
Sweden:	*a person who has committed a crime under the influence of a severe mental disorder may be sentenced to forensic care with an order for special assessment prior to discharge when there is any risk of relapsing into criminal behaviour. The patient can only be released after a trial before a County Administrative Court*

Appropriateness of Length of Forensic Placement

It may be a matter of debate among legal experts, whether or how the length of a forensic placement should relate to the upper limits of the prison sentence that could have been imposed if the offender were *not* suffering from a mental disorder.
There may be arguments from a judicial as well as from a human rights perspective not to dismiss as inappropriate the idea of equivalence between the length of a forensic placement and the severity of the offence or the maximum term of imprisonment it would carry. This may be of increasing importance the longer a forensic placement lasts, in that it may last longer than any prison sentence would have for the crime in question.

However, equivalence does not appear to be a criterion for deciding on time of discharge from forensic placements in most of the Member States. The majority seem to favour a more medical perspective, emphasising the treatment needs of the patient and safety issues as criteria in discharge decisions. (see table 25).

Tab. 25: Equivalence between Severity of Offence and Length of Stay as Decisive Criteria for Timing of Discharge from Forensic Placement

Yes	No
Germany	Austria
Ireland	Belgium
Italy	Denmark
Portugal	England & Wales
	Finland*
	France
	Greece
	Luxembourg
	Netherlands
	Spain
	Sweden

** Finland: not legally defined but in routine practice equivalence is considered*

Conditional Discharge or Discharge on Licence

Conditional discharges and discharges on licence from forensic placements are part of a concept of graded re-integration of mentally disordered offenders into society.
After what may have been a lengthy period of detention under conditions of strict security, it is understandable that a forensic patient may need assistance and close monitoring for a certain period of time after discharge, before a final decision is taken to remove additional restrictions imposed on him.
Legal regulations for conditional discharges or discharges on licence offer the opportunity to take measures to assist the patient and to protect the public in the event of subsequent deterioration in the patient's mental health or a perceived increase in the risk of danger to the public. There are three Member States which do not provide specific regulations for conditional discharges or discharge on licence in their respective forensic laws (Ireland, Italy and Sweden, see table 27), whereas laws in the remaining Member States' include this as an option. In some Member States, e.g. in Portugal, conditional discharge is linked to the duration of the sentence, whereas it is only in Austria and Germany that discharges from forensic care only are always conditional (see table 27).

Tab. 26: Times-frames for Discharge on Licence / Conditional Discharge

Member State	Time frames
Austria	five years for offences threatened with a sentence less than ten years ten years for offences threatened with a sentence longer than ten years
Finland	Six months at a time
Germany	Two to five years
Portugal	remaining duration of sentence
Netherlands	one year (TBS with mandatory hospitalisation); one third of an additional prison sentence can be conditional (in case of a sentence from one year to three years).
Spain	up to a maximum of five years whenever compulsory out-patient treatment has been ordered.

Tab. 27: Legal Regulations on Discharge on Licence / Conditional Discharge

Provided, conditional discharge in each case	Provided, individual decision on conditional discharge	Not provided
Austria	Belgium	
Germany	Denmark*	Ireland
	England & Wales*	Italy
	Finland*	Sweden
	France	
	Greece*	
	Luxembourg	
	Netherlands	
	Portugal*	
	Spain*	

** Denmark:*	*all patient with a treatment order receive outpatient treatment either by forensic psychiatry or general psychiatry, which could be considered as a type of conditional discharge*
England & Wales:	*the power to release patients with non-restricted hospital orders resides with the treating psychiatrist., who may discharge the patient at any time. Aftercare under supervision is possible if the psychiatrist applies form a civil community supervision order. When a person has been convicted of a serious offence, a crown court has the power to add to a treatment order a so called "restriction order", removing the power to release the patient from hospital from the treating psychiatrist to the Home Secretary or an independent tribunal. As part of a conditional discharge from a restriction order, the Mental Health Appeal Tribunal may impose conditions (e.g. attendance at a psychiatric clinic, taking medication, keeping in contact with a social worker, residing at a specific address)*
Finland:	*the Authority for Medico-Legal Affairs makes the decision on conditional discharges, which is an option but not obligatory. Forensic treatments may also be terminated without a period of so called "continued release"*
Greece:	*discharge on licence is not legally defined in Greece, although courts have the power to impose a probation order, which is a very unusual in mentally disordered offenders*
Portugal:	*only when discharge occurs before the sentence is completed*
Spain:	*discharged mentally ill offenders can be ordered to attend outpatient follow-up within the general health system follow up*

Patients' Rights

Consideration of patients' or human rights in the context of mentally ill offenders is a delicate subject. It is an issue of some dispute in most Member States and receives a considerable degree of public attention. This is often reinforced by spectacular cases which attract intense media coverage and prompt intense discussion as to whether the patients' needs for treatment and reintegration into society are properly balanced with the need to ensure public safety. It is particularly in this context that the dual status of a mentally ill or disordered offender becomes evident, in that he or she is on the one hand a patient in the mental health care system and on the other an offender within the criminal justice system.

Right to Appeal

The most crucial patient right concerns mechanisms of appeal. The overall right to appeal against detention is granted to mentally disordered offenders in all Member States, thus according with basic human rights principles. The question here is at which stages of the process appeal mechanisms are open to a mentally ill offender.
The variable and complex procedures in the Member States incorporate a range of starting points for appeals during the various stages of the criminal justice process.
Whereas the right to appeal against a verdict is unquestioned throughout the European Union, not all Member States consider pre-trial assessment or placement procedures as being eligible for appealing (see table 28).

Tab. 28: Right to Appeal

Right to appeal against		Member States
pre-trial assessment	*yes*	Greece, Ireland, Luxembourg, the Netherlands, Portugal
	no	Austria, England & Wales, France, Germany, Italy, Spain, Sweden
	not applicable	Belgium, Denmark
pre-trial placement	*yes*	Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal
	no	Belgium, England & Wales, Spain, Sweden

Due to the provisional character of a pre-trial assessment or detention, appeals for mentally ill suspects in some Member States may fall under the same regulations as for civilly committed persons, as is the case for instance in Finland.

Appeals against issues of minor importance, e.g. denied leave requests, are also permitted. Usually these are filed and decided at lower judicial or administrative levels, e.g. by the director of the respective facility.

Legal Right to a Second Expert Opinion

One of the most crucial rights during trial procedures concerns the defendant's right to a second expert opinion in order to engage in and have a certain level of control over the assessment procedures and thus the long-lasting consequences that may arise.
This right is explicitly stipulated in several Member States (e.g. England & Wales, the Netherlands or Sweden in case of a major forensic assessment, see chapter "Forensic psychiatric assessment") and at least addressed in the respective codes or laws in others.
Most probably, Member States that do not explicitly stipulate this option in law, do accommodate this option. However, an obstacle here might be that, in these countries, the government will not cover the cost of a second opinion.

Tab. 29: Right for an Independent Expert covered by Law

Addressed by law	Not addressed by law
Belgium	Austria
England & Wales	Denmark*
Greece	Germany
Italy	France
Ireland	Finland
Luxembourg	
the Netherlands	
Portugal	
Spain	
Sweden	

* *Denmark:* *The Medico-Legal Council as a consultative medical board gives medical and pharmaceutical opinions in legal cases. The statements of the Council rest on experts who are independent of the parties involved and of financial interest. Only courts and public authorities can ask for the opinion of the Council but the defence can approach the Medico-Legal Council through the court or the prosecution.*

Assigned Counsel against Defendants Will

In trials against mentally ill defendants the role of the defence counsel is of utmost importance. The appointment of an assigned counsel against the defendant's will is possible in two-thirds of all Member States (see table 30). In the Netherlands, however, a suspect presumed mentally disordered who has been in pre-trial custody is assigned a defence counsel by the government, which he is able to refuse. But that happens very rarely.

Trial without Defence Counsel

In only four Member States is the option available to proceed with a trial without a defence counsel, namely in England & Wales, Germany, the Netherlands and Portugal (see table 31). However, it needs to be born in mind that in most Member States there are no special regulations regarding mentally ill defendants. Therefore, the case of a mentally ill defendant standing trial without any defence counsel is rare and more of a theoretical option. And, as it is the case in England & Wales, courts are cautious about letting mentally ill defendants defend themselves and usually grant this option only after psychiatric expert evidence has confirmed the defendant's fitness to plead and capability to represent himself.

Tab. 30: Counsel against Defendant's Will

Counsel against defendant's will
Austria
Belgium
Denmark
England & Wales
Germany
France
Italy
The Netherlands*
Portugal
Spain

** The Netherlands: defendant may reject counsel, but that rarely happens*

Tab. 31: Trial without Defence Counsel

Trial without defence counsel possible
England & Wales
Germany*
the Netherlands
Portugal

** Germany: only in minor cases.*

Civil Rights and long-lasting Restrictions for Mentally Ill Offenders

In some of the member states, there is special reference in national legislation to restrictions on the rights of mentally ill offenders, mostly for reasons of safety. In the Netherlands, specific civil rights are less restricted for mentally ill non-offenders than for TBS-patients e.g. regarding communication with the outside world or the care of children.
A different picture can be seen in Austria. Here, prisoners with sentences of more than one year loose their right to vote. In contrast to this, mentally ill offenders "not guilty by reason of insanity" (§ 21,1 Austrian penal law) have the right to vote. However, mentally ill offenders who are criminally responsible (§ 21,2 Austrian penal law) and who receive a prison sentence plus a criminal commitment for an indefinite period of time do not have the right to vote, even after having finished the prison sentence. Nevertheless, apart from the above mentioned exception of Austria, there are no long-term restrictions on mentally ill offenders following the release from prison and/or the completion of forensic treatment in any of the Member States.

Leave Regulations for Mentally Ill Offenders

One of the most crucial questions which receives a considerable amount of public and media attention and is a regular topic of controversy and discussion is that of leave conditions for mentally ill offenders. This issue highlights the special and sometimes contradictory aims of forensic-psychiatric care for mentally disordered offenders. On the one hand, the aim is to re-integrate the patient into society, which requires treatment conditions "as normal as possible" including leaves; on the other hand, attention must be given to protecting the public and preventing re-offending by

the persons concerned. Thus, various forms of leaves from forensic facilities are permitted for mentally disordered offenders in all Member States, although these are regulated on variable judicial or administrative levels. Leaves may include

- escorted and unescorted leaves on the premises of the treating facility,
- escorted and unescorted leaves outside the premises of the treating facility,
- escorted and unescorted over-night stays off the premises of the treating facility.

In Greece, escorted and unescorted over-night stays off the premises of the forensic psychiatric facility are unknown. In Spain, the concepts of unescorted leave on the premises of the facility as well as escorted overnight stays off the premises are unknown: mentally ill offenders may go on leave for week-ends or for one or more weeks. It should be noted that, in Denmark, leave regulations are only relevant for patients with a placement order.

Leave Concepts explicitly Named in National Laws

Although being a controversial issue, leave regulations are only addressed in national legislation in about one third of all Member States, namely in Austria, Denmark (for patients with a placement order) England & Wales, Germany, Luxembourg, the Netherlands and Sweden. In England & Wales, for example, "leave of absence from hospital" is explicitly dealt with and, in addition, the Mental Health Act also contains an advisory code, which gives more specific details as to good practice in certain leave types. However, the Code does not have the force of law. The Dutch law specifically refers to unescorted and escorted leave as well as overnight stay and group leave. In Germany, federal enforcement laws provide for regulations differing from Federal State to Federal State.

Deciding Authority over Leave Request

A highly controversial issue refers also to the decision-making on a leave request, since this is perceived by the general public and the media as an indicator of how far the need for public security is considered. In most Member States, it is the medical institution which decides on leave requests by mentally ill offenders, including various forms of unescorted leave (see table 32). Naturally, the court plays a more prominent role when it comes to more extended forms of leave, such as over-night stays outside the premises (see table 33).

Tab. 32: Decision-making on Leave Request

	Court decision necessary	Form of leave not available
Escorted leave on the premises	in none of the Member States	
Unescorted leave on the premises	Sweden*	Spain
Escorted leave off the premises	Belgium, Sweden*, Spain	
Unescorted leave off the premises	Belgium, Germany, Italy, Spain, Sweden*	
Escorted over-night stays off the premises	Austria*, Belgium, Germany, Italy, Portugal *, Sweden*	Denmark, Greece, Spain

** Sweden* *Hospital order with pre-determined discharge regulation*
Austria *Only when longer than two weeks*
Portugal *Only when longer than 48 hours*

Tab. 33: Decision-making on unescorted Overnight Stay off Premises of Forensic Facility

	Deciding authority
Austria*, Belgium, Germany, Italy, Portugal, Sweden*	Court
England & Wales	Treating psychiatrist
Finland	Treating and chief psychiatrist
Denmark	Prosecutor with chief psychiatrist
Ireland*, Luxembourg	Special Commission
France	"Prefet", Special Commission
The Netherlands	Ministry of Justice

** Sweden* *Hospital order with pre-determined discharge regulation*
Austria *Only when longer than two weeks*
Ireland *Consented by the Ministry of Justice*

Exclusion from Leave

Almost all Member States do not categorically exclude certain types of patients from leave, such as offenders with a record of recidivism or a record of serious offending. Only in Denmark are patients placed in the high-security facility generally not granted any form of leave outside the premises. However, these cases number up to 15 of the most dangerous patients among a total of approximately 1,400 forensic patients.
Nevertheless, the detailed regulations suggest sensible and responsible leave procedures across the Member States, which allow for detaining mentally disordered offenders considered as extremely dangerous without loosening security measures for long periods or even permanently.

Application of Treatment against the Will

A disputed issue concerning the rights of mentally ill patients is that of compulsory treatment against the person's will. Such compulsory treatment is possible in 12 Member States (table 34). It has to be kept in mind that, in most Member States, the relevant regulations are defined in the national health acts and concern both forensic as well as civilly committed patients, this being the case for example in Denmark and in Finland. Nevertheless, certain treatments, although defined in the national mental health acts, are hardly applied in practice. In Finland, for instance, anti-hormonal therapy and ECT are usually applied only with the consent of the patient, although the law theoretically allows for their involuntary application. In France, no treatment is specified by the law, which only refers to the placement against a patient's will. However, in routine practice, placement allows the imposition of treatment against a patient's will.
In Ireland, there is no specific legal consideration of treatment, except for psychosurgery which can only be undertaken with the consent of the Mental Health Commission, and for ECT which can only be administered to an involuntary patient if it is deemed essential for the health and welfare of the patient by two consultant psychiatrists. However, medication continuously given to an involuntary patient by a consultant for a period longer than three months must be reviewed by an independent consultant psychiatrist. This would include anti-hormonal treatment. In practice, despite legal authorisation to administer these treatments to involuntary patients under the conditions specified, consultants would be very hesitant to deploy such treatments unless the patient gave informed consent and would only disregard a refusal if there were strong clinical grounds for the treatment, such as for the safety of the patient or others, thought to be at risk.

Tab. 34: Involuntary Treatment Regulations as Specified in the Laws

	Anti-hormonal therapy	Psychopharmaco-logical treatment	Electroconvulsive treatment (ECT)	Not possible at all
Austria	●[1]	●	●[1]	
Belgium				●
Denmark		●	●	
England & Wales		●[2]	●[3]	
Finland	●[1]	●	●	
France		●[4]		
Germany		●[5]		
Greece				●
Italy		●		
Ireland	●[1]	●	●	
Luxembourg	●	●		
the Netherlands	●[6]	●[6]	●[6]	
Portugal				●
Spain		●		
Sweden	●	●	●	

[1] *Only theoretically*
[2] *First decision by a doctor followed after three months by review by an independent commissioner.*
[3] *Decision by a commission.*
[4] *Not specified by law, but provided for in routine practice.*
[5] *Variable regulations in federal laws. In several states treatment is possible only with consent of the offender (with the exception of emergency situations.*
[6] *Can be applied against patient's will, but is not specifically mentioned by law, which provides more general terms.*

Treatment of Mentally Ill Offenders

In most Member States, treatment of mentally ill offenders differs from treatment of mentally ill non-offenders suffering from the same mental disorder only in terms of security measures. Additional differences can be found in Austria and Finland with specific legal conditions for applying or terminating a treatment. In Germany and the Netherlands, the targeted results of treatments may vary. Treatment of mentally ill offenders aims additionally to reduce dangerousness or the risk of recidivism, which may affect treatment strategies. As reported by the experts from Belgium and France participating in this study, treatment standards in these countries are generally lower for mentally ill offenders than for civilly committed patients.

So, with the exception of Germany and the Netherlands, there are no specific legal indicators to be found which may reflect the double function of forensic care for mentally ill or disordered offenders, which includes crime-prevention. On a judicial basis, the majority of Member States seem to trust that psychiatric treatment will automatically be likely to diminish the risk of future offending. This is a particular medical concept which some might claim to be no longer in line with empirical evidence. The application of well-established criminal-therapeutic approaches (e.g. reasoning and rehabilitation programmes) seems to be rather scarce. Several experts contributing to this study declared standards of forensic care in many Member States to be lower than in general mental health care, although they should be considerably higher in this sensitive and controversial field.

Service Provision

The configuration and delivery of services for mentally ill offenders is influenced by the need to balance the interests of public safety against those of individual rights and treatment needs. Thus provision of forensic services in the EU Member States (and worldwide) tends to reflect national legal frameworks in terms of the respective emphases that national laws or statutes place on such considerations.
As a specialised sector of mental health care, forensic psychiatry has inevitably been affected to some degree by the changes in this field over the last four decades. However, varying degrees of involvement in the reform process have resulted in the emergence of varied models of forensic care across Europe. Some Member States have integrated their forensic services quite tightly into the general mental health care system, whereas other countries have developed separate arrangements for the care of mentally ill offenders, which are set apart from general psychiatry.

Definition and Classification Problems

All Member States use specialist forensic facilities, general mental health care services and the prison system to place and treat mentally ill or disordered persons who have committed minor or serious offences. The degree of involvement of each of these sectors and their individual patterns of usage differ widely throughout the EU. In addition, within each of these sectors, different Member States provide a variety of service-types which differ considerably with regard to organisation as well as to quantity or intensity of care.

In England & Wales, for example, there is no absolute division of hospitals or wards into forensic and non-forensic, and there are no forensic hospitals within the prison service. Local psychiatric hospitals and secure “forensic” hospitals treat both general and forensic patients and do so on the same wards. On the other hand, in Germany, all forensic hospitals are clearly separated from general psychiatric inpatient services.

The responsibility for forensic care and even the designation of forensic facilities differs across the Member States, complicating any attempt to define categories for cross-national overviews or comparisons. In Austria, for example, despite its being directed by a psychiatrist and fulfilling hospital functions, the national forensic facility answers to the Ministry of Justice and is known as a “Justizanstalt”, which is the common Austrian designation for prisons. Even more confusing is the fact that the major forensic facilities in Spain are referred to as “Psychiatric Penitentiary Hospitals”, a label suggesting the combining of correctional and security aspects with medical function.

A consistent, Europe-wide system of classification for forensic facilities based on functional criteria would be preferable for a number of purposes, including research or health-reporting. Unfortunately, no such system currently exists.

Facilities and Services for Mentally Ill or Disordered Offenders

Overviews or typologies of forensic services in the Member States must take account of differences in legal concepts between states, as well as of the different stages in the legal process through which a person passes, when suspected of, or found to have committed, a crime whilst mentally disordered. All these factors determine the type of detention ordered and the type of service concerned. The type of detention is influenced principally by

- the stage in the legal process (pre- or post-trial)

- the legal status of the person concerned – whether a suspect, defendant, convicted person, detained person or a patient, and
- the criminal responsibility of a mentally ill or disordered offender.

Tab. 35 Post-trial Placement of Mentally Ill or Disordered Offenders (whose Criminal Responsibility is Diminished or who are Non-Responsible)

General psychiatric facilities	Specialist forensic facilities (forensic hospitals, forensic wards)
Austria	Austria
Belgium	Belgium
Denmark	Denmark
England & Wales*	England & Wales*
Finland	Finland
France	France
Germany*	Germany
Greece	Greece
Ireland*	Ireland
	Italy*
	Luxembourg
Netherlands	Netherlands
Portugal	Portugal
	Spain
Sweden	Sweden

** England & Wales:*	*criminal responsibility is not an applicable concept, except in homicide cases; the level of security and the need for treatment are the major placement criteria*
Germany:	*the overall concept foresees the separate placement of mentally ill offenders in forensic facilities. Due to overcrowding in specialised care, however, some Federal States place forensic patients in general psychiatric hospital services*
Ireland:	*placement in general psychiatry only in case of unfitness to plead*
Italy:	*a recent Supreme Court ruling might allow post-trial forensic placement in general psychiatric facilities, although consequences for routine care are yet unknown*

Specialist Forensic Facilities

Specialist forensic facilities are the most common type of service in which criminally non-responsible mentally ill offenders are placed and treated. As an overall category, this includes specialist forensic hospitals, specialist forensic wards in psychiatric hospitals or even - as a rare option - specialist forensic departments or wards within general hospitals. Although such placements are used most frequently post-trial, they may also be used for mentally ill or disordered persons who have yet to come to trial.

All 15 Member States included in this study provided data about their forensic facilities , with respect to admission criteria, organisational features, quality of care, bed numbers and patient characteristics. There were wide variations. Some of the less populous Member States (e.g., Luxembourg, Ireland and Austria) have one central forensic hospital that serves the whole country and which might be supplemented by minor forensic care capacities in general psychiatric hospitals, whereas more populous Member States (e.g., Germany) are characterised by a diversity of forensic provision. For capacity (i.e. numbers of facilities and beds) see below and in the various national chapters.

Mentally ill offenders who have committed serious offences and who are being held as criminally non-responsible (in so far as this concept is applicable in individual Member States) constitute the

core clientele of forensic facilities, although there are some exceptions to this rule, most often for reasons of bed availability or security.

Tab. 36 Placement of Dangerous Mentally Ill Patients (Non-Offenders) in Forensic Facilities

Placement of mentally ill or disordered non-offenders in forensic facilities
Denmark
England & Wales
Finland
France
Greece
Ireland
Netherlands*
Sweden

** The Netherlands: not in TBS hospitals, but in forensic psychiatric hospitals and in forensic departments of general psychiatric hospitals (for details see chapter for the Netherlands)*

A substantial proportion of Member States (Finland, France, Ireland, England & Wales, Sweden, see table 36) admit aggressive, violent or "high risk" non-offending mentally ill individuals to forensic facilities. This is done most often under civil detention orders, but this is not necessarily so in all cases. Amongst these countries, Finland, in not requiring an offending history as a major criterion for admission, has adopted one of the most straight-forward approaches, taking illness-related dangerous or destructive behaviour as the major criterion for admission to forensic care.

General Psychiatric Facilities

During the pre-trial phase, it is common in most Member States for offenders suspected of being mentally disordered to be admitted to general psychiatry hospitals on a short-term basis (e.g. for assessment purposes). Post-trial, admissions to the non-forensic wards of general psychiatric hospitals are rare in most states, especially as far as criminally non-responsible patients are concerned. But only Italy, Luxembourg and Spain explicitly exclude these patients from post-trial placement in general mental health care facilities.

The situation is different in countries that do not apply the concept of criminal responsibility, like England & Wales, Ireland and Sweden, or for Member States that give priority to the need for treatment as a placement criterion, such as Finland and Denmark. In these countries, security considerations or the availability of treatment places may influence a decision for placement in general psychiatry. In Ireland, however, mentally ill offenders are admitted to general mental health care facilities only when they are unfit to plead. In England & Wales, only psychiatric hospital services in the area of residence are entitled to admit, a form of community-centred forensic approach.

Unfortunately, it was not possible to examine forensic provision in general psychiatric wards as part of this study, either in Member States which apply the concept of criminal responsibility in forensic care or in those which do not. This was because very limited data were available to examine. It is therefore difficult to draw any firm conclusions about the overall quality of forensic care in general psychiatry wards. Post-trial placement of forensic patients on general psychiatric wards might be evidence of positive features - the existence of a wide range of psychiatric provision or of an integrated treatment approach (where sufficient services are available, both in general mental health care and in the forensic sector). But it could also mask a shortage of places in specialised forensic care and a shift of the burden to general psychiatry, which may often be poorly placed to offer appropriate treatment or security. See the flow charts in the national chapters for estimates of forensic bed numbers in general mental health care in the various Member States.

Outpatient Forensic Care

Although outpatient care is today an integral part of general mental health care, specialist outpatient care for forensic patients is underdeveloped. Follow-up may be usual in many Member States or indeed mandatory in the case of probation orders, conditional discharge or as a general aftercare measure, but specialist services are usually lacking. Only Austria, Belgium, Germany and the Netherlands currently provide forensic outpatient services as a specific post-trial measure (for Austria see footnote of table 37). The Netherlands are the most well-provisioned Member State in this regard, equipping each forensic hospital (TBS facility) with an outpatient unit to provide forensic outpatient and aftercare, in addition to such highly specialised services as forensic home-treatment or forensic sheltered accommodation (see table 37).
In some countries (e.g., Italy), informal types of forensic outpatient care are implemented, when criminally non-responsible mentally ill offenders representing no public threat are cared for on a voluntary basis by community mental health services.

Currently there is a debate among experts in England & Wales, with many considering forensic outpatient treatment as far preferable. Similar debates may occur among experts from other Member States. In terms of reintegration and rehabilitation, this is considered to be a major area for future reform of forensic care systems.

Tab. 37 Availability of Specialist Services for Forensic Outpatient Treatment

	Specialist forensic outpatient services
Austria*	
Belgium	
Germany	
Netherlands	

** Austria: only for treatment during leaves, after discharge or in case of conditional criminal commitment*

Forensic Services for Offenders with Specific Mental Disorders

Where Member States offer forensic services for offenders with specific mental disorders, these services in most cases concern substance abuse. Austria, Belgium, Germany and the Netherlands currently offer such substance abuse services for offenders. Specific diagnosis-related treatment programmes may also be available for forensic patients in other Member States, but most often only as part of wider treatment programmes in general psychiatric hospital services, forensic units or prison services (e.g., so-called “drug-free units” in Portuguese penitentiaries or the Eleon Institution in Attica, Greece).

Treatment for sex offenders is also provided in some Member States, but these usually are of limited capacity, and usually part of more general prison-based programmes (e.g., in Austria, Belgium, Denmark, England & Wales, Germany and Spain).
Due to unclear definitions and differences between Member States as to whether disorders of sexual preference are included as a legal criterion for forensic placement orders, no overview is included here.

Tab. 38 Availability of Specialist Forensic Services for Specific Disorders or Patient Groups

Specialist forensic services for substance-abusing offenders
Austria
Belgium*
Germany
Netherlands

** Belgium: only outpatient treatment programmes*

Prison Services

Prison services are the most crucial sector and the most difficult to describe when evaluating procedures for the placement of mentally ill offenders across the Member States. All Member States that apply the concept of criminal responsibility in their jurisdiction place mentally ill or disordered persons who are held fully responsible for their offences in prison services or penitentiaries. However, that does not necessarily mean that special prison wards or adequate psychiatric treatments for such people are indeed available.

Tab. 39 Prison Placement of Mentally Ill or Disordered Offenders

Criminally responsible mentally ill offenders (if concept is applicable)	During pre-trial or transitional periods prior to final placement
Austria	Austria
Belgium	Belgium
Denmark	Denmark
	England & Wales
Finland	Finland
France	France
Germany	Germany
Greece	Greece
	Ireland
Italy	Italy
	Luxembourg
Netherlands	Netherlands
Portugal	Portugal
Spain	Spain
	Sweden

** Luxembourg: data not available*

Prior to trial, prison services are considered acceptable and are used by most of the Member States for detaining offenders suspected of suffering from a mental illness or disorder, e.g., for assessment purposes or during transitional periods until the final placement is ordered. In Portugal, however, the court is never entitled to place in prison a person who is suspected of being mentally ill; instead the individual is placed in a specialist forensic facility, even if the mental state of the suspect has been not assessed by an expert.

Post-trial placement of criminally non-responsible mentally ill offenders in a prison is hardly a legal option across the European Union. However, exemptions to this general rule are not as rare as might be expected. In several Member States, limited capacities in forensic facilities may determine the placement in prison of people fulfilling the legal criteria for specialist forensic treatment. Such a practice has been reported during this evaluation by Austria, Belgium, Finland, France, Greece and The Netherlands. Other Member States probably experience similar capacity problems.

People who have committed serious crimes and who are suffering from psychiatric disorders not legally qualifying them for forensic care are usually given prison-sentences. However, exclusion criteria for psychiatric disorder vary throughout the Member States. Most often excluded are the non-psychotic mental illnesses, substance abuse disorders, personality disorders or disorders of sexual preference (see chapter "Legislation and Key Concepts"). Individuals suffering from these disorders impose a heavy burden on prison systems. It is likely that there is a serious under-provision of psychiatric services for such conditions. However, a thorough evaluation of the situation of mentally disordered prison inmates across the European Union is lacking and seems to be overdue.

Forensic Bed Capacities

Any valid indicator for comparing forensic care capacities across the Member States would provide a very useful tool for research or service-planning purposes. However, variations in definition of forensic beds and considerable, yet unknown numbers of undeclared beds for mentally ill offenders in general psychiatry or the prison system are serious methodological obstacles to calculating forensic bed rates or any such indicators. Consequently, recent studies to develop a set of European mental health indicators do not include any estimates of forensic care capacity (Korkeila et al. 2003).

Despite the lack of common definitions, this study attempts to quantify specific beds for the care of mentally ill offenders across the Member States in order to describe and compare the relative weight of national forensic sectors across the Member States. Thus, for each Member State for which data was available

- the total number of declared forensic beds (for pre- and/or post-trial placement) and
- the number of declared forensic beds per 100,000 population (forensic bed-rate) were calculated.

To calculate these estimates, the most recent data on the population of the Member States were gathered from the Internet. However, time frames differ slightly. Population figures in most cases refer to 2001, whereas the reference years for forensic beds may vary from 1998 to 2003.

Additional problems of definition have to be considered. Beds on psychiatric or general prison wards were not included in the estimates, although some Member States may occasionally use prison placements for detaining criminally non-responsible offenders due to shortages in specialist facilities. Unspecified forensic beds in general psychiatric hospitals could be identified for some Member States and were included in the total number of forensic beds, whereas for others the undeclared or unspecified capacities in general mental health care facilities could not be quantified and thus were left out.
Overall, estimates in table 40 or figure 1 suggest a north-south divide within the European Union, with remarkable differences between similarly populous countries in Central and Southern Europe (e.g., Austria or Belgium compared to Portugal, or Spain compared to England & Wales). Low forensic capacities in Italy, Portugal, Spain or Greece might reflect a different concept of mental health care in those countries, commonly characterised by low numbers of hospital beds in general psychiatry, home-based care and a considerable burden on the families of the mentally ill. However, it is doubtful whether general mental health care conditions in these countries also affect forensic service provision, given the rather different security considerations and other requirements of forensic care.

Tab. 40 Forensic Bed Capacities Across the Member States (years of reference vary from 1998–2003)

Member State	Total number of specified forensic beds (approx.)	Forensic capacity in general psychiatry	Prison placement due to shortages in forensic sector	Forensic bed rate (specified forensic beds per 100,000 population)
Austria*	384	yes (included)	yes	4.7
Belgium*	1,061	yes (not incl.)	yes	10.3
Denmark	250	yes (not incl.)	unknown	6.6
England & Wales*	3,200	yes (not incl.)	no	6.1
Finland	360	yes (included)	unknown	6.9
France*	486	yes (not incl.)	yes	0.8
Germany*	7,123	yes (not incl.)	yes*	13.1
Greece*	250-330	yes (included)	yes	2.4-3.1
Ireland	80	yes (not incl.)	unknown	2.2
Italy	1,282	no	no	2.2
Netherlands*	1,304	yes (not incl.)	yes	9.8
Portugal	189	no	no	1.8
Spain	593	yes (not incl.)	no	1.4
Sweden*	713	yes (included)	unknown	8.0

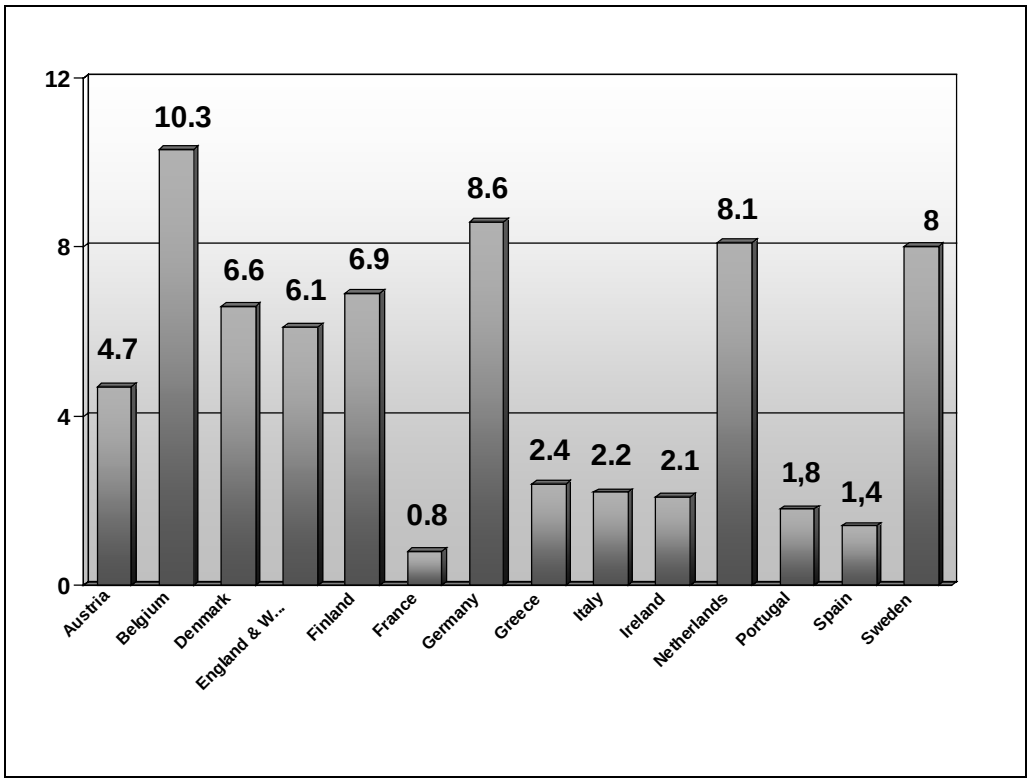
** Luxembourg:*	*data not available*
Austria:	*forensic beds including 80 beds for offenders with addiction disorders in specialized facilities*
Belgium	*only approx. 400 forensic beds are well staffed (services in Tournai and Mons), while other 'forensic beds' don't differ much from general prison beds with poor psychiatric treatment possibilities.*
Denmark:	*specification of currently non-specified beds in general mental health care (but nevertheless occupied by forensic patients) as forensic is planned*
England & Wales:	*estimated number of beds or places in high security and medium security facilities are taken as forensic beds, although a forensic sector might not be distinguished in the same way as for other Member States*
France:	*total number and rate is not a reliable figure compared to other Member States. Considerable and non-separable forensic capacities in general psychiatry are not included, due to the overall French routine to detain forensic patients in general psychiatry under civil detention regimes*
Germany:	*forensic beds include beds for offenders suffering from addiction (§ 64 StGB), figures in table refer to 2003. There was a considerable increase from 1999 (beds: 5 836, rate: 8.6 per 100.000 pop.) Prison placement is known only for substance abusers*
Greece:	*declared forensic beds are rough estimates due to overlapping placement of dangerous non-offending mentally ill in forensic facilities*
the Netherlands:	*declared forensic beds in 2002, included: TBS-beds plus individual care unit beds (IBA-) and forensic observation and care (FOBA-) beds in penitentiaries*
Sweden:	*other sources indicate 20% of all psychiatric beds as being designated for forensic care*
Please note:	***total numbers or rates of forensic beds should only be considered as rough estimates, due to uncertainties in pan-European definitions and poor availability of valid figures***

For Central-European or Scandinavian Member States, further analysis is needed to determine whether high forensic bed rates do indeed reflect a policy of separating forensic from general mental health care whilst providing adequate capacity (as could be hypothesised for Germany), or whether there may be other reasons.

The poor reliability of current indicators should always be kept in mind, and caution exercised in drawing any conclusions or making comparisons of capacity between Member States. E.g. the low forensic bed rate in France is due to the specific practice of placing mentally ill offenders under civil detention regimes which prevents from declaring specific forensic beds as is done in other Member States.
So, table 40 and figure 1 were included here only as a proposal for future indicators of forensic care, and would require much improved and harmonised basic data from the Member States. For a

more detailed description of forensic service provision in the Member States, see the national chapters.

Fig. 1 **Declared Forensic Beds per 100,000 Population (Forensic Bed Rates) in EU-Member States** (years of reference vary from 1998–2003, data for Luxembourg not available)



Certification and Supervision of Forensic Facilities

Responsibility for funding, supervising and regulating forensic facilities differs across the Member States. Regulation and supervision of facilities and of treatment are a means of quality control.
Although levels and intensity of regulation and supervision may vary across the European Union, one indication as to whether the main emphasis in forensic care in a given country is upon the medical or the procedural aspects (e.g., security aspects) may lie in whether the responsibility for supervision or regulation lies with the judicial authorities, (e.g., the Ministry of Justice) or with a health agency (e.g., the Ministry of Health).

Tab. 41 **Regulation**

Ministry of Justice	Ministry of Health	Shared	Others
Greece	Denmark*	Austria	Finland*
Italy	England & Wales	Belgium	Spain*
Portugal	Germany	Ireland	
	France	Netherlands	
	Luxembourg		
	Sweden		

** Denmark:* *Ministry of Justice endorses regulations for the only high-security forensic facility (30 beds) run by county administrations*

Finland: Authority for Medico-legal Affairs (TEO), supporting the Ministry of Health & Welfare
Spain: Ministry of Internal Affairs

Funding Arrangements

Forensic placements are funded from varying departmental budgets within the Member States, with a substantial financial responsibility for treatment placed upon the national Ministries of Justice (see table 42), whereas general mental health care is financed through health budgets.
The reimbursement of forensic care by Justice Departments, may cause some problems, e.g. by setting financial incentives for exporting into forensic care mentally ill individuals who have committed only minor offences or who are merely aggressive. This paradoxical and stigmatising effect, which is likely to undermine the integration of forensic and general psychiatric care, has been observed at least in Austria (Schanda et al. 2000).

Tab. 42 Financing of Forensic Placement or Treatment Episodes

Austria	Ministry of Justice
Belgium	Joint Payments*
Denmark	County Council
England & Wales	National Health Service (NHS)
Finland	State or Municipalities
France	Joint Payments *
Germany	Federal Ministries of Health or Social Affairs
Greece	Ministry of Justice
Ireland	Department of Health and Children *
Italy	Ministry of Justice
Netherlands	Ministry of Health and Ministry of Justice (jointly)
Portugal	Ministry of Justice
Spain	Ministry of Justice
Sweden	County Council

** Belgium: Payments by Federal Ministries of Justice, Public Health or Social Welfare may differ with facility or region*
France: Social Security pays for treatment in hospital or prison, Ministry of Justice contributes a fixed rate
Ireland: Any treatment or cost of medication in prison are the financial responsibility of Ministry of Justice

Forensic Facilities in the Private Sector

Forensic facilities in the private sector are used to varying degrees in some of the Member States (see table 43). In The Netherlands, the majority of forensic institutions (five out of nine TBS-hospitals) are in private ownership.
In Spain, out of the three large national psychiatric penitentiary hospitals, the one in Catalonia is privately run, whereas in England & Wales private forensic units are used by the NHS only where no beds are available in its own facilities. In England and Wales, on the other hand, the intention is to phase out private involvement in forensic care by building more forensic units within the National Health Service. Some Federal States in Germany currently plan to privatise federal forensic facilities.

Preventive Detention

In many countries, preventive detention following forensic treatment of or the completion of prison sentences by mentally ill or mentally non-disturbed offenders who are considered to be extremely dangerous or resistant to treatment is a topic of discussion. The measure is seen as a specific means of enhancing public safety and reducing the risk of re-offending. Most commonly, such measures are advocated by public opinion or mass media campaigns, especially in the aftermath

of spectacular crimes committed by mentally ill or disordered persons. Many experts consider preventive detention to be a most delicate subject, likely seriously to tip the balance between public safety and the human rights of the persons concerned if it is not applied with special care and according to clearly defined legal criteria.

Tab. 43 Forensic Facilities in the Private Sector

Private-sector running of forensic facilities (partial or total)	Forensic facilities completely run by national or federal agencies
Belgium	Austria
England & Wales	Denmark
Germany (planned)	Finland
Netherlands	France
Spain	Germany
	Greece
	Ireland
	Italy
	Luxembourg
	Portugal
	Sweden

Although criteria or legal procedures may differ, preventive detention is currently implemented in some Member States. E.g. in Denmark, unlimited detention is possible in cases of dangerous non-psychotic mentally ill offenders. The measure is ordered at trial. Preventive detention after completion of a prison sentence or a treatment order is not provided in Denmark, however.

In several Member States that do not recognise the concept of preventive detention, civil commitment laws may provide a legal means of continuing detention of dangerous patients who have served prison sentences in full or have been discharged from forensic facilities (e.g., in the Netherlands).

Tab. 44 Preventive Detention

Preventive detention as a legal option	No preventive detention
Belgium	Austria
Denmark	England & Wales
Germany	Finland
	France
	Greece
	Ireland
	Italy
	Netherlands
	Portugal
	Spain
	Sweden

Lifelong Forensic Placement

Aside from any measures allowing preventive detention, life-long detention of mentally ill offenders can be imposed in the majority of the Member States, in the event that the legal or medical criteria for forensic care are met and are confirmed regularly by re-assessment. The frequency of life-long forensic placements differs, although in general it does not occur very often. Modalities might vary also. For instance, in England & Wales, life-long orders when imposed may allow compulsory supervision of patients in the community after discharge and allow recall to hospital when they relapse, whereas in other Member States, life-long forensic care means an uninterrupted inpatient stay in a forensic facility.
In Spain, where life-long forensic care is unknown, most forensic patients are transferred to general psychiatric hospitals for continued treatment on an involuntary basis after their stay in a forensic hospital. However, security and capacity problems in general psychiatry increase the risk of quick discharges of or escapes by these patients.

Tab. 45 Lifelong Placement in Forensic Care

Theoretically possible	Not possible
Austria	Portugal
Belgium	Spain
England & Wales	
Denmark	
Finland	
France	
Germany	
Greece	
Ireland	
Italy	
Netherlands	
Sweden	

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Epidemiology

Availability, Reliability and Validity of Data

Across the European Union, information on outcomes of legal interventions or judicial procedures against mentally ill offenders such as prevalence or incidence rates is scarce, and that which is available is beset with methodological pitfalls. Even data on indicators as simple as the number of court trials or decisions against mentally ill offenders are largely unavailable. Usually, there is no national register linking the forensic psychiatric sector with the judicial authorities or even the national health services. Even Member States renowned for their case-registers in general psychiatry (e.g. Denmark) seem to be rather inconsistent in entries on the legal status of registered patients. Only Sweden and the Netherlands obviously run official nation-wide data bases which could be classified as forensic case registers.

Thus, in many Member States, relevant data may be spread among various authorities like the Ministry of Justice, the National Bureau of Statistics, the Ministry of Health, the police or other agencies. Moreover, variations in definitions and conflicting classification systems frequently confuse information for calculating annual frequencies of forensic cases or other basic indicators, even within individual Member States. Methodological problems multiply when trying to compare forensic frequencies or rates over time or across countries. Unfortunately, recent proposals for a European set of mental health indicators omitted to include estimates for forensic care, which would probably have promoted international standardisation.
All in all, similarly to forensic service provision across the EU (see chapter “Service Provision”), there are serious obstacles to pan-European comparison of legal outcomes with mentally ill offenders at the moment. Nevertheless, during this study, it was possible to assemble more or less consistent data for several basic indicators. These are presented in this chapter.

Data was taken from a variety of sources. When available, official statistics were used. In some cases, this information was cross-checked with results from national studies. Due to the aforementioned methodological and definitional problems, the reliability of figures from these sources may be reduced, and in a number of Member States, figures cannot be taken as being exact, but must be considered only as an approximation. This is the case, for instance, for Finland or Germany, where national statistics do not cover East German Federal States from the former German Democratic Republic, and therefore were weighted by a population factor (see footnote to table 46). Unless otherwise stated, figures below relate to court-confirmed mentally ill offenders with diminished responsibility or lacking in criminal responsibility (where the concept is applicable) who are detained under forensic treatment orders or similar legal regimes. Mentally disordered offenders judged to be criminally responsible are not included. All national definitions were harmonised as much as possible according to this basic distinction, but nonetheless may differ more or less across the Member States. Conclusions must be drawn rather cautiously.

Frequency of Forensic Cases across the Member States

A basic epidemiological indicator for evaluating legal concepts and the outcome of judicial procedures against mentally ill offenders is the annual number of cases in forensic care. Time series for this estimate from 1990 onwards were available for more than two thirds of the Member States. Most of these figures represent census data, thus including all cases falling under the definition at the end of each year (unless otherwise stated).

Tab. 46 Total Number of Forensic Cases across the Member States (court decided cases in forensic care, point-prevalence or census data unless otherwise indicated)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Austria	117	126	130	149	172	176	195	189	206	229	256	244	274	
Belgium	528	512	523	525	560	576	531	590	622	589	640	675	644	
Denmark	634	672	718	789	827	883	971	1043	1063	1122	1120	1110	1223	1371
Finland									339	416	340	306	319	
France	n.a.													
Germany		2992	3214	3289	3314	3511	3576	3891	4282	4394	4958	5199	5399	6192
Greece	212	229	230	249	294	236	211							
Italy	1154	1022	1061	1033	1011	1044	1039	986	977	1069	1156	1282		
Ireland	343	371	345	304	334	207	138	155	155	256	184	134	107	
Luxembourg	n.a.													
Netherlands	522	550	597	685	772	855	840	1110	1200	1244	1328	1409	1509	
Portugal									277	283	261	235	220	
Spain	n.a.													
Sweden				846	929	954	952	1031	1006					
England & Wales						2478	2549	2650	2749	2842	2858	3002		

n.a.: *data not available*

Austria *Point-prevalence at end of each year. Detained mentally ill offenders not guilty by reason of insanity according to §21/1 StGB. When including criminal responsible mentally ill offenders (§21/2 StGB), annual figures more or less double. Data source: Austrian Ministry of Justice*

Belgium: *Point-prevalence, total no. of interned persons under forensic detention regimes (excluding patients of facilities in Tournai and Mons). Data source: FOD Justitie, DG Uitvoering van Straffen en Maatregelen*

Denmark: *Point-prevalence. Data source: Danish Department of Prison and Probation as referred to by Kramp & Gabrielsen (2003), updated by oral communication from the authors*

Finland : *Point-prevalence. Treatment orders by Authority of Medico-Legal Affairs TEO, uncorrected data from National Hospital Discharge Register NHDR*

Germany: *Point-prevalence, March 31 each year, patients in forensic custody (§ 63 StGB), excluding addiction disorder cases (§ 64 StGB). Data source: National Bureau of Statistics, which registers only data from West-German Federal States. For each year 21% was added according to the proportion of inhabitants in East-German Federal States.*

Greece: *Point-prevalence. Only male patients. Data source: National Service of Statistics*

Ireland: *Figures represent all annual admissions to the Central Mental Hospital in Dublin (serving as a rough estimate for 12-month prevalence of mentally ill offenders in Ireland). Data Source: Mental Health Board. Point-prevalence for Ireland in 2002 and probably throughout the 1990s was approx. 80 per year.*

Italy: *Point-prevalence (December 31 each year, except for 2001 which is March 31). Data source: Italian Ministry of Justice, Dipartimento Amministrazione Penitenziarie*

Netherlands: *12-month-prevalence: all persons detained with TBS-measure during the respective year. Data source: Dutch Ministry of Justice, Agency of Penal Institutions as referred to by van der Heide & Eggen 2003. Number of beds in TBS-facilities may serve as an estimate for point prevalence (1990=405, 1991=506, 1992=541, 1993=570, 1994=607, 1995=630, 1996=728, 1997=866, 1998=970, 1999=1175, 2000=1183, 2001=1222, 2002=1304)*

Portugal: *Most probably point prevalence. Data source: Portuguese Ministry of Justice*

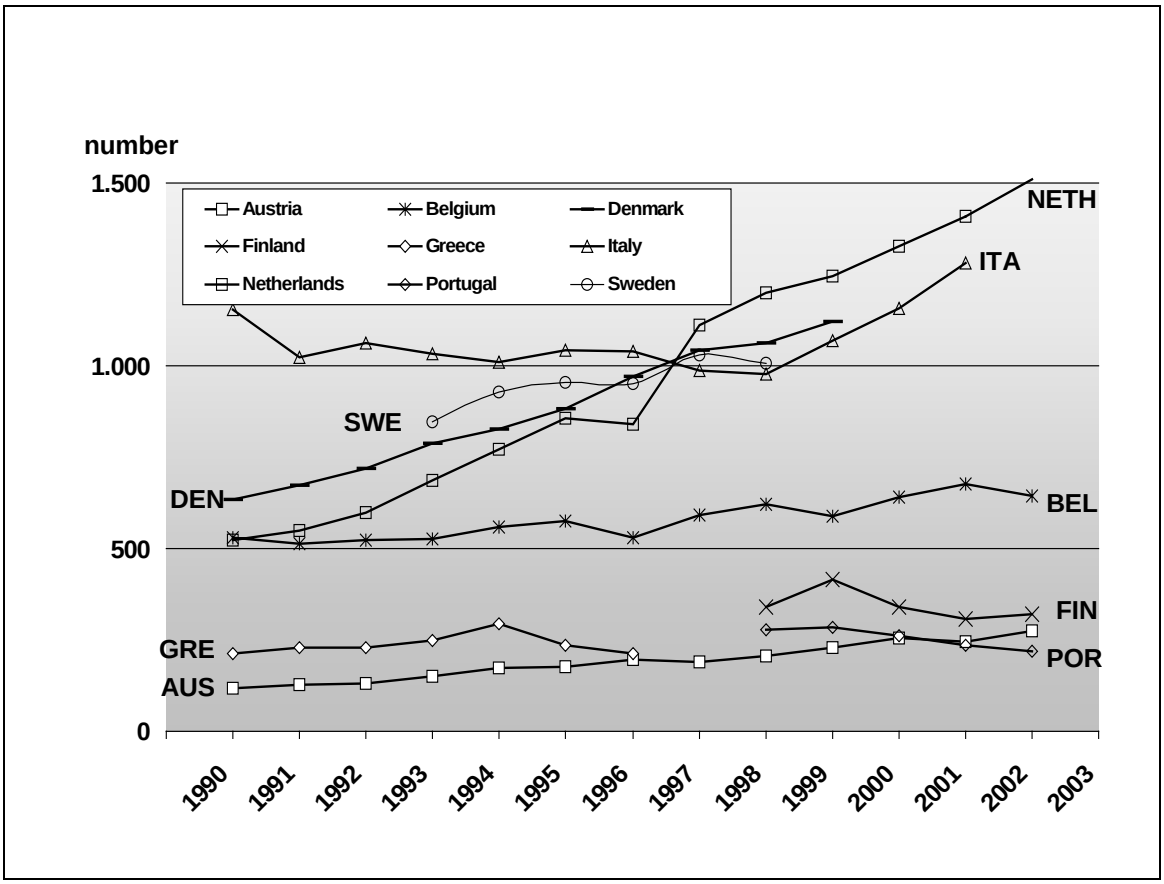
Sweden: *12-month-prevalence. Point-prevalence known for 1991 (834), 1994 (708), 1997 (781) and 2002 (900). Data Source: National Board of Health and Welfare*

England & Wales: *Point-prevalence. Data Source: Statistics of mentally disordered offenders 2001 (Steven Johnson & Ricky Taylor, National Statistics). Included are restricted patients detained in hospital by following legal categories: hospital order with restriction order, transferred from prison established after sentence or while un-sentenced or untried, recalled after conditional discharge, transfers from Scotland or Northern Ireland, unfit to plead, not guilty by reason of insanity, hospital and limitation direction, other.*

Given the large differences in population size, total numbers of forensic cases differ widely across the Member States (see table 46 or figure 2). Although comparing these figures across national boundaries would not be valid, national time-series allow some conclusions at least to be drawn on trends or tendencies within each country.

In this regard, some characteristic patterns can be detected. Throughout the 1990s, the annual number of cases (point-prevalence) in Germany, the most populous Member State, was much greater than the level in other Member States (see figure 2). Unfortunately, the German National Bureau of Statistics registers only data from West-German Federal States. To get nationwide estimates, for each year 21% was added according to the proportion of inhabitants in East-German Federal States. Moreover, the German figures presented here would have been more complete if offenders suffering from addiction disorders placed in forensic custody (according to § 64 StGB) had been included. These offenders have been omitted here for purposes of harmonising case definition. If they are added in, German figures increase by approximately 30 to 50 % (prevalence) or by 120 to 150 % (incidence).

Fig. 2 **Total Number of Forensic Cases across the Member States** (court decided cases in forensic care, point-prevalence or census data unless otherwise indicated)



Data sources and definitions see table 46
France, Luxembourg, Spain not included due to unavailability of time-series
Trends for Sweden and the Netherlands are slightly overestimating due to usage of 12 month-prevalence
Ireland not included due to unavailability off point prevalence data
England & Wales (3,002 cases in 2001, see table 46) not pictured here for better resolution
Germany (6,192 cases in 2003 see table 46) not pictured here for better resolution

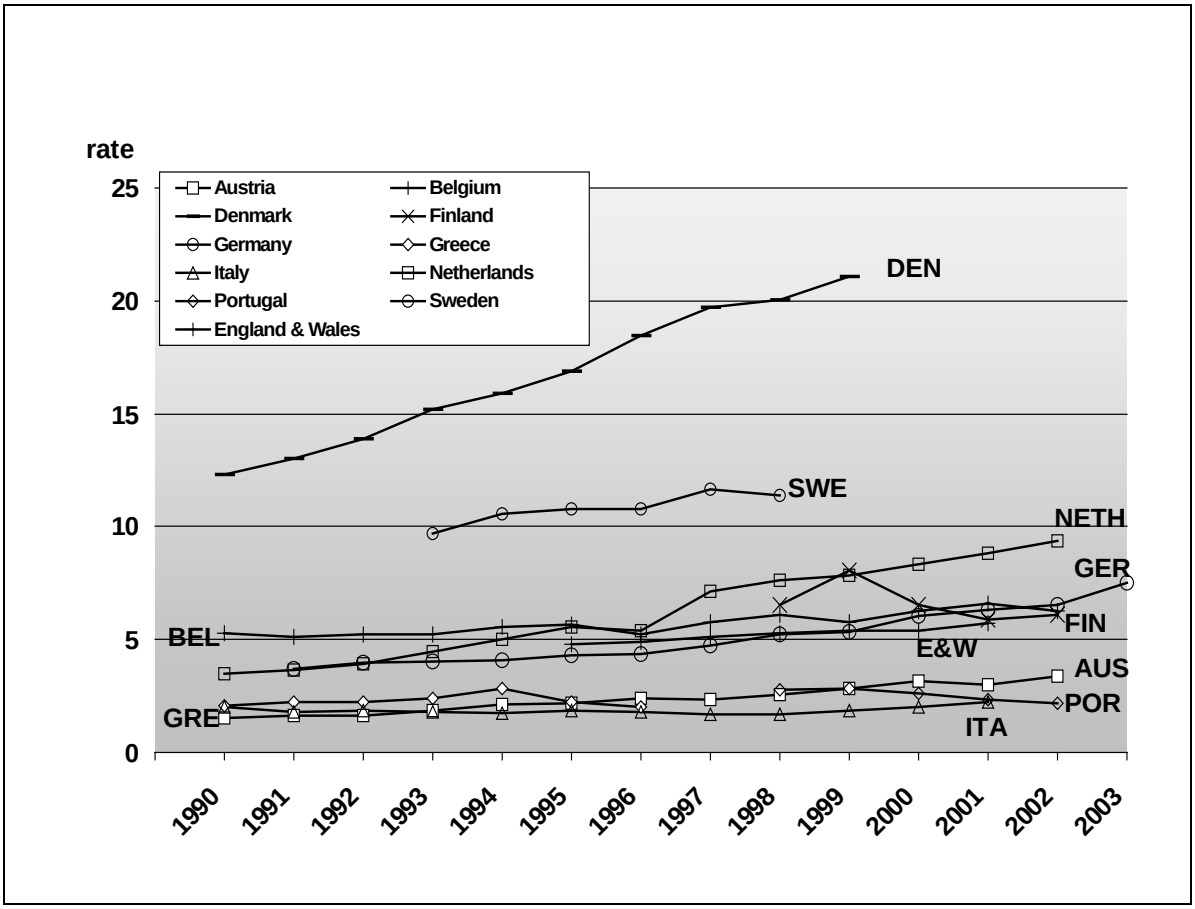
Whereas total numbers from Germany and other countries show either a fast growth (e.g. Denmark, the Netherlands) or a consistent but less steep increase (Austria, Belgium), there are Member States where the prevalence curve over time is more or less U-shaped (e.g. Italy) or even goes down (Portugal, Greece, see figure 3).

These differing patterns do not suggest a common trend for the Member States during the 1990s. Most probably, national figures depend on a variety of influences, which have to be analysed separately for each country. However, any consistent relationship between numbers and external factors is hard to identify.

For instance, the decline of forensic cases in Italy until 1998 was partly paralleled by a dramatic increase in the rate of imprisonment in Italy, where the prison population doubled from 1990 to 1994. This was mainly due to a change in legal provisions about drug crimes. However, a stagnation in the number of prison-inmates after 1994 – when forensic cases decreased still further - prevents clear-cut conclusions being drawn about any interdependency between the two phenomena.

The situation in other Member States is similarly complex, usually lacking clear explanation. Thus, there is an urgent need for facing the challenge of identifying and analysing factors influencing forensic prevalence for each country separately.

Fig. 3 **Prevalence Rates (Forensic Cases per 100,000 Population)** (court decided cases in forensic care, point-prevalence or census data unless otherwise indicated)



data sources and definitions see table 46
France, Luxembourg, Spain not included due to unavailability of time series
Rates for Sweden and the Netherlands are slightly overestimating due to basing on annual 12 month-prevalence
Ireland not included due unavailability point-prevalence data

Prevalence Rates (Forensic Cases per 100,000 Population)

To allow for cross-national comparison, total numbers of forensic cases were controlled by population of the Member State concerned. The resultant prevalence rates (forensic cases per 100,000 population), are shown in figure 3 (time series for the 1990s and beyond) and figure 4 (rates for the most recent year available). Rates range widely, from 21.7 (Denmark in 1999) down to 2 per 100,000 population (Greece in 1996), supporting the hypothesis that there is a wide variety of factors influencing rates.

Tab. 47 **Prevalence Rates (Forensic Cases per 100,000 Population)** (court decided cases in forensic care, point-prevalence or census data unless otherwise indicated)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Austria	1.5	1.6	1.6	1.9	2.1	2.2	2.4	2.3	2.6	2.8	3.2	3.0	3.4	
Belgium	5.3	5.1	5.2	5.2	5.5	5.7	5.2	5.8	6.1	5.8	6.2	6.6	6.3	
Denmark	12.3	13.0	13.9	15.2	15.9	16.9	18.5	19.7	20.0	21.7				
Finland									6.5	8.1	6.6	5.9	6.1	
France														
Germany		3.7	4.0	4.1	4.1	4.3	4.4	4.7	5.2	5.4	6.0	6.3	6.5	7.5
Greece	2.1	2.2	2.2	2.4	2.8	2.3	2.0							
Italy	2.0	1.8	1.9	1.8	1.8	1.8	1.8	1.7	1.7	1.8	2	2.2		
Ireland *													2.1	
Luxembourg														
Netherlands	3.5	3.7	3.9	4.5	5.0	5.5	5.4	7.1	7.6	7.9	8.3	8.9	9.4	
Portugal									2.8	2.8	2.6	2.4	2.2	
Spain														
Sweden				9.7	10.6	10.8	10.8	11.7	11.4				10.4	
England & Wales						4.8	4.9	5.1	5.3	5.4	5.4	5.7		

Data sources and definitions see table 46, France, Luxembourg, Spain not included due to unavailability of time series
Netherlands: 1990-2002 based on 12-month-prevalence. Estimated rate for 2002 based on point-prevalence : 8.1 (n=1304, see footnote for table 46)
Ireland: approximation based on estimated 80 inmates of Central Mental Hospital in Dublin
Sweden: 1993-1997 based on 12-month-prevalence, point-prevalence for 2002: 10.4

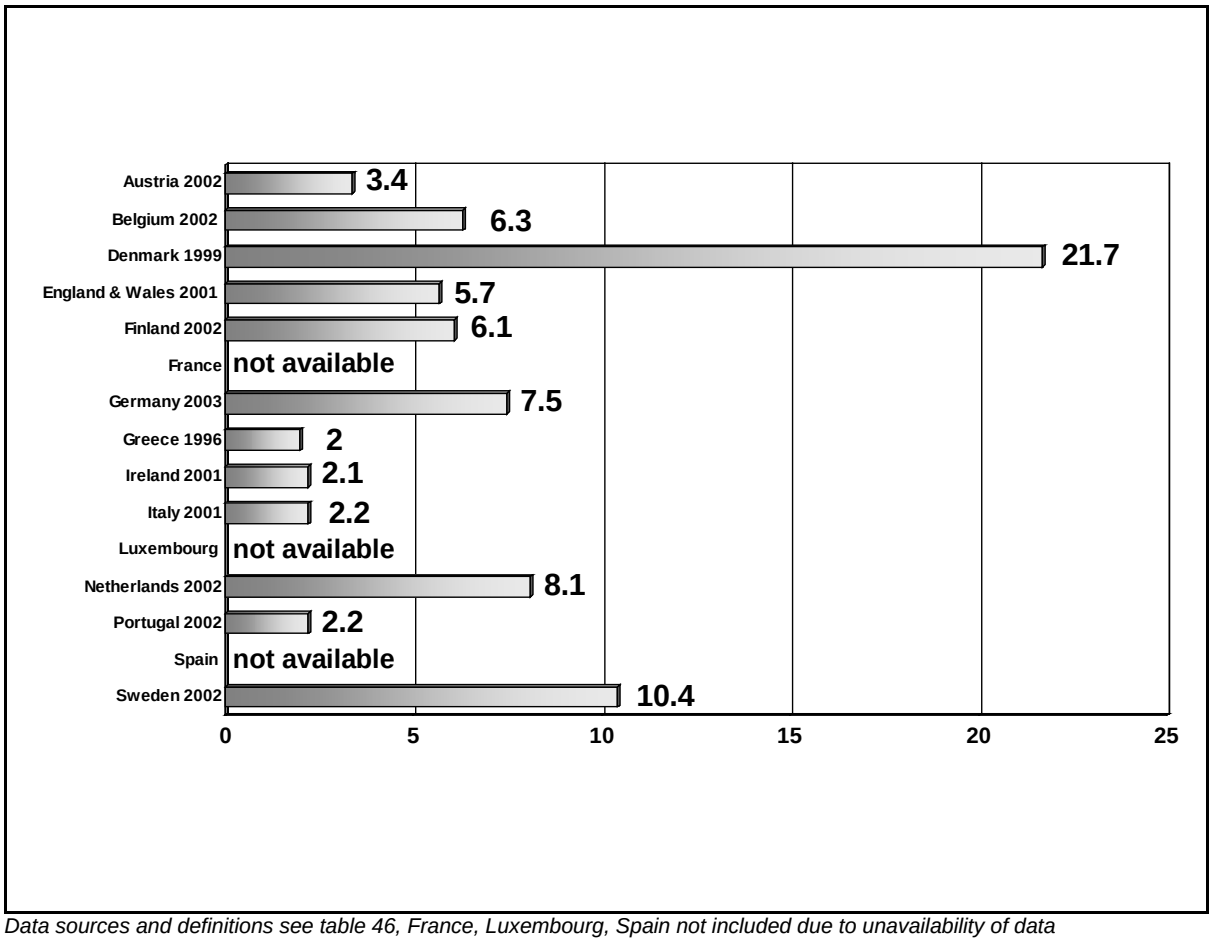
Compared to the figure showing total numbers, the U-shaped curve for Italy has levelled out, due to a low overall forensic prevalence compared to Italy's large population.
Similarly, forensic rates from Germany, whose total numbers tower above those from all other Member States, fit rather neatly into the range of most neighbouring Central European countries.

Among all Member States, Denmark shows the highest rates and the most striking increase (see figure 3). The annual Danish growth rate has been estimated by national studies to be 6 to 7%, which could not be explained by changes in legislation or administrative or diagnostic routines. Instead, the exponential increase has been attributed to the effect of de-institutionalisation, resulting in increasing levels of criminal behaviour amongst schizophrenic patients (Kramp & Gabrielsen 2003).
However, there are countries with similar growth rates throughout the 1990s, namely the Netherlands Austria and Germany, where prevalence rates have doubled (Germany, Austria) or even showed a three-fold increase (the Netherlands).

Other patterns would also need deeper analysis, for instance the similarly low rates in Southern European Member States. More detailed study is necessary to determine whether this phenome-

non is a consequence of the low levels of forensic service bed provision in Greece, Italy and Portugal.
Again, a common European trend is hard to deduct, although in figure 3 there appears to be a tendency towards slowly rising rates shared by a majority of Member States throughout the last decade
Generally, when comparing prevalence rates across countries, data-biases (caused by differences in inclusion criteria, case definitions, recording routines, algorithms for calculating figures etc.) should be taken into account as a probable source for differences.

Fig. 4 **Most Recent Prevalence Rates (Forensic Cases per 100,000 Population)** (court decided cases in forensic care)



Data sources and definitions see table 46, France, Luxembourg, Spain not included due to unavailability of data
the Netherlands: rate based on estimated point-prevalence for 2002 (see footnote for table 46)

Incidence

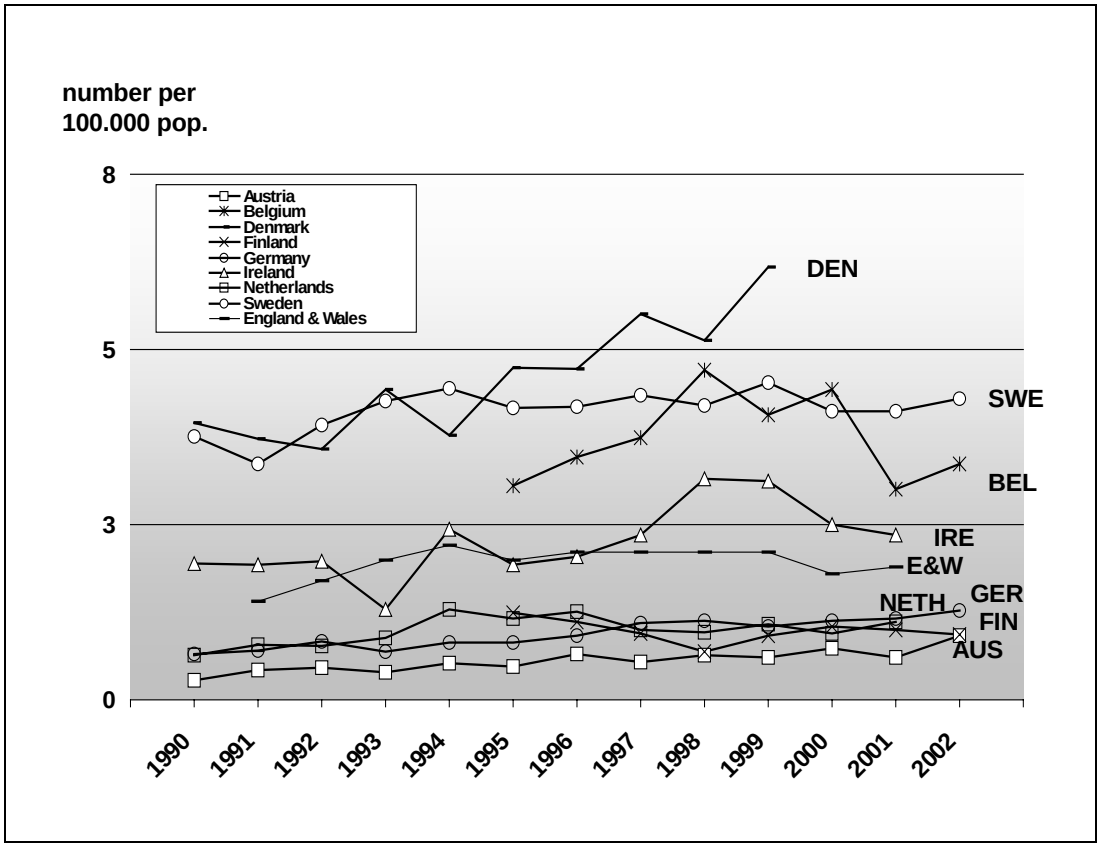
The number of newly admitted cases (criminally non-responsible offenders, where concept is applicable) per year is another fundamental epidemiological indicator. Time series on forensic incidence (table 48) as well as on incidence rates (figure 5) from the Member States show a more uniform pattern than forensic prevalence. Uneven total numbers or rates over time are probably an effect of rather small figures. Only in Germany and in England and Wales do new forensic episodes exceed 500 cases per year, whereas in most of the less populous Member States, annual incidence stays consistently below 100. Again, Denmark constitutes an exception in showing a steep increase in incidence, as was the case with forensic prevalence.

Tab. 48 **Incidence (New Admissions to Forensic Care per Year)** (court-decided cases in forensic care, data source and definitions see table 46)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Austria	22	33	36	32	42	39	53	44	51	50	60	49	76
Belgium						310	353	381	481	416	454	308	345
Denmark	203	192	185	230	197	248	249	291	272	329			
Finland						64	57	49	35	48	54	52	49
France													
Germany	522	573	669	565	666	676	759	894	931	857	917	955	1045
Greece													
Italy													
Ireland	68	68	70	46	87	69	74	86	117	117	95	89	67
Luxembourg													
Netherlands	95	117	117	134	199	180	196	156	150	171	151	177	203
Portugal													
Spain													
Sweden	322	290	340	372	391	367	370	384	372	400	364	365	380
England & Wales		680	846	1036	117	1008	1079	1092	1091	1119	972	980	

Similarly to prevalence, included are detained mentally ill offenders not guilty by reason of insanity, where the concept is applicable. In Austria, when adding criminal responsible mentally ill offenders (§21/2 StGB), annual figures more or less double.

Fig. 5 **Incidence Rate (New Admissions to Forensic Care per Year and 100.000 Population** (court-decided cases in forensic care, data source and definitions see table 46)



Mean Length of Stay in Forensic Care

Data on length of stay in forensic institutions are scarce throughout the Member States, although this is a crucial indicator for evaluating the systems in question. However, comparing prevalence and incidence rates within a Member State allows some conclusions to be drawn as to the average length of stay of forensic cases during a given year.
Thus, a high proportion of new admissions per year would suggest frequent annual discharges and thus a tendency towards a short mean length of stay under forensic care regimes. Table 49 shows the percentage of new admissions during one year of all forensic cases (point prevalence) from those Member States in years where data was available
According to this rather rough indicator, Belgium experiences probably the highest turn-over of mentally disordered offenders in forensic facilities, although the quality of forensic care is very low in most services. So many cases turn-over in facilities with low treatment standards. In England & Wales and Sweden, there are also high proportions of annual admissions, indicating a short average length of stay, whereas other Central European and Scandinavian Member States (Austria, Germany, Denmark, Finland, the Netherlands) each have similar proportions of new cases (between 15 to 30 % annually).

In Belgium, the Netherlands, Sweden and England & Wales, there is a tendency towards decreasing proportions of new admissions during the periods covered, indicating a trend towards longer placements.

Tab. 49 **Share of New Admission on all Forensic Cases per Year in %** (court decided cases in forensic care, data source and definitions see table 46)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Austria	18	26	27	21	28	22	27	23	24	22	23	20	28
Belgium						54	70	65	77	71	71	46	54
Denmark	32	29	25	29	24	28	26	28	26	30			
Finland									10	12	16	17	15
France													
Germany		19	21	17	20	19	21	23	22	20	19	18	19
Greece													
Italy													
Ireland													
Luxembourg													
Netherlands	18	21	20	20	26	21	23	14	13	14	11	13	13
Portugal													
Spain													
Sweden				44	42	39	39	37	37				
England & Wales						40	42	41	40	39	34	33	

Austria: Detained mentally ill offenders not guilty by reason of insanity according to §21/1 StGB, criminal responsible mentally ill offenders (§21/2 StGB) were excluded.

Mentally Disordered Offenders judged as Criminally Responsible

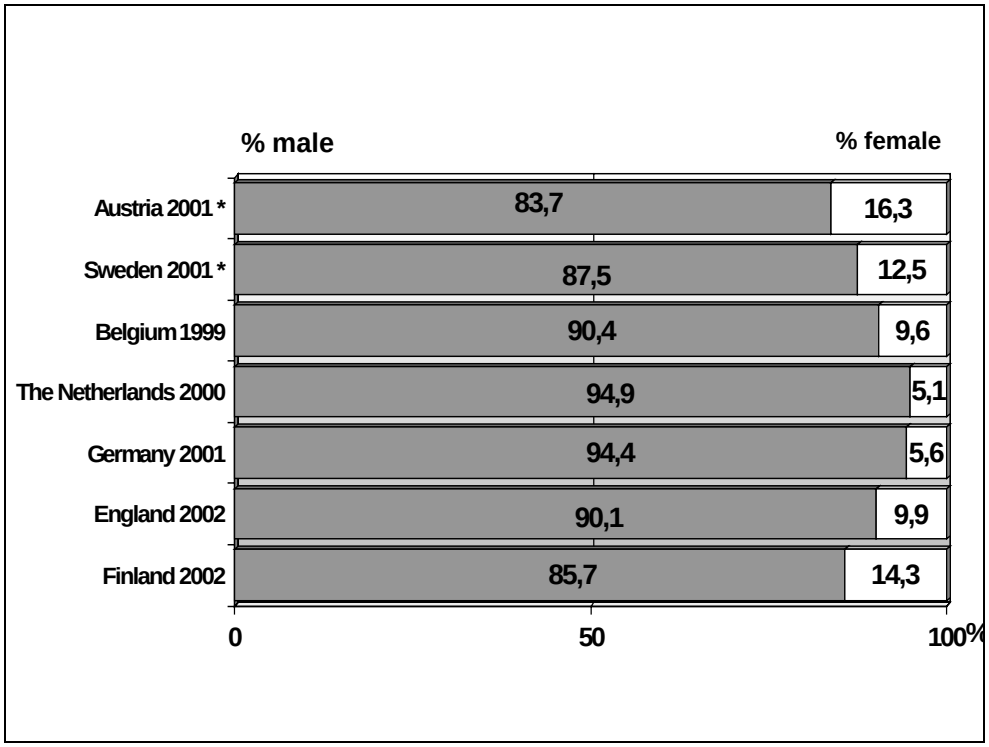
In most of the Member States, the numbers of offenders suffering from mental disorders but judged criminally responsible by the courts are usually hard to distinguish amongst the overall prison population. This is because, in severe offences, these persons are usually sentenced to prison terms, and National prison statistics usually do not distinguish between the relevant categories of prisoner.

So, incidence or prevalence data on this sub-group – which would allow an estimation of the balance of cases judged criminally responsible and non-responsible - is rarely available.
Only in Austria is it known, that during the 1990s, the annual number of those held by the courts to be responsible (according to § 21/2 StGB) and non-responsible (according to § 21/1 StGB) was more or less balanced. In Finland, a tendency towards rising numbers with full criminal responsibility as a result of forensic assessments was observed during the 1990s, whereas at the beginning of the decade numbers for diminished responsibility and lack of criminal responsibility more or less balanced those judged to be fully responsible..

Gender

The proportion of females amongst mentally ill offenders is low and does not exceed 17% in those Member States which were able to provide information on gender distribution in forensic care (see figure 6). However, it is unclear in how far these figures are nationwide represent only selected samples.
The dominance of males is not surprising, since as regards criminal behaviour in general as well as violent behaviour in mental disorders, males are well-known to be over-represented. However, there is no information available as to whether service provision is adapted to the needs of female patients.

Fig. 6 Gender of Persons in Forensic Care (most recent year available)



** Sweden: analysis of selected group (120 patients discharged during 6 months in 2001)*
Austria: detained mentally ill offenders not guilty by reason of insanity according to §21/1 StGB

Disorders / Diagnoses

Official statistics or data-bases do not provide overviews on the diagnostic distribution of patients in forensic care. This is partly due to the confusing and out-dated terminology for describing mental

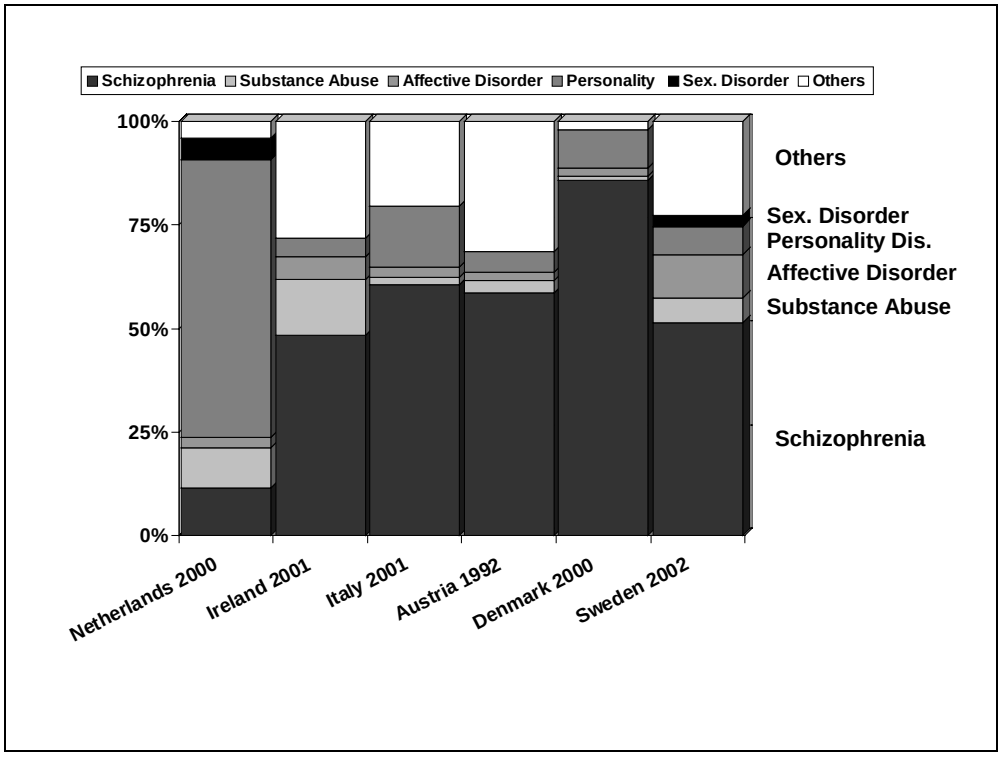
disorders which is still prevalent in legal frameworks, and which is incompatible with diagnostic schemes as used in contemporary psychiatric care.

In consequence, available data on diagnostic patterns usually stems from research studies or one-off assessments, covering only selected populations or facilities. Even then, the classification systems used vary between ICD-9, ICD-10, DSM-III and DSM-IV.

Figure 7 shows diagnostic overviews from some Member States, most of them covering selected groups of mentally disordered offenders and not representing national data. The various diagnostic schemes have been transformed into ICD-10 terminology for better comparison.
Nevertheless, the figure shows that the majority of mentally disordered offenders in those Member States which were able to provide diagnostic data suffer from schizophrenia or other psychotic disorders (50% or more). Figure 7 also illustrates the rather different approach in the Netherlands, where patients with personality disorders form the core-group of mentally disordered offenders subject to a TBS-order (the legal regime of "terbeschikkingstelling").

Time series on mental disorders are even more scarce. However, in Ireland, time series suggest a slow but stable increase of schizophrenic cases and changing proportions of personality disorders over time.

Fig. 7 Diagnostic Groups of Mentally Disordered Offenders (most recent year available)



Sweden:	*2002: 328 persons undergone forensic assessments*
Ireland:	*2001 only 79 newly admitted diagnosed, Inmates to Central Mental Hospital*
Netherlands	*2000: persons with TBS-order, DSM-diagnosis, mood and anxiety added to affective disorder, total n taken: 1526 (van Emmerik, 2001)*
Denmark	*2000 Copenhagen sample (n:330, more or less representative for all forensic patients in Denmark: F0: 3%, F10:1%, F20:84%, F30:2%, F60:9%, others: 2%), published research data, source available*
Austria	*1992 only non responsible males, first diagnosis*
Italy:	*1282 patients (total point prevalence for Italy, census day 31.3.2001)*

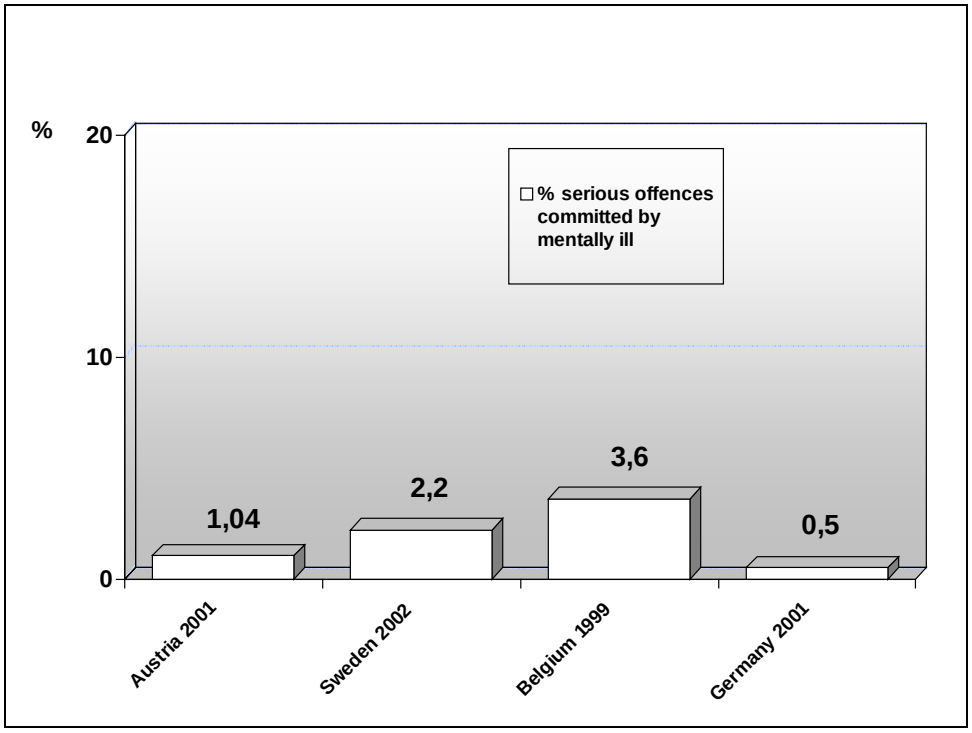
Offences

Not all criminal statistics from the Member States provide information on the proportion serious or minor offences committed by mentally ill persons, although the issue is of major interest to the public and is given extensive media coverage in cases of spectacular crime. A very recent example was the murder of Swedish Foreign Minister, Anna Lindh, in 2003.

Where data is available, offence criteria or definitions are usually not harmonised between states, so that an overview across national boundaries must lack reliability. Nevertheless, some figures are presented here to give an impression of the dimensions of the problem.

Figure 8 shows the annual proportion of serious crimes committed by mentally ill persons (court decided cases) in the most recent year available from four Member States. Serious crimes include homicide, robbery, assault or sex offences. Categories or recording procedures are not harmonised. The variation between states may also be influenced by narrow or wide legal definitions of mental disorders.
Nevertheless, proportions are low, and there are Member States like Ireland where none of the persons indicted for murder (n=26), robbery (n=678), assault (n=2058) or sex offences (n=715) in 2001 were found mentally disordered or unfit to plead.

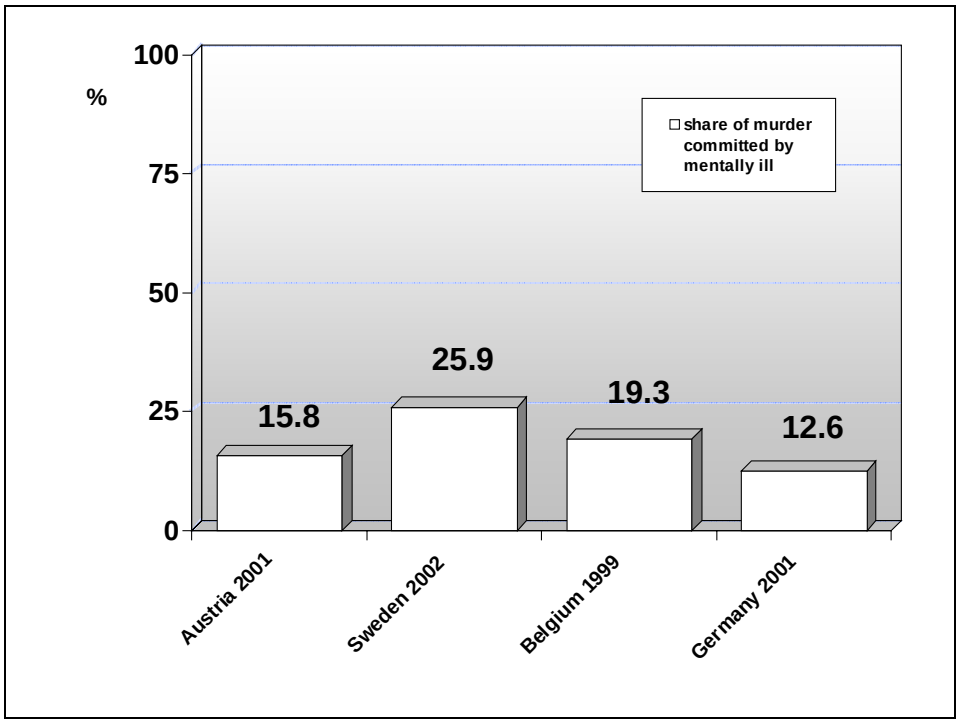
Fig. 8 **Proportion of Serious Offences Committed by the Mentally Ill** (most recent year available)



The proportion of mentally ill murderers is considerably higher than the proportion of mentally ill amongst those committing serious crimes in general (see figure 9). In 2001, six out of 38 murders

in Austria were committed by non-responsible mentally ill offenders. In Sweden, in 2002, it was 35 out of 135, and in Belgium in 1999, 34 out of 176. However, definitions may differ here as well, for instance whether or not manslaughter is included in this category.

Fig. 9 Proportion of Murders Committed by the Mentally Ill (most recent year available)



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4 Concepts and Procedures in the Member States

The following section contains a description of country-specific circumstances, judicial procedures and routine practices for placing and treating mentally ill offenders.
Each Member State is described in a separate chapter, written by the assigned experts who collaborated in this study.

The chapters follow more or less the same structure. Each chapter is complemented by a flow chart giving an overview of the national judicial procedures and the pathways to forensic placement, and by a figure outlining the forensic service provision in the respective Member State.

Austria

Hans Schanda

Introduction, Historical Development

Up until the 1970s, mental health care in Austria was confined mainly to traditional inpatient treatment in psychiatric hospitals, with high rates of involuntary admissions (Katschnig et al., 1975, 1975a). The situation of mentally ill offenders remained unchanged compared with the situation in previous decades: If a patient was found not guilty by reason of insanity (NGRI), he was exculpated and handed over to the regional psychiatric hospital for treatment without any further control or surveillance by the court (Schanda et al., 2000). In the course of a penal reform in 1975, the treatment of mentally ill offenders NGRI came under the control of the Ministry of Justice. This change accommodated the interests of the psychiatrists in the hospitals, who saw the forensic patients as an obstacle to opening the wards and other reforms.

According to the new penal law (Strafgesetzbuch, StGB), the patients were to be committed by the courts to inpatient treatment at a special institution for an indefinite period. However, as the designated central institution was only in planning at that time, in practice things did not change very much between 1975 and 1985. Despite new judicial conditions regulating admission and discharge, the offenders NGRI continued to be treated in closed wards of mental hospitals. After a delay of 10 years, the Ministry of Justice opened the central institution for the treatment of mentally ill offenders NGRI (Justizanstalt Göllersdorf) in 1985, thus disburdening the psychiatric hospitals of a good number of male criminally non-responsible offenders. The 1975 penal reform also prescribed criminal commitment for those offenders who, though found to be responsible for their offences, were acting under “a higher degree of mental abnormality”.

The new distribution of responsibilities for mentally ill offenders NGRI turned out to be meaningful not only in terms of costs but also in terms of the opinions of politicians and the public on the relationship between mental illness and crime. It also became meaningful for the way in which general psychiatry regards all those aspects of treatment that deal directly or indirectly with aggressive behaviour by some of its patients.

The changes in general mental health care began in Vienna with the psychiatry reform at the end of the 1970s, continuing in the rest of the country with the sectorising of inpatient treatment at the beginning of the 1990s. The reforms in the outpatient sector moved along rather sluggishly and even today still have not been completely implemented. The last steps of the mental health care reform were a new formulation of inpatient civil commitment (Unterbringungsgesetz, UbG) in 1991 and a reform of the funding of inpatient treatment in 1997 that enforced short-term inpatient treatment (Schanda et al., 2000; Schanda, 2001).

Legislation

Austrian law sees the “will to harm” as prerequisite to criminal culpability, which can be traced back to the Constitutio Criminalis Theresiana from 1770. §11 of the StGB, coming into force in 1975, says that a lack of “discretion” (ability of insight) and/or “disposition” (ability to control one’s actions) at the time of the offence, caused by functional or organic psychoses, severe intellectual disability, or other pathological mental states equal to the aforementioned conditions, makes a person not guilty. Along general lines, the terms discretion and disposition correspond with the McNaughten-rules of Anglo-American jurisdiction.

Figure 13 shows the judicial and placement procedures for mentally ill offenders. In contrast to German law, for example, Austrian jurisdiction knows only a dichotomy responsible/non-responsible. If the court has doubts with respect to the mental health of an arrested offender and assumes the possibility of later exculpation, it can order – after commissioning an obligatory written expert opinion – the preliminary placement and treatment of the offender in the regional psychiatric hospital. (Optionally: it can order treatment and placement in the central institution for mentally ill offenders NGRI, or in a special department of a large remand prison in Vienna) according to §429/4 StPO (Strafprozessordnung, code of criminal procedure).

At least one other obligatory expert assessment is necessary for the preparation of the trial, in which the court has to decide about guilt, criminal responsibility and further illness-related ("specific") dangerousness. In the case of a mental state according to §11 StGB (functional or organic psychosis, mental retardation or other mental states equal to the aforementioned mental conditions) in direct ("causal") association with a minor offence (misdemeanour, potential penalty of less than one year) the offender is exculpated and has to be set free. In the case of a mental state according to §11 StGB in direct association with a major offence (felony, potential penalty of more than one year), together with a high probability of at least one further illness-related severe offence, the offender is also exculpated, but undergoes criminal commitment for an indefinite period according to §21/1 StGB, until the illness-related "specific dangerousness" has been substantially reduced. Naturally, not all preliminary pre-trial commitments under §429/4 StPO are followed by definitive criminal commitments according to §21/1StGB. If sufficient treatment during the remand (pre-trial) period is able to improve an initially poor illness–related prognosis, the person will be released.

As mentioned above, Austrian penal law does not provide for the legal category of diminished responsibility. However, if an offence (potential penalty of more than one year) was actually committed not under the conditions of §11 StGB, but under the influence of a "higher degree of mental abnormality" (mainly targeting more severe forms of personality disorders), penal law provides for the possibility of criminal commitment for an indefinite period parallel to a prison sentence, if the court assumes a poor "specific dangerousness- prognosis" (§21/2 StGB). The analogue to §429/4 StPO for pre-trial placement of responsible mentally ill offenders is defined in §438 StPO, however, it is very seldom applied to subjects awaiting trial.

The courts decide only about the placement of an offender in general (prison sentence or criminal commitment according to §21/1 or §21/2 StGB). Placement after trial (which kind of prison in the case of normal convictions, central institution for mentally ill offenders NGRI or psychiatric hospital in the case of §21/1 StGB, special forensic facility or special department of a normal prison in the case of §21/2 StGB) is under the responsibility of the Ministry of Justice. Criminal commitment according to §21/1 or §21/2 StGB has to be maintained until the "specific" illness-related dangerousness has been substantially reduced. The regional penal courts have to reconsider the requirement of further inpatient treatment once a year (at any time on request of the offender). Discharge (§47 StGB) is in any case probationary for five or ten years, depending on the severity of the index-offence. Because of the enormous increase in the number of mentally ill offenders during the last ten years, an amendment to the penal law since 2002 offers the possibility of conditional criminal commitment, as well as the prolongation of the probation period.

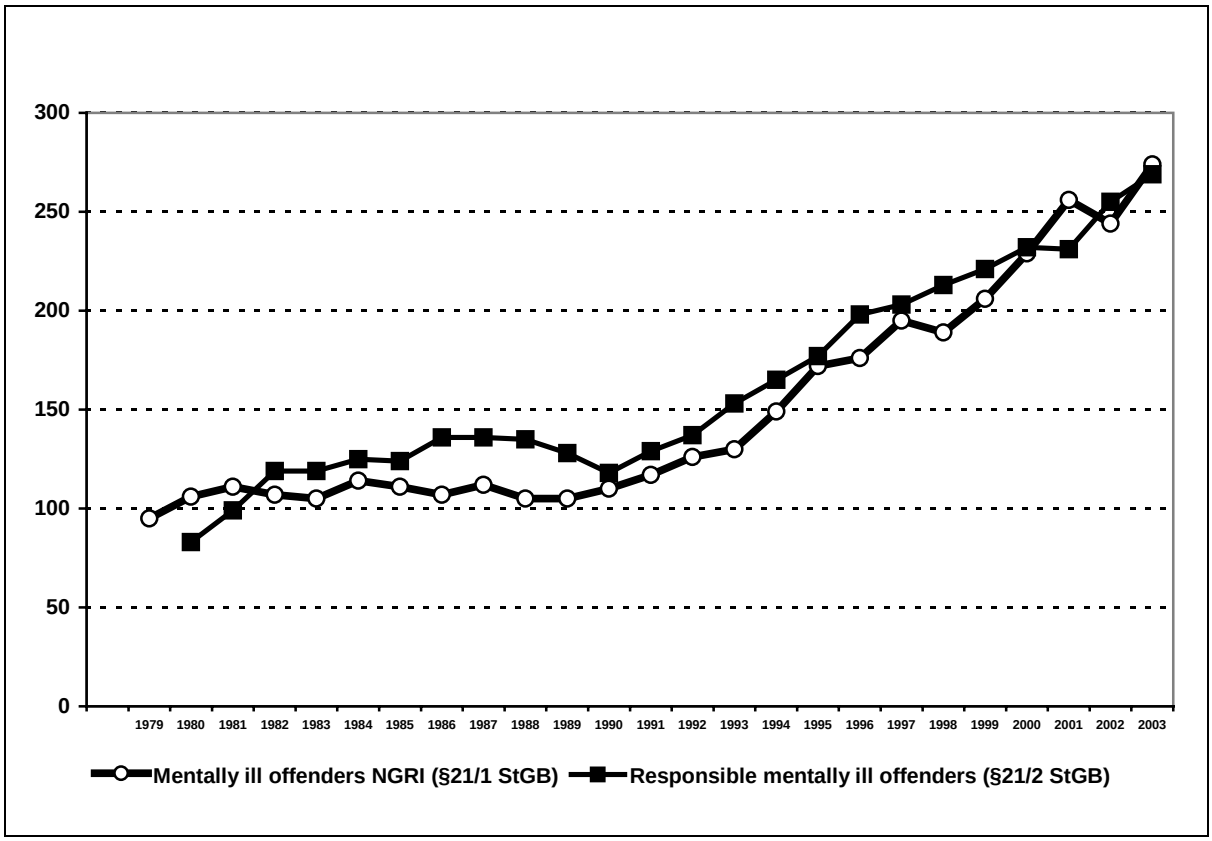
Criminal commitment – but only for a maximum of two years, and if the total duration of the prison sentence is two years or less – is possible for subjects with offences due to substance abuse (§22 StGB), if a positive change in the behavioural/addictive pattern of the offender by specific treatment can be expected. However, only a relatively small number of persons is treated under this condition in a special forensic facility for addiction treatment in Vienna.

Problems

Figure 10 shows the point-prevalence rates of mentally ill offenders during the last 29 years. Five years after the introduction of the new penal law in 1975, a steady state of subjects under criminal

commitment was reached which remained stable between 1980 and 1990: the mean prevalence in mentally ill offenders NGRI (§21/1 StGB) was 109, in responsible mentally disordered offenders (§21/2 StGB) 127. Since 1990, we are facing a remarkable development: While the prevalence of normal prisoners did not substantially change, the prevalence of mentally ill offenders showed a dramatic increase (in responsible ill offenders by 128%, in non-responsible ill offenders even by 177%).
In the former case (§21/2 StGB) this may possibly be due to a change in the legal practice and – at least partly – to an increase in the mean length of stay under criminal commitment. In the latter case (§21/1 StGB), it is the internationally well-known side-effect of the psychiatry reforms (Munk-Jörgensen, 1999; Schanda, 1999, 2000; Schanda et al., 2000) which started in Austria rather slowly in the seventies of the 20th century and have been translated into action with increasing velocity since the early 1990s (see Introduction, historical development). Like everywhere else, the insufficient provision of outpatient facilities and sheltered care accompanied hospital downsizing. The new law that has regulated inpatient civil commitment since 1991 (UbG) and the reform of inpatient funding in 1997, which encourages psychiatrists to shorten even more the length of inpatient treatment by means of financial pressure, have worked as a kind of magnifier that makes the existing problems in general psychiatry visible and available to scrutiny (Schanda et al., 2000).

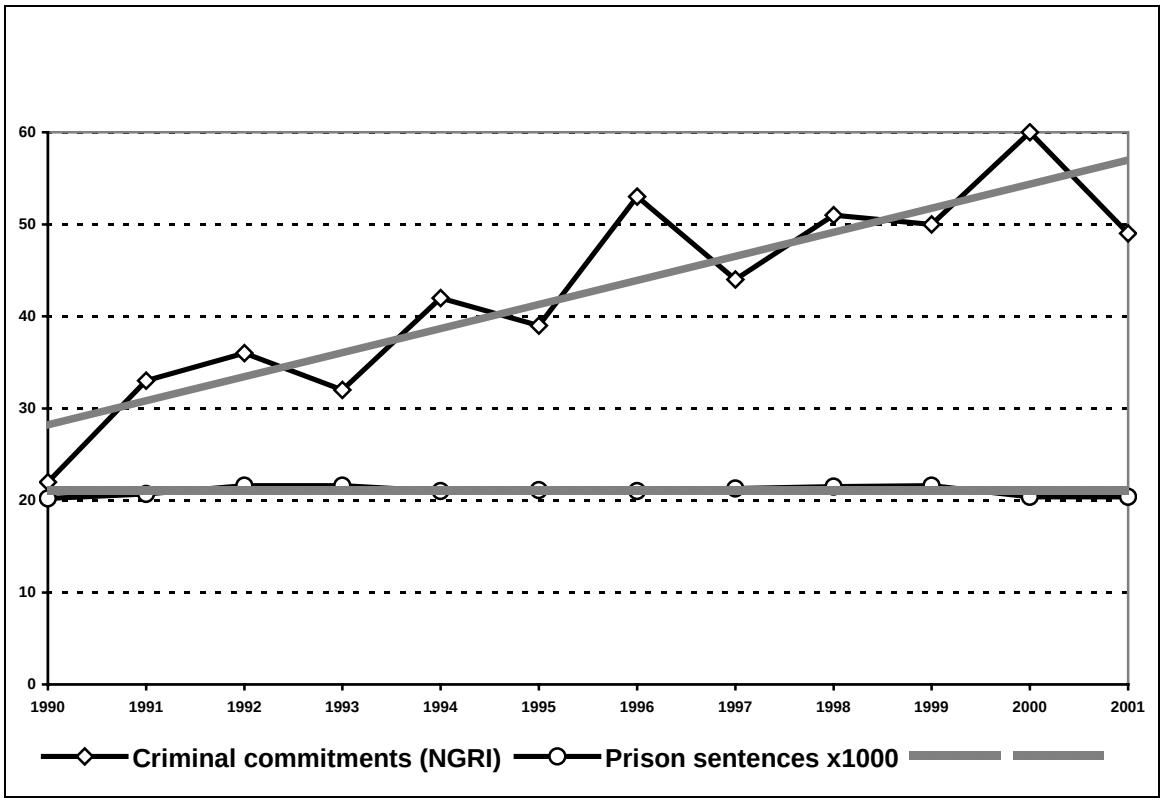
Fig. 10 **Prevalence of Mentally Ill Offenders in Austria 1979 – 2003** (census data, January 1, each year)



The consequences for the most severely ill patients with respect to the mean duration of stay in hospital and the quality of treatment are obvious (Schanda, 2001; compare also Dickey, 1998; Norton, 1998). Problems primarily arise in each of the two intersections between general and forensic psychiatry (before the offence and at discharge): General psychiatry is increasingly unable or unwilling to deal with the unpleasant effects of clinical reality, mainly those with respect to the violent

behaviour by some of its patients and with respect to coercive treatment (Schanda, 1999, 2000). This has led to an enormous increase in the rates of admission for mentally ill offenders NGRI *(see figure 11)*. Fifty-six percent of the 280 non-responsible patients under criminal commitment at 1st April 2003 were admitted during the last three years. The original aim of the legislator to reserve criminal commitment only for a small group of extremely dangerous mentally ill subjects has been undermined by a disproportionate increase in the number of patients with less severe offences (threat, compulsion), who represent a well-known type of psychotic patient with a lack of insight and compliance and high rates of co-morbidity (substance abuse and/or personality disorders). These "difficult-to-treat" and "difficult-to-place" patients are the losers of the psychiatry reforms, also in Austria (compare e.g., Munk-Jörgensen, 1999 for Denmark).
Their indirect shift from the general mental health system to the forensic system (Schanda, 2001; Schanda et al., 2000) is accelerating also for financial reasons. As the the Ministry of Justice is responsible for the treatment of mentally ill offenders, the criminal commitment of a patient not only disburdens the counties' health administrations from the expenditures for care as long as he/she is under criminal commitment. In recent years, the local health authorities have also become increasingly reluctant to take on the care of discharged patients, arguing that even aftercare is beyond their (financial) responsibility, as discharge is probationary and as such "exclusively a matter of the justice system". This makes discharge increasingly difficult as it also reduces the courts' confidence in the sufficient translation of necessary aftercare measures into practice. Thus, the Ministry of Justice is under increasing financial pressure.

Fig. 11 Incidence of Criminal Commitments NGRI (§21/1 StGB) / Prison Sentences. Austria 1990- 2001



Several attempts by the Ministry of Justice to cope with this problem (to make forensic beds "cheaper", to establish own outpatient facilities, hostels and sheltered care) are in fact suited to provide at least partial relief. However, all these measures again reinforce the other parties' opinion

that the violence of and coercion against mental patients lies outside their responsibility. The effects of the aforementioned regulatory measures introduced in 2002 (conditional criminal commitment and prolongation of the probation period) have to remain open. Up to now there seems to be no change in the tendency towards an ongoing increase in admission rates.

Practice

Mentally ill remand prisoners (§429/4 StPO, see Legislation) are primarily kept in closed wards or in the forensic departments of the regional psychiatric hospitals and in a special department (12 beds) in Austria's largest remand prison in Vienna.

Mentally ill offenders NGRI (§21/1 StGB) are treated:

1. in the Justizanstalt Göllersdorf (120 beds for male offenders). (The Justizanstalt Göllersdorf, though formally one of Austria's 29 correctional institutions, functions de facto as a psychiatric hospital and it is the only judicial institution with 24-hour presence of a psychiatrist and of nursing staff.), and

2. in three small forensic departments of psychiatric hospitals (total 84 beds),

3. while the rapidly increasing number of the rest of the offenders (meanwhile 32%) is treated in closed wards of the regional mental hospitals together with the (mainly acutely ill) civil patients.

The latter institutions are not able to offer any special programmes for forensic patients. This results in the transfer of "difficult" patients who pose problems with regard to security, dangerousness or absconding to the Justizanstalt Göllersdorf, despite the fact that this institution is extremely understaffed compared to the (forensic) departments of mental hospitals (Schanda, 2000, 2001a). The situation in the special staff sector of the Justizanstalt Göllersdorf answers for the most part the question concerning systematic programmes designed for specific groups of offenders. Treatment – apart from medication – for the primarily psychotic patients targets the improvement of compliance, impulse control, problem-solving strategies and social skills, mostly by use of group therapies. The use of prognostic instruments like the PCL-R and the HCR-20 is a matter of routine there.

Even more problematic is the situation with respect to criminally responsible mentally disordered offenders (§21/2 StGB), who for the greater part are committed for sexual offences, arson and violent offences (Katschnig et al., 2001). The special forensic institution in Vienna (Justizanstalt Mittersteig) for male offenders (130 places) is extremely understaffed. This institution has a tradition of psychodynamically oriented individual psychotherapies – a concept that has now gradually changed in favour of a more cognitive-behavioural approach. Additionally, each of the three large Austrian prisons has a small special department (with a total number of 39 places) for criminally responsible mentally disordered offenders. As the prevalence of this group is on the rise too and e.g. some sex-offenders without any legal order have to be treated in the Justizanstalt Mittersteig, an increasing number of criminally responsible mentally disordered offenders (§21/2 StGB) is kept in prisons together with non-mentally disturbed inmates. The situation with respect to the therapeutic staff in the prisons is even worse than that in the Justizanstalt Mittersteig (Schanda, 2001a). None of these institutions/departments, including the aforementioned small department for mentally ill remand prisoners (§429/4 StPO) in Vienna's large remand prison, has at its disposal a psychiatrist or of nursing staff during the night hours.

The patients' rights of criminally non-responsible mentally ill offenders (§21/1 StGB) differ somewhat depending on their placement: If the offender is treated in hospital, he is subject to the civil commitment law (UbG) which – in contrast to the situation with regard to civil patients – has to be executed by the local penal court. However, once the offender has been transferred to the central institution for the treatment of mentally ill offenders NGRI (Justizanstalt Göllersdorf), the decision

about e.g. involuntary medication is – like in all other correctional institutions –the responsibility of the Ministry of Justice.

Conclusion

Austria is a small country with eight million inhabitants. Despite a relatively favourable situation (prosperity, low crime rates, low rates of drug abuse), general mental health care is developing in a problematic direction with respect to increasingly insufficient care for a subgroup of severely mentally ill patients with a lack of insight and compliance and high rates of co-morbid substance abuse and personality disorders. The enormous increase in the number of mentally ill offenders NGRI (§21/1 StGB) indicates the indirect shift of these patients from the general mental health system to the forensic system (Schanda, 1999, 2000, 2001; Schanda et al., 2000).

This development is the source of increasing problems for the Ministry of Justice, intensified by the aforementioned peculiarities of financial responsibilities (see Problems). Any improvement of this situation seems difficult due to its complex genesis, reflecting the changes in society in general with diverging interests and (partially hidden or unconscious) motives for acting. The directly involved parties take up differing points of view: Patients' self-help groups target coercion in general and try to generate support for a better understanding of their situation, however, sometimes carefully omitting the problem of violence by some of their fellow sufferers. Self-help groups of the patients' relatives take up an intermediate position, additionally criticising the lack of support when left alone with their untreated, non-compliant relatives. Patients' advocates often restrict their activities to questions of civil rights, arguing that the assessment of future violence cannot principally influence this position. General mental health care professionals, whose reputation is impaired by violent incidents involving their patients, sometimes exhibit an ambivalent attitude, characterised by the (increasingly difficult) denial of the problem and an attitude of helplessness, sharing the projective blaming of others with patients' advocates, judges and politicians.

A fundamental improvement in the situation is impossible without the cooperation of mental health care professionals, all other groups involved in the (involuntary) placement and treatment of a subgroup of high-risk patients and the mental health administrations of the several Austrian counties. For the latter, cooperation would mean the acceptance of financial burden – i.e. their share of expenditures for the treatment of offenders according to the principle that the party responsible (for the local increase in the number of criminal commitments) is responsible for its costs. Therefore, the activities of the Ministry of Justice are restricted to attempts to reduce the exploding costs (see Problems). A revenue sharing which was recently agreed upon and intended to reimburse a certain share of hospital costs of the "Länder" (federal states) by the national Ministry of Justice brought only gradual relief.

This situation does not seem suited to reduce the old, well-known prejudices of the public regarding violence of the mentally ill in general. Rather one can notice a change in the reporting of the media during recent years: Institutional coercion, having been one of the two major topics of the news media when reporting about psychiatry, has lost some of its importance – leaving "security/dangerousness" (violent incidents, "irresponsible" discharge and practice with regard to leaves). Thus, we have been facing a rapidly changing situation these past few years. Nobody knows when the curves in figures 10 and 11 will flatten. Until now, it has not been possible to assemble the various representatives and institutions responsible for mental health care (civil and penal legislation, regional/county governments, mental health administrations, mental health professionals) for a general discussion. Obviously, appeals to reason and a sense of responsibility are hardly successful where emotions and money are involved.

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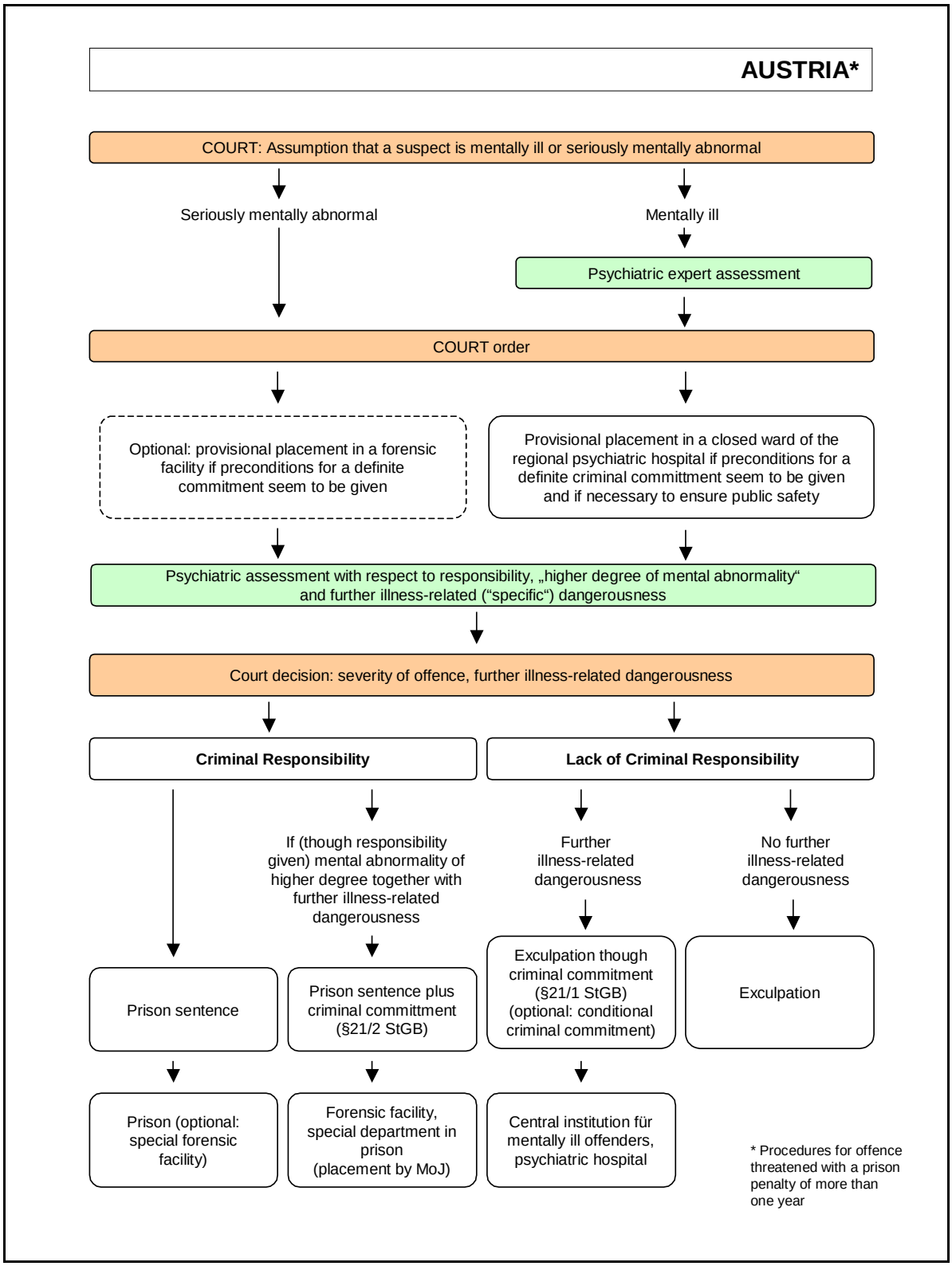
Fig. 12 Forensic Service Provision in Austria

AUSTRIA: Forensic Service Provision

	GENERAL PSYCHIATRIC HOSPITALS & FACILITIES	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	- unspecified capacities in psychiatric hospitals without forensic departments (approx. **100 beds** in closed wards) for pre-trial phases and for treatment purposes	**1 Central Forensic Hospital** Justizanstalt Göllersdorf founded 1985 provider: Ministry of Justice **120 beds**, only male patients clientele: - criminal non-responsible mentally ill offenders (§21/1) - dangerous mentally ill (non-offenders) **3 Forensic Departments at Psychiatric Hospitals** provider: Health Authorityof "Länder" (federal states) **84 beds** in total	**1 Specialized Forensic Prison Department** Justizanstalt Mitterstieg clientele: - criminal responsible mentally ill offenders (§21/2) **3 Forensic Prison Wards** - Justizanstalt Stein - Justizanstalt Graz Karlau - Justizanstalt Garsten **169 beds** in total
clientele	clientele: - criminal non-responsible mentally ill offenders (§21/1)	clientele: - criminal non-responsible mentally ill offenders (§21/1)	clientele: - criminal responsible mentally ill offenders (§21/2) - personality disordered offenders
criteria for placement		**1 specialized Forensic Facility for Addiction Disorders** Justizanstalt Favoriten provider: Ministry of Justice approx **80 beds** clientele: - offenders suffering from addiction (§22) criteria: maximum stay 2 years when treatment is effective	

Fig. 13 Judicial and Placement Procedures for Mentally Ill Offenders in Austria



Belgium

Paul Cosyns & Roel Verellen

Legislation

In Belgium the placement and treatment of mentally ill offenders is governed by the Social Protection Act of 1st July 1964 "concerning abnormal offenders, habitual offenders and certain sexual offenders". According to the Social Protection Act mentally disordered offenders can be declared criminal irresponsible. An accused person who has committed a crime or an offence and who at the time of the act was either in a state of insanity, or in a state of severe mental unbalance, or in a state of severe mental deficiency rendering him/her incapable of controlling his/her actions will be interned. Internment is not a punishment but a measure of social protection for an undetermined period of time. From that time onwards the interned person is subject to the decisions taken by a Social Protection Committee. The Social Protection committees are competent to designate, in complete independence, the place of confinement. The most important available options include confinement in an Institute of Social Protection, confinement in a forensic psychiatric facility offering adequate treatment and where appropriate security measures prevail, confinement in a regular psychiatric hospital, partial release from one of the aforementioned or definitive release under certain conditions mostly related to the diagnosis which motivated the internment and to the act that was committed.

History

The Social Protection Act was introduced on 9th April 1930. This Act included the placement of an accused person under observation. The purpose of the procedure for placing an accused person under observation is to assess his mental state and to ensure the most favourable material conditions for such an examination. The courts became competent to order internment for a fixed period of time (5, 10 or 15 years) and Social Protection Committees were established to decide upon the place of confinement and provisional or permanent release of mentally ill offenders.
The revised version of the Social Protection Act of 1st July 1964 consolidated the legal position of the interned person. The fixed periods of internment were abolished and the installation of a prison research and observation centre was written into the law.

Procedures

The examining judge who issued the arrest warrant may, exceptionally, through a well-founded order, recommend that the warrant be executed in the psychiatric unit of a prison ('placement under observation') if there is reason to believe that the accused is either suffering from a mental disorder or is in a serious state of mental instability or deficiency that renders him incapable of controlling his actions. The competent examining body and the trial court also have the power to place under observation an accused person who is already bound by an arrest warrant. The purpose of placing an accused person under observation is to assess his mental state and to ensure the most favourable material conditions for such an examination. The period of placement under observation may not exceed one month

unless the competent body that decided on or confirmed placement under observation orders an extension for a further month. The extension may be renewed but the entire period of placement under observation may not exceed six months.

According to the wording of the Social Protection Act, courts can order for an undetermined period of time the internment of an accused person who has committed a crime or an offence and who at the time of the act was either in a state of insanity, or in a state of severe mental unbalance, or in a state of severe mental deficiency rendering him/her incapable of controlling his/her actions. From that time onwards the interned person is subject to the decisions taken by a Social Protection Committee which is composed of a presiding magistrate, a lawyer representing the bar and a psychiatrist. The Social Protection Committees are competent to designate, in complete independence, the place of confinement. These administrative bodies are fully autonomous and enjoy jurisdictional powers. The committees place internees either in an Institute of Social Protection, in a forensic psychiatric facility offering adequate treatment and where appropriate security measures prevail or in a regular psychiatric hospital that agrees to accept such patients.
Before taking important decisions in the case in which the information needed may be lacking, the Social Protection Committee can appoint a psychiatrist other than the one who is already a member of the committee, who shall submit to them an appropriate report.

The Social Protection Act is applicable only to persons of legal age; the Youth Protection Law of 1965 makes it possible for Youth Courts to entrust psychiatrists with the examination of minors.
The interned person, assisted by his lawyer, can appear every six months before the Social Protection Committee. The committee decides how the internment will be carried out. Provisional or permanent release is possible if the mental condition of the interned person has improved sufficiently and if the conditions for reintegration have been fulfilled. Medical-social treatment is an obligatory condition for provisional release.
The decision to release the person in question may be opposed by the Crown Procurator. In such cases the file is submitted for a decision to a Higher Social Protection Committee, which rules on the case. The internee's lawyer may appeal a decision in which the committees have decided that there are no grounds for release.

Practice

The Social Protection Act prescribes that the psychiatric examination of an accused person take place, during a renewable period of observation of one month, in the psychiatric unit of a prison. In practice the placement under observation is rarely done because of the lack of well-equipped psychiatric observation units.
More often than not, psychiatric examinations will be carried out on simple requisition of an expert by the examining magistrate, by the public prosecutor or by the court before which the accused is appearing. An expert psychiatrist (or, exceptionally, a college of three expert psychiatrists) will be appointed to answer at least three questions:

(1) Was the accused at the time of the act in a state of insanity, of severe mental unbalance, or in a state of severe mental deficiency that rendered him/her incapable of controlling his/her actions?
(2) Does the state of the accused make him/her socially dangerous?
(3) Is the accused at present in the same state?

The expert-psychiatrist may also be asked to outline the main personality features of the accused and to point out what conditions of a medical, social and psychological nature should be taken into account in order to enable a judicious application of the law.

There is a strong tendency among the Social Protection Committees to attribute a permanent value to the initial psychiatric report leading to an internment and, in the absence of more recent examinations, to turn them into instruments of irreversible stigmatisation. These reports will be joined to the penitentiary file of the person and like his shadow, will follow him without ever being contradicted or corrected. In a majority of cases it is practically out of the question that an interned person might ask for a critical assessment by an independent psychiatrist of a previously endured psychiatric examination. The expense would be simply prohibitive.

In Flanders (Dutch-speaking Belgium) the main Institute of Social Protection ('Merksplas') is financed by the Federal Minister of Justice. The psychosocial team (psychiatrist, psychologist and social worker) is responsible for the reception, screening and treatment of interned persons. However, treatment is hardly organized in this institute. The lack of qualified staff and a non-therapeutic setting are major organizational deficits. 'Merksplas' has a capacity of 210 interned persons. Due to a lack of capacity in the main Institute of Social Protection, and additional 240 interned persons are incarcerated in Flemish prisons. Forensic units in psychiatric hospitals are financed jointly by the Federal Minister of Justice and the Federal Minister of Public Health. Specialized outpatient services for sex offenders are financed by the Flemish Minister of Social Welfare. These services are integrated into regular mental health outpatient services.

In Wallonia (French-speaking Belgium) two Institutes of Social Protection ('Tournai' and 'Mons') are financed by the Walloon Minister of Social Welfare. Another institute of Social Protection in Wallonia ('Paifve') is financed by the Federal Minister of Justice. Specialized outpatient services for sex offenders are established and financed by the Walloon Minister of Social Welfare. These services are integrated into regular mental health outpatient services.

Internment Committee for Revision of The Social Protection Act

An internment committee was established on 23rd September 1996. The task of the committee was to make a critical study of the Social Protection Act and practices in that area, and to develop future prospects. The final report of the committee was issued in April 1999. The principal recommendations contained in the internment committee's report are the following.

The requirements for internment should be more clearly stated in the Social Protection Act. The internment committee proposes to change the archaic medical terminology (e.g. 'insanity' and 'mental unbalance') into 'diagnosis and persistence of a mental disorder'. The Social Protection Act should explicitly mention the assessment of the person's cognitive capacities and his ability to control his actions. In addition, the new act should provide expressly that internment be ordered only if the offender poses a danger to society (danger being defined as the "risk of relapse").

The Act should provide for the possibility of multidisciplinary assessment in addition to solely psychiatric assessment. The multidisciplinary assessments will result in a single, coherent report. The internment committee agrees that the fees of the expert-psychiatrist should be raised since poor payment regulations generate a low standard of quality in psychiatric reporting.

A new structure should be put in place for the eight psychiatric units in prison, which, to this day, have never fully carried out their mandate of placing arrested persons under observation. The units should be responsible only for detainees with psychiatric problems during their detention. In this regard, the committee welcomes the recent establishment of a prison research and clinical observation centre. The task of this centre, which has been given the status of a State Scientific Institution, is to carry out multidisciplinary observation under optimum conditions. However, in March 2004 this centre is not yet operational.

The composition of the Social Protection Committees should be reviewed. They should be presided over by a serving judge, and the lawyer, who is currently a member of these committees, should be replaced by a specialist in social reintegration. The presence of a lawyer on the committee is no longer justified since the Act of 1964 provided that internees must be assisted by a lawyer.
The definitive release of an internee is possible only after receipt of a psychiatric report re-evaluating his mental state and the danger he poses.

Adequate medical structures for the treatment and follow-up of internees should be created,. In this regard, the committee proposes the establishment of a "justice - public-health" partnership, and an integrated and diversified network of both outpatient and residential treatment. In addition, the care of internees should be the subject of a written, tripartite agreement on guidance and therapy that specifies the rights and duties of the internee, of the therapist or therapy service, and of the Social Protection Committees.

Future Prospects

The deputy chairman of the Internment Committee for Revision of The Social Protection Act deposited in April 2001, by order of the Minister of Justice, a first draft of the revised Act. This document resulted in a bill approved by the Council of Ministers in July 2002. Major changes in the planned revision of the Social Protection Act include the distinction between psychiatric examination, multidisciplinary examination and placement under observation; the terminology "state of insanity, or in a state of severe mental unbalance, or in a state of severe mental deficiency" will be changed to "mental disorder"; a Committee for the Execution of The Internment will replace the Social Protection Committee, and a prison research and clinical observation centre will be made operational.
After a special meeting of the Council of Ministers in March 2004, the Minister of Justice launched the project of a new Institute of Social Protection ('Antwerp') with a capacity of 300 to 400 interned persons. An Institute of Social Protection in Wallonia ('Paifve') was promised a capacity extension from 80 to up to 200 interned persons. These measures should deal with the overcrowding of the Belgian prison system.

Conclusion

Mentally disordered offenders can be declared criminally irresponsible according to the Belgian Social Protection Act (July 1st, 1964) and as a consequence they will be "interned". The psychiatric treatment of this population is inadequate and the law must be revised.
An Internment Committee for Revision of The Social Protection Act has, at the request of the Minister of Justice, put forward conclusions in his report of 1999. The political authorities plan to review the Social Protection Act, but these efforts will remain in vain if no decisions are taken to implement the medical requirements of the law, and if no valuable forensic psychiatric treatment network is developed.

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Fig. 14 Judicial and Placement Procedures for Mentally Ill Offenders in Belgium

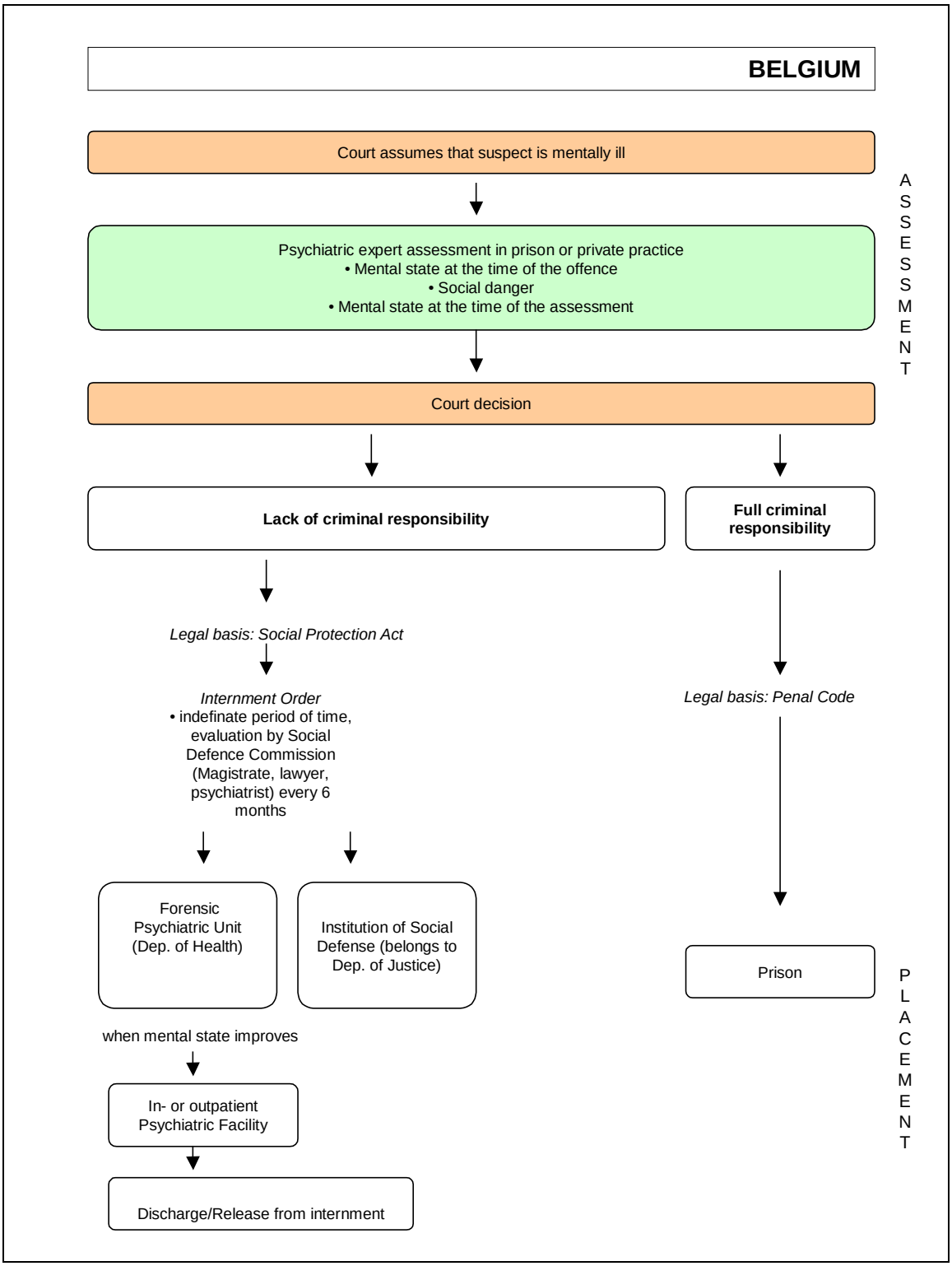

Fig. 15 Forensic Service Provision in Belgium

BELGIUM: Forensic Service Provision (situation in June 2004)

	GENERAL PSYCHIATRY	INSTITUTES OF SOCIAL PROTECTION	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	unspecified capacities for forensic patients in community **psychiatric hospitals** (open or closed wards) In 2004, 16% (539) of all internees were treated in psychiatric hospitals	**3 Institutes of Social Protection (for high risk patients)** **Flanders** Merksplas 273 beds Turnhout 50 beds **Wallonia** Paifve 160 beds	**6 Forensic Units in Psychiatric Hospitals** **Flanders** Rekem 83 beds[1] Zelzate 45 beds Bierbeek 41 beds **Brussels** Brussels 16 beds **Wallonia** Tournai 341 beds Mons 32 beds	**8 Psychiatric Prison Wards** **Flanders** Antwerp 45 beds Leuven 25 beds Gent 17 beds Brugge 15 beds[2] **Brussels** Forest 50 beds **Wallonia** Jamioulx 25 beds Namur 20 beds Mons 16 beds
clientele	mostly criminally non-responsible offenders but also criminally responsible offenders, mix of mentally disordered offenders and non-offending mentally disordered	criminally non-responsible offenders (only post-trial) mentally disordered offenders	criminally non-responsible offenders mentally disordered offenders	Suspects prior to trial for observation or treatment criminally responsible offenders and waitinglist for criminally non-responsible offenders
criteria for placement	mental disorder (including provisional release after detention or internment)	criminally non-responsible offenders	provisional release of criminally non-responsible offenders	mentally disordered offenders detainees with psychiatric problems during detention

(1) additionally 70 places for supervised housing in the community
(2) only for women

Denmark

Peter Kramp

Legislation

In Denmark forensic psychiatry is not a speciality in itself but part of general psychiatry. The growing number of forensic patients means, however, that more and more psychiatrists are working within this field. It is assumed that within a few years forensic psychiatry will become a more formalised subject area.

Each of the fourteen Danish counties and the municipalities of Copenhagen and Frederiksberg (which together have the same tasks as a county) bear the responsibility for providing the total psychiatric service, including forensic psychiatry, to the county residents. As to forensic psychiatry, the counties differ widely. In some counties all forensic patients are treated within the general psychiatric facilities, while other counties have established small units for the most difficult-to-treat forensic patients; and a few counties have larger forensic facilities that are responsible for the treatment of most of the forensic patients, including their outpatient treatment. The various forensic facilities do not have any formal legal status and neither local nor governmental authorities certify them.

Denmark, with a population of five million inhabitants, has one high-security psychiatric facility with 30 beds. This facility receives very dangerous and psychotic patients, civil as well as forensic. In recent years, around half of the patients have been civil commitments, with the other half being forensic admissions, including a few admissions per year for whom psychiatric assessments must be prepared for the courts. One of the counties runs this special facility, but the Ministry of Justice has endorsed the regulations.
Denmark has 82 district courts, two high courts; one for the western, and one for the eastern part of the country, and one Supreme Court. In Denmark one court system processes all types of cases, and apart from the Maritime and Commercial Court of Copenhagen, special courts, e.g., juvenile courts, are not known.

If a defendant pleads guilty, and he/she is not suspected to be mentally ill, only one judge (jurist) tries the case, regardless of the severity of the case. If a defendant pleads not guilty, one judge (jurist) and two lay judges try the case (minor crimes). In all cases in which a defendant is suspected to be mentally ill, one judge (jurist) and two lay judges try the case.
In cases of serious crime, to which a defendant - mentally ill or not - pleads not guilty, a jury is involved. It is for the jury (twelve lay persons) alone to rule on the guilt or innocence of a defendant, whereas the jury (twelve votes) and three judges (jurists, each four votes) together decide the sentence.

The judgement is divided into two parts. Based on the evidence of the case (including the degree of “intention”), the court decides whether a defendant is guilty or not. Mentally ill and mentally healthy defendants are tried in precisely the same way. Secondly, the court decides the sentence – for the mentally healthy, an ordinary sentence, be it prison, a community penalty, a suspended

sentence, etc.; for the mentally ill, a psychiatric measure according to the Penal Code.* (For a brief account of the Danish Court System and criminal procedure see: www.domstol.dk)

Structure of the Legal System

The current Danish Penal Code dates from 1930, with a revision carried out in 1973/1975, which was important from a psychiatric point of view. The 1930 law was heavily influenced by the optimistic therapeutic attitude of its era. Psychiatrists took it upon themselves to explain and combat crime. Indeterminate security measures were favoured and forensic psychiatrists held key positions in the legal system, participating in evaluating and sorting offenders, placing them in criminal asylums, labour camps, and special institutions for alcoholic offenders, for recidivists and for young offenders. This treatment-oriented approach was at its height in the early 1950s.
Then the pendulum swung back. Treatment was abandoned, and what has been called the "neoclassic" school of penology reappeared in Denmark as also in many other countries. This resulted in the reform of the penal code in 1973/1975, with particular regard to the sanctions that could be imposed on non-psychotic mentally abnormal offenders. Under the new legislation they received ordinary sentences. Denmark still has a sanction of unlimited duration, known as security detention, which is imposed upon non-psychotic, dangerous offenders with severe personality disorders (Penal Code, § 70).

During the 1990s, however, this "nothing works" attitude began more and more to be replaced by the attitude that "something works on somebody". There have been minor changes to the Penal Code and regulations belonging to the law, e.g., that a disposal in cases of non-violent sexual crimes can be a suspended sentence on condition of psychiatric/sexological treatment or in cases of alcohol-abusing drunken drivers, a suspended sentence on condition of treatment against alcohol abuse. Along the same lines, the Danish Department of Prisons and Probation has developed treatment programmes for young inmates, drug abusers and other groups during the recent years.
The age of criminal responsibility is fifteen years. For criminals who are 15-17 years old there exist an array of social disposals. Psychotic (and mentally retarded) adolescents are treated in the same manner as adults.

A minor revision of the Penal Code in 2000 set time limits upon psychiatric measures in cases of not too dangerous criminality. Patients' organisations had pointed out that in some cases the duration of the psychiatric measure was much longer than the ordinary sentence that would have been imposed had the offender not been mentally ill. Many psychiatrists, including the Medico-Legal Council (vide infra*),* explained that the reason for the long duration was seriously ill offenders, who were not motivated to seek treatment. Discontinuation of the treatment might therefore mean a relapse into crime. Parliament, however, weighted proportionality higher than the psychiatrists' viewpoint. But Parliament also decided that a research project should evaluate the consequences of the new legislation.

Psychotic Offenders

The general philosophy of the Danish legislation from 1930 (and even before that) has been that psychotic offenders shall be treated, not punished. § 16 (1) of the Danish Penal Code states: "Persons, who, at the time of the act, were irresponsible owing to mental illness or similar conditions or to a pronounced mental deficiency, are not punishable". The legal term "mental illness" is equivalent to the psychiatric term "psychotic".
In other words, persons who have been found guilty by the court, but who are irresponsible owing to a psychosis (or a pronounced mental retardation) are not punishable. Mental retardation will not be discussed further because the rules and practice for this group correspond exactly to those ap-

* The translation of the Danish Penal Code into English uses the words "psychiatric measures", which also will be used in the following.

plicable to psychotics. Two elements have to be fulfilled to exempt an offender from punishment – he must be psychotic *and* for that reason be considered not responsible for the crime. If the psychiatrist finds a defendant psychotic, it is for the court to decide whether the person in question is responsible or not. The psychiatrists have to work only within their own discipline, describing and diagnosing mental disorders. It is the court, never the psychiatrist, who takes the final decision as to whether or not a defendant is punishable. The word "irresponsible" thus contains an additional requirement of a legal nature. The word is neither defined in the law nor in the preparatory work for the law or elsewhere. Knud Waaben, Professor LL.D. of Criminal Law, has formulated its meaning as follows: "All that can safely be said is that the word is intended to serve as a vague reservation in order to ensure that the final decision rests with the court." (Waaben, 1982).

It is important to stress that the use of § 16 does not require that there be any relationship between the psychotic condition and the criminal act. However, in the very few cases of psychotics who have received ordinary sentences, the court has said that there was no connection between the mental abnormality and the crime. The offence in such cases has most often been white-collar crimes – fraud, violation of fiscal legislation etc.

Case 1:
A dentist was charged with violation of fiscal legislation. The examining psychiatrist found the offender shy, introverted and preoccupied with bizarre sexual fantasies. At least partly because of these fantasies he had developed delusions, feeling that other people looked at him and talked about him. He was diagnosed as suffering from a paranoid psychosis and consequently came under § 16. While the lower court supported the psychiatrist, in the High Court he was sentenced to 30 days imprisonment. The High Court determined this sentence by saying that there was no connection between his mental abnormality and his manipulation of his accounts and the presentation of false information to the taxation authorities.

However, cases like this are very rare – less than one per year - and for all practical purposes, the court considers psychotic offenders to be irresponsible.
In accordance with the meaning of the word "irresponsible" in § 16, the concept of diminished responsibility is not used in the Danish legislation.

The concept of "similar conditions" (to mental illness) has been added to the concept of psychosis in order to exempt from punishment cases where a mental abnormality, although not classified as a psychosis, has had a similar effect on the mental faculties and behaviour of the offender. Clinically a "similar condition" almost always is a state of confusion due to somatic diseases such as hypoglycaemia or epileptic seizures. There are at most one or two such cases per year.

The Psychiatric Orders

§ 68 (1) of the Penal Code establishes that measures other than ordinary punishment can be used against psychotic offenders: "Where an accused person is acquitted in accordance with section 16 of this act, the court may decide on the use of other measures, which it considers to be expedient for the prevention of further offences". § 68 (2) mentions some of these measures: "If less extreme measures such as supervision … psychiatric treatment and so on are considered insufficient, the court may decide that the person in question shall be placed in a psychiatric hospital." Some more socially oriented disposals mentioned in the law are not discussed here; nor are the disposals which can be used against the mentally retarded, as these are in principle the same as those for psychotics.

The subsection mentions two possibilities: psychiatric treatment or placement in a psychiatric facility. The differences between the two possibilities are mainly a question of how much security the court considers necessary, a placement order being the most radical measure. Both imply transferral of the offender to the general psychiatric service run by the counties. There are other psychiatric measures: At one end of the scale, psychiatric treatment on an outpatient basis only; at the other

end, the very rarely used high-security facility for dangerous psychotics. However, both of these extreme psychiatric measures, outpatient treatment and the high-security facility, play only a minor role.

Placement Order

Placement in a psychiatric facility means that the offender is admitted to a (forensic) psychiatric facility and cannot be discharged without a new court order. Leaves are restricted. The psychiatrist can grant unattended leaves on the premises of the psychiatric facility and unattended leaves up to three hours per day off the premises of the psychiatric facility. Longer unattended leaves, overnight stays at home, etc., have to be granted by the regional prosecutor together with the psychiatrist. It is entirely a matter for the psychiatrist to decide where the patient should be placed within the facility, e.g., in an open or a closed ward, just as all decisions about treatment are taken only by the psychiatrist.
Basically patients placed in the high-security facility are not granted leaves, but the Ministry of Justice can grant short-term attended leaves.

“Placement orders” are used in cases of criminality dangerous to others, e.g., homicide, manslaughter, some cases of arson, rape etc. Most of the patients suffer from schizophrenia of the most severe kind. The “placement orders” are almost always of unlimited duration. Normally, after a few years a “placement order” will be changed into a “treatment order”.

Case 2:
A 50-year-old unmarried man was charged with attempted homicide. He had shot at a police officer, who was injured, but not critically. The offender had no criminal record and, on his pleading not guilty, the court ordered his admission to a psychiatric facility for mental observation. The report to the court concluded that he had suffered from paranoid schizophrenia for at least 20 years. Some years previously he had been admitted to a psychiatric facility and treated there with antipsychotic drugs; he improved, but discontinued treatment upon his discharge, being convinced that he was not ill. During the admission for mental observation he was preoccupied with ideas of reference, grandiosity, formal thought disorder, and autistic contact. He refused medical treatment, saying he was not ill. The examining psychiatrist concluded that the offender had been psychotic at the time of the criminal act and thus he came under § 16 of the Penal Code. Placement in a psychiatric hospital was proposed and the jury agreed.

Treatment Order

The order of “psychiatric treatment” means that an offender by and large is to be treated like any other patient. Legally there are two types of ”treatment order”. Under the first type, an offender is admitted after the judgement; under the second type, treatment may start on an outpatient basis. For all other practical purposes, the two types are identical. The psychiatrist decides on any leaves and also on the type of leave. The patient can work outside the psychiatric facility, can go home at weekends and can be discharged by the psychiatrist when appropriate. Following his discharge, the patient is obliged to enter outpatient treatment. In nearly all cases the court will also order supervision by a probation officer. The task of the probation officer is to offer social support to the discharged patients and, together with the hospital, control their attendance at outpatient treatment. Moreover, the probation service is nationwide, whereas the psychiatric health care system, as previously mentioned, is run by the individual counties. Some forensic patients often move from one county to another, thus it is much easier for the probation service than for the psychiatric system to follow the patients from place to place and establish contact to a new (forensic) psychiatric facility. If necessary, the psychiatrist, together with the probation officer, can readmit a patient to the psychiatric facility. As mentioned previously, a “placement order” eventually changes into a “treatment order”, and thereby the former placement-patient can gradually be integrated into society.

Case 3:
A 27-year-old married woman was charged with homicide; she had fatally poisoned her two-year-old child with gas and at the same time attempted to commit suicide. She was severely depressed and already at the preliminary examination the court ordered her admission to a psychiatric facility for mental observation. The forensic psychiatric report concluded that she suffered from a bipolar affective disorder. She had previously been admitted several times for both manic and depressive episodes. It was further concluded that she had been suffering from a major (endogenous) depression at the time of the crime. During the admission for assessment, she was treated with antidepressants and recovered to some extent, but still needed psychiatric treatment and support. She was found to come under § 16, and the examining psychiatrist recommended "psychiatric treatment". In court the prosecutor argued for a "placement order", emphasising the severity of the crime. The High Court, however, followed the forensic psychiatrist (and the defence) and decided on "psychiatric treatment".

This case illustrates that it is the offender's mental state at the time of the crime, not at the time of conviction, that is decisive for the applicability of § 16. Most "treatment orders" are time-limited, lasting three or – most often – five years. This period can be extended by a new court order.

Psychotic States after the Offence

If an offender develops a more permanent psychotic condition *after* the time of the criminal act, but before the trial, § 16 cannot be used. The court then has two alternatives. The first alternative is an ordinary sentence, but, under § 73 of the Penal Code, the offender shall be placed at a psychiatric facility until he has recovered sufficiently to serve the ordinary sentence. The time the offender spends at the psychiatric facility constitutes part of the sentence. The other alternative is a psychiatric measure – be it placement or treatment – and no prison sentence. Whichever alternative is found most expedient in such cases depends on the severity of the case, the diagnosis, etc.

According to § 78 of the Act on Enforcement of Sentences etc., prisoners, who become psychotic while serving a sentence will be admitted to a (forensic) psychiatric facility and remain there until recovery or until release.

Psychotic States at Time of Crime, Recovery before Trial

It follows from § 16 that persons who were psychotic at the time of the act (and are irresponsible), are not punishable, and according to § 68 (1) "other measures" (than ordinary sentences) must be "expedient for the prevention of further offences". This means that there might be cases where a person is not punishable *and* "other measures" are not considered "expedient" because the defendant has recovered completely. The person may leave the court without any sentence. Such cases are very rare, less than one per year, but they do exist.

Case 4:
A 46-year-old man was charged with violence. He had been an alcoholic for many years. He lived alone and drew a disability pension due to the somatic consequences of his abuse. In order to stop his increasing and very heavy alcohol consumption, two lay persons from an alternative treatment group followed the man to an isolated house at the countryside. There he developed a full-blown delirium tremens and due to visual hallucinations, he assaulted the two companions. He was admitted to hospital and his delirium tremens were treated.

At the time of the assessment he appeared as a chronic alcohol abuser, slightly demented but not psychotic. He came under § 16 (1) (being psychotic at the time of the act), and a "treatment order" was recommended. However, before his case came to trial a fire accident injured him seriously. He was admitted to a surgery ward (and developed a new delirium tremens). Afterwards he decided to stop drinking, and he was briefly admitted to a psychiatric facility for treatment of withdrawal symp-

toms and then discharged. At the trial he pleaded guilty, but maintained that he did not need any treatment, because he no longer abused alcohol. The court decided upon a new assessment. This confirmed that for many months the defendant had been totally sober and that clinically he had improved considerably, in terms of both his somatic and his psychiatric state. The new assessment concluded that the man had recovered and no psychiatric measure could be suggested. The court followed the assessment.

Non-psychotic but otherwise Mentally Disturbed Offenders

For non-psychotic but otherwise mentally abnormal offenders the regulations are as follows (Penal Code, § 69): "*Where the offender at the time of the act was … in a condition which was dependent on inadequate development, or an impairment or disturbance of his mental abilities, not being of the character referred to in § 16, the court may, if considered appropriate, decide upon the use of measures such as those referred to in subsection two of § 68, instead of punishment*".

These few words "inadequate development, or an impairment or disturbance of his mental abilities" cover most, if not all non-psychotic psychiatric disorders, such as neurotic, stress-related and somatoform disorders, personality disorders, substance use disorders etc. This section establishes that rather than punishing this category of offenders, the court instead can use psychiatric measures if these are recommended by a psychiatrist.

A psychiatric measure may be considered in the case of schizotypal disorders, grave (but non-psychotic) organic disorders, mild cases of Asperger's syndrome, and a few cases with neurotic, stress-related and somatoform disorders, who are motivated to seek psychiatric treatment.
The measure used is practically always "psychiatric treatment". The orders imposed on § 69-cases are of limited duration. The court determines the total maximum time, e.g., the sum of the duration of each admission, an offender can be detained in a psychiatric facility, most often up to one year. This period can be extended by a new court order. Outpatient treatment is most often also time-limited, lasting three or five years depending on the severity of the crime.

Case 5:
A 20-year-old unmarried man was charged with several cases of burglary, traffic offences and arson. During the last two years he had received several fines and a suspended sentence for burglary. He was placed in custody and the assessment took place on an outpatient basis. He was found to be emotionally withdrawn but not autistic. His train of thought was vague although he was not found to be clinically depressed. Psychological testing confirmed the clinical description and revealed latent paranoid features. However, he could not be classified as psychotic; he had never hallucinated, his sense of reality was not disturbed nor was he paranoid. The examination concluded that he might be suffering from latent schizophrenia or from a schizotypal disorder. He was classified as a § 69-case and "psychiatric treatment" was recommended, partly on account of the diagnostic uncertainty, and partly because the offender needed and was motivated to seek treatment. The court followed the recommendation.

Case 6:
A 27-year-old divorced man was charged with robbery and serious assault. He had previously been sentenced several times for burglary and assault. For some years he had abused alcohol, and he had been admitted to psychiatric facilities several times because of parasuicidal behaviour. On one occasion, a short-term psychosis with paranoid features had been suspected. However, all the admissions had been short, as he had soon discharged himself. During mental observation some organic disturbances were recognised, probably associated with a head injury in childhood and alcohol abuse. He was emotionally labile, suspicious, and narcissistic. He minimised his alcohol problems, his criminal behaviour and his previous psychiatric admissions, stating that the latter only had occurred because he had wanted a bed and something to eat. The mental observation concluded that he suffered from an antisocial personality disorder with some organic disturbance and

alcohol abuse. He was found to come under § 69 but no special sanction under § 68 (2) was thought more appropriate than ordinary punishment. In the event he was sentenced to 3.5 years imprisonment.

These two cases illustrate that an important factor in recommending a psychiatric measure in § 69-cases is whether there is a realistic possibility of a favourable response to treatment. Very closely related to this is the attitude of an offender towards psychiatric treatment. In the first case, the offender expressed a serious desire for treatment: During the last few years, supported by his parents, he had several times considered consulting a psychiatrist, but in this as in many other situations, he had been indecisive. In the second case, while the offender declared that he was interested in psychiatric treatment, his history clearly demonstrated that this was not the case.

The Herstedvester Institution

In Denmark offenders with severe personality disorders have never been regarded as forensic patients in a narrower sense. From the 1930s on, this group of offenders who have committed dangerous crimes has served their sentences at the Herstedvester institution, which is a prison operating under exactly the same regulations as other prisons. With around 120 inmates, the Herstedvester institution is at the same time a well-staffed treatment-oriented institution which offers the inmates all sorts of psychiatric treatment. Involuntary treatment cannot be used within the prison system. The treatment staff consists of five psychiatrists and seven psychologists, together with psychiatric nurses and social workers. The prison management is composed of the prison governor and the chief psychiatrist.
The security detention of unlimited duration is seldom used, the actual number of cases in 2004 being roughly 20. This sanction is imposed only for reasons of security, not for treatment. As a rule, however, these offenders are placed at Herstedvester and are offered psychiatric treatment.

Some offenders from Greenland serve their sentences, including security detention, at Herstedvester. This has been criticised, because the Greenlanders, some of whom do not even speak Danish, are removed from their culture.

A special group of offenders consists of those sentenced for serious sexual crimes. For years, this group has served their sentences at Herstedvester. Consequently, the institution has a long history of experience in the treatment of sexual deviants. Previously castration was used in some cases. The treatment now used in the most serious cases is anti-hormone drugs, always combined with an offer of psychotherapy. The anti-hormone therapy treatment can only be initiated with the offender's consent. As regards treatment of sex offenders, Herstedvester has established a formal collaboration with three psychiatric facilities spread around the country. This link means that an offender can be released on probation under the stipulation that he continue the treatment initiated at Herstedvester.

The combination of punishment and treatment has occasionally generated debate and criticism. The broadly accepted advantage is that offenders with severe personality disorders are treated within the prison system and not brought together with psychotics (and a few others), who are treated entirely within the psychiatric health care system.

Procedures

In accordance with the overall principle that mentally ill offenders shall be treated, not punished, all defendants suspected to be mentally ill shall undergo a formal psychiatric assessment for the court except in cases of minor offences, which are sentenced to a fine. Diversion is not applied in Denmark.

According to an instruction from the Prosecutor General, the prosecution will also ask for an assessment if a defendant is charged with a serious crime – homicide, arson, repeatedly odd violent

behaviour, rape and other serious sexual crimes etc., even he is not suspected to be mentally ill. In these cases, the court will normally follow such a request from the prosecution.

Remanded Defendants

The court decides whether a remanded prisoner shall undergo a formal psychiatric assessment (procedural law § 809), but the defence and the prosecutor can ask for it. Formalised medical pre-trial assessments are not known in Denmark, but many defendants undergo a socially oriented examination carried out by a probation officer. This social inquiry report might recommend a formal psychiatric assessment. The prison staff is instructed to be attentive to signs or symptoms of mental illness, and the prison doctor can ex officio recommend an assessment. Most often the court's decision is based on such information as previous psychiatric admissions, the social inquiry report, police reports about the defendant's behaviour during interrogations, statements from prison doctors or information from relatives.

The court also decides whether the assessment must take place during admission at a (forensic) psychiatric facility or on an outpatient basis. The former takes place in a (forensic) psychiatric facility within the home county of the defendant. The latter takes place at one of four forensic centres, covering most of Denmark. (The rest of the country (part of Zealand) will in the nearest future probably be attached to one or two of the existing centres.) The remanded prisoners are thus transported from the remand prison to the centre where the assessment takes place. The Ministry of Justice pays three of the centres, run by three counties, for the assessments. While the Ministry itself administratively runs the last centre, the Clinic of Forensic Psychiatry in Copenhagen, the clinic is independent within its own professional area. The clinic was established in the 1930s, and today it is by far the largest outpatient centre in Denmark, receiving around 250 assessment cases per year. In addition, the clinic has research and educational activities.

The Ministry of Justice has entered into an agreement with each of the four centres with respect to the minimum standards for the reports. According to the agreement, the maximum time limit for the assessment and writing the report is six weeks. Inpatient assessments usually take longer due to, among other things, a shortage of psychiatric beds. The courts therefore are reluctant to order an inpatient assessment. The prosecution decides in a few cases per year that a court-ordered inpatient assessment shall take place at the high-security facility.

Admission for Treatment

The court can decide that a remanded prisoner who consents shall be admitted to a psychiatric facility for treatment (Procedural Law § 765 (2)). In special cases, such as for security reasons or an obvious need for treatment, the admission can take place without the defendant's consent (Procedural Law § 777). In emergency cases a prison doctor can admit a remanded prisoner to a psychiatric facility (Procedural Law § 770 (2)). The legal authorities shall be informed as soon as possible.
Admitted defendants are still remanded, and therefore a court order concerning a formal assessment is necessary. In such cases, the court will often obtain a brief statement from the psychiatrist about the need for an assessment.

Defendants Charged but not Remanded

A defendant might not be remanded in cases of theft, burglary, minor violence etc. In such cases, the prosecutor or the police can ask for an assessment on condition of written consent from the defendant or his defence. These assessments will always take place at one of the above-mentioned centres along the same lines as previously described. If the defendant refuses to participate, the prosecutor or the police may bring the case to court. Ultimately the court can decide that the defendant should be admitted for an assessment if the defendant continues to refuse to participate but this option is seldom used.

Practice

When the court (or the prosecution or the police) has decided to commission an assessment, the police are responsible for the following practical steps: collection of relevant legal documents from previous convictions, prints from the central crime register, previous assessments if any, social inquiry reports, if any, and so on. When these documents have been gathered together, the police send the whole case, together with the order or the defendant's written consent, to the psychiatric facility. The psychiatric facility asks for e.g., medical and social records and statements from hospitals and social authorities. If the defendant does not consent, the psychiatrist can ultimately bring the matter before the court. The psychiatrist returns the legal documents together with the assessment report to the police, who are then obliged to immediately send a copy of the report to the defence. Normally the court will not see the report until the trial date is set.

Report

The above-mentioned agreement between the Ministry of Justice and the four centres describes some quality standards, mainly the content of the assessment report:

- Introduction
- Existence of neuro-psychiatric disorders and/or criminality in the family
- A detailed social history
- A summary of previous somatic diseases based on the defendant's own information and records commissioned from the General Practitioner, somatic wards etc.
- Previous sentences
- The present charge, with a short summary of the defendant's explanation to the court (or to the police in cases of minor crimes, where the defendant is not remanded and has not been in court for a preliminary examination)
- Information about the defendant from other sources such as records from psychiatric facilities, records from social and welfare authorities, substance abuse treatment facilities, psychiatrists in private practice and in some cases, interviews with relatives
- A thorough and comprehensive psychiatric examination with the main emphasis on psychopathology
- A psychological test (if clinically relevant)
- An "objective" clinical psychiatric description
- A somatic examination with e.g. an EEG or a CT-scan (if clinically relevant)
- The defendant's present situation – remanded or not, medication, if any etc.
- Discussion (in complicated cases)
- Conclusion

The conclusion contains the psychiatrist's position on the key questions: Was the defendant psychotic at the time of the crime? Is he psychotic at the time of the assessment? Is he mentally retarded? The premises for any diagnosis are mentioned briefly. In cases of psychosis or mental retardation, the psychiatrist makes a proposal for a psychiatric measure. Basically the reason for a proposal is medical and the psychiatrist is not supposed to take the severity of the crime, the sense of justice, or other legal matters into consideration (cf. case number 3).
Is (was) the defendant not psychotic (or mentally retarded), the question then is whether he comes under § 69 and if he does, whether a psychiatric measure can be proposed. The psychiatrist will never give a direct opinion about ordinary sentences.
In cases where security detention of an unlimited duration is mentioned, the psychiatrist will be asked to make a risk-assessment; if not asked to so, the psychiatrist can make such an assessment ex officio.

The Danish Medico-Legal Council

The Medico-Legal Council is an independent consultation medical board. The task of the Council is to give expert medical and pharmaceutical opinions to the public authorities in legal cases. Tradi-

tionally, the Council is also asked to assist in some fundamental legal questions such as law revisions involving medical issues. The Council currently consists of ten ordinary members and more than 150 extraordinary experts covering the whole field of medicine. The members have their own specialities and membership on the council is a part-time function only. A lawyer heads the secretariat, which examines all the cases and offers guidance to the medical experts concerning legal aspects.

Only courts and public authorities can ask for the opinion of the Council but the defence can approach the Medico-Legal Council through the court or the prosecution.
In the majority of cases, the Council's opinion is based on written material only. In special cases, however, the opportunity exists to examine a person directly.

At least three members are involved in each case and express their opinion in writing. A case may circulate several times until agreement has been obtained, or it has been established that this is not possible, in which case the Council's opinion then will include a dissenting opinion.

The annual number of psychiatric and non-psychiatric cases is about 2,000. Many of these are more or less routine cases concerning e.g., intoxicated drivers; others are more complicated, involving, for example, malpractice. Roughly 600 are psychiatric cases, many of which are complicated and time-consuming. This is illustrated by the fact that six of the ten ordinary members of the Council are psychiatrists.

The majority of psychiatric cases concern mentally abnormal offenders. Around one third of the assessments for the court are laid before the Council, such as all cases where a "placement order" is suggested, cases where the diagnostic and thereby the legal classification is doubtful, and cases involving serious crimes such as murder or some sexual crimes. The Council's opinion is also requested in many cases concerning changes to or abolition of a psychiatric measure. Furthermore, the Council is involved in some civil cases.

In forensic psychiatric cases the Council's statement includes a short summary of the essential part of the psychopathological findings, a diagnostic classification, and the Council's position on the legal aspects – whether an offender comes under § 16 or § 69? Can a psychiatric measure be recommended, and if so, which type? Is it justifiable from a psychiatric point of view to abolish a psychiatric measure?

The Medico-Legal Council is solely an advisory body, serving as a link between psychiatry and the legal system. In general, the public, psychiatrists and the legal system accept the authority of the Council. The statements of the Council rest on experts who are independent of the parties involved and of any financial interests. Furthermore, the existence of the Council ensures uniform guidelines for forensic procedures in different jurisdictions of the country, and last but not least, guarantees a certain level of quality in forensic psychiatric work. The Council thus asks for further information in 15-20% of all cases, and from time to time even requests a new formal assessment. In 10-15% of the cases, the Council's opinion differs more or less from the conclusion in the material laid before the Council. In such cases, the examining psychiatrist is requested to comment on the Council's opinion and the comment is enclosed the Council's statement.

Practice

The principles for the assessment and treatment of psychotic offenders have remained unchanged in Denmark for decades. These principles are broadly accepted within the society, be it the public, the politicians, the legal profession or the psychiatrists. From time to time, small groups such as some patients' advocacy groups have suggested fundamental changes, but the debate, if any, has been brief and limited.

Legislation

The Danish legislation on mentally ill offenders only supplies the framework, whereas the detailed regulation is found in circulars and instructions, such as a comprehensive instruction on mentally disordered defendants from the Prosecutor General. This is looked upon as an advantage because it is relatively easy to change such legal instruments and by this means, adjust practice due to e.g., new knowledge or structural alterations within society, including psychiatry.

Another major advantage is the formulation of the laws. § 16 (1) uses the word “mental illness”, which according to a more than 100-year-old tradition is equivalent to the psychiatric term “psychosis”. Consequently, psychiatrists know the exact meaning of the judicial term, because it corresponds precisely to a medical concept.

Furthermore, changes in the psychiatric classification systems, such as the introduction of ICD-10 in 1994, or of new diagnostic entities, do not play any role, because the legal system accepts that psychiatry like other medical disciplines continuously develops theory and practice. In 1885 the Danish psychiatrist Knud Pontoppidan (1885) wrote about a paranoid horse-dealer charged with threats: “It may be that this man 100 years ago would not have been regarded as mad, and it may be that in 100 years he will not be regarded as mad. As for now, however, according to our present knowledge, this man is mad”. The same applies today. The term “similar conditions” (to psychosis) in § 16 (1) furthermore gives the psychiatrist some elbow-room in atypical cases.

Last but not least, Danish forensic psychiatrists do not have to deal with the philosophic or legal concept of “responsibility”.

§ 69 of the Penal Code deals with non-psychotic, but otherwise mentally abnormal offenders. The words used are vague – “inadequate development, or an impairment or disturbance of his mental abilities”. The psychiatrists recommend a psychiatric measure for some defendants within § 69, and the terminology used in this section makes it possible to adjust practice according to current psychiatric knowledge, such as suggesting psychiatric measures to some offenders with PTSD or pervasive developmental disorders.

Collaboration

Generally speaking, the collaboration among the various parties within Danish forensic psychiatry is smooth, with respect and understanding for the duties and tasks of the different professions.

Forensic psychiatrists are regularly invited to lecture at meetings and seminars for judges, prosecution or defence lawyers and vice versa. Every year or every two years, the Section for Forensic Psychiatry of the Danish Psychiatric Society arranges two- or three-day seminars on current forensic psychiatric issues with roughly 100 participants, around 30 of whom are from the legal profession. The above-mentioned instruction from the Prosecutor General came into force in 2002. The Prosecutor General requested a forensic psychiatrist to participate in the working group preparing the draft. Thereby many practical details were adjusted to psychiatric viewpoints, to the benefit of both forensic psychiatry and the prosecution.

Sex Offenders

During the 1990s in Denmark as in many other countries sexual crimes became a rather heavily debated issue, and in 1997 a nationwide treatment programme for sex offenders was launched. The treatment is carried out in collaboration between the psychiatric health care system and the Department of Prisons and Probation. As previously mentioned, offenders who have committed non-violent sexual crimes and who are motivated for treatment might receive suspended sentences on condition of psychiatric/sexological treatment. The treatment takes place at one of the three psychiatric facilities collaborating with the Herstedvester institution, all of which are departments of

university psychiatric clinics. Two of the three clinics are also connected with the aforementioned assessment centres. Based on individual needs, the clinics offer counselling, cognitive therapy, psychoanalytically oriented psychotherapy or group therapy, together with psychopharmacological treatment if indicated. An offender is also under the supervision of a probation officer, who is responsible for social support and help in cooperation with the local social authorities.

Offenders who have committed more serious sexual crimes receive ordinary sentences. The imprisonment, however, starts with a short stay in a special unit at the Herstedvester institution for the purpose of examining an offender's motivation for treatment, and if needed and possible, to motivate him for treatment. Treatment-motivated offenders then serve their sentences in open prisons and receive psychiatric/sexological treatment as previously described.
The most dangerous sex offenders are not included in this arrangement, but are still offered treatment during their imprisonment in Herstedvester.

A research project on the efficacy of treatment of sex offenders has from the very beginning been integrated into the treatment programme. Preliminary results (Department of Prisons and Probation, 2004), however, show that neither the rate of recidivism for sexual crimes nor the type of reoffending differs among those who have received treatment and those who have not. Changes in referral and treatment procedures, for example with greater emphasis on alcohol abuse, are under consideration.

Capacity Problems

The paramount problems within Danish forensic psychiatry are problems of capacity. The number of forensic patients has increased from around 300 in 1980 to around 1,500 in 2004. During the same period, the total number of psychiatric beds has decreased from around 10,000 to around 4,000. The causes behind the increasing number of forensic patients are disputed, but deinstitutionalisation probably plays a major role (Kramp & Gabrielsen, 2003). The growing number has many consequences for the assessment and treatment of forensic patients.

Due to the shortage of psychiatric beds, some defendants suspected to be mentally ill must wait for weeks or even months for admission for an inpatient assessment and then the report may be delayed due to a lack of resources.

For many years the assessments of outpatients presented similar problems in some parts of the country, but these have been alleviated by the establishment of the aforementioned four centres.

The shortage of beds also implies that mentally ill prisoners – remanded or not – have to wait for admission or – and perhaps more often – are quickly returned to the prison once treatment, for example neuroleptic treatment, has been initiated. Psychotic inmates may also prefer to stay in a prison rather than be admitted to an overcrowded psychiatric facility.

Studies of the treatment of forensic patients have shown that some outpatients in need of inpatient treatment and care may wait months for admission and that outpatient treatment in some cases is far from being intensive enough (Kramp et al., 2001).

At the political-administrative level, the counties and the government discuss the issue of who is to pay – the legal system is run by the government, the psychiatric health care system by the counties. Do forensic patients belong to the former or the latter?

Patients Rights

Generally speaking, the rights of Danish forensic patients are one or the other in accordance with international conventions. The instruction from the Prosecutor General mentions that the police shall be aware of possible signs of mental disorder in defendants and not interrogate mentally ill

defendants without the presence of the defence. A defence lawyer will be appointed to a mentally ill defendant from the start of the case, and a defendant can appeal against all decisions to a higher court.

During the course of a psychiatric measure – be it "placement" or "treatment" - the prosecution is obliged to make regular inquiries about a patient, and the psychiatrist responsible for the treatment may at any time suggest that a psychiatric measure be changed or abolished, if e.g., a patient's condition has improved to such a degree that the measure presumably is not needed any longer. In such cases, a court hearing will take place. Every forensic patient is appointed a representative, either of their own choice or from among a corps of interested lay persons. Every six months, the patient or his representative can ask the prosecution to bring his case before the court, pleading that the measure should be changed or abolished. Concerning the "placement sanctions" of unlimited duration, the prosecution is obliged to bring the case before the court at the latest five years after the judgement and thereafter, every second year.

The regulations about involuntary treatment, coercion etc. are stipulated in the Mental Health Act and are the same for forensic and for civil patients. An independent regional board must approve involuntary treatment. In certain emergency cases the psychiatrist can initiate involuntary treatment and afterwards lay the case before the board.

The Danish ombudsman inspects prisons (including the Herstedvester institution) and closed (forensic) psychiatric facilities. Minor mistakes like misunderstandings or insufficient notes about e.g., decisions on leaves can always be found, but the ombudsman has not expressed any general criticism of the patients' rights. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has visited the same types of facilities and observed the same as the Danish ombudsman.

Epidemiology

Denmark has a long tradition of epidemiological research within general psychiatry and during the last ten years, some epidemiological forensic studies have been carried out by a group based at the Clinic of Forensic Psychiatry in Copenhagen. Generally, however, forensic psychiatric research is limited, probably because until recently this area has not attracted attention.

The Danish Psychiatric Register is a well-known tool in epidemiological research (Munk-Jorgensen & Mortensen, 1997); the Danish Crime Register is the most thorough, comprehensive and accurate crime register in the Western world, and has been used in major epidemiological studies (Brennan et al., 2000). Every citizen in Denmark has a civil registration number, registered in the Civil Registration System. The civil registration number makes it possible to link data from various registers such as the Psychiatric and the Crime Registers. All such register-based studies are subject to rigorous safety regulations. The exchange of register data for clinical use is forbidden.

Gottlieb et al. (1987a & 1987b) have studied homicide in Greater Copenhagen and shown that the number of psychotic (schizophrenic) homicides increased from 1959 to 1983, and that alcohol abuse and homicide are connected.

In a clinical study, Andersen has investigated possible psychiatric/psychological consequences of solitary confinement (Andersen et al., 2000) and psychiatric morbidity, substance abuse etc., among remanded prisoners (Andersen et al., 2004). Roughly two thirds of the prisoners were diagnosed according to ICD-10, including substance abuse disorders. The mental and physical health of many prisoners improved due to regular food, health care service etc. Solitary confinement delays this improvement and some of those sentenced to solitary confinement develop adjustment disorders or mild depressive reactions.

Sestoft (1997) has made a thorough clinical study of remanded schizophrenics, including those admitted to a psychiatric facility. Criminal schizophrenics are socially much more strained than

criminals who are not mentally ill. Not all schizophrenics are diagnosed by the prison health service.
Munkner (2004) has studied a Danish cohort of schizophrenic patients and among other things shown that close to 50 % of all young schizophrenic males are registered in the Crime Register for transgression of the Penal Law. Many males, however, had committed the first crime(s) before they were diagnosed as schizophrenics, whereas the crime debut for females lies after the disease has been diagnosed.

In a clinical study, Gosden has found a high psychiatric morbidity in a representative sample of remanded adolescents. A register-based study showed that the risk of developing a schizophrenic disorder is increased among adolescents who have been charged or sentenced for violence and who also have previous admissions to a psychiatric facility (Gosden, 2004).

Kramp and Gabrielsen (2003) have estimated the annual growth rate of the population of forensic patients in Denmark from 1980 to 1999 to be 6 % - 7 %. At present around 75 % of all forensic patients suffer from schizophrenia. Significantly more schizophrenics than the general population commit acts of violence and arson (Kramp & Gabrielsen, 2004).

A recent study has established that 56 % of the Department of Prisons and Probation's entire clientele – prisoners, remanded prisoners, and clients under supervision – commit substance abuse: 14 % abuse opioids (and many other drugs), 6 % abuse mainly stimulants, 14 % mainly cannabis, and 22 % commit alcohol abuse (Kramp et al., 2003).

Risk-assessment has not been a big issue in Denmark, but studies concerning this field are considered.

Public Opinion and Mass-Media

The debate in Denmark concerning crime and criminals, as it appears in the media, is contradictory. On the one hand, public opinion calls for severe punishment, while demanding more treatment on the other. Both possibilities have been realised. The punishment for offences such as violence, some sexual crimes, and organised drug dealing has become more severe; at the same time, a treatment programme for sex offenders has been initiated and various "anti-violence" educational programmes, together with many other programmes, have been introduced in prisons as well as within the probation service.
There is little debate about mentally ill offenders. The main theme is the aforementioned capacity problems. This debate, however, takes place mainly among psychiatrists themselves and between psychiatrists and administrators/politicians, not with the public. As a result of this debate, some new forensic psychiatric beds will probably be established within the years to come, mainly by converting general psychiatric to forensic psychiatric facilities
From time to time, the question about security and dangerousness blows up in the media. Some forensic facilities are located in old mental hospitals with a rather low level of structural security, and escapes have occurred. If a patient is supposed to be dangerous, blame has been placed on the security and perhaps on the psychiatrist, but not on the legislation about mentally ill offenders. With regard to court cases against mentally ill offenders, the media are by and large subdued, restricting themselves to descriptions like "severe psychic problems" or "clearly mentally ill". The assessment report is presented in court, but details from the report are almost never reproduced in the media.

Psychiatry has always been a matter of public debate and the current topics in Denmark are the homeless and/or substance-abusing mentally ill, the use of coercion and involuntary treatment, and how to treat immigrant patients. While forensic psychiatry is part of general psychiatry, and may thus be included in the debate, of itself forensic psychiatry is not in the public focus, neither for the good nor for the bad.

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Fig. 16 Judicial and Placement Procedures for Mentally Ill Offenders in Denmark

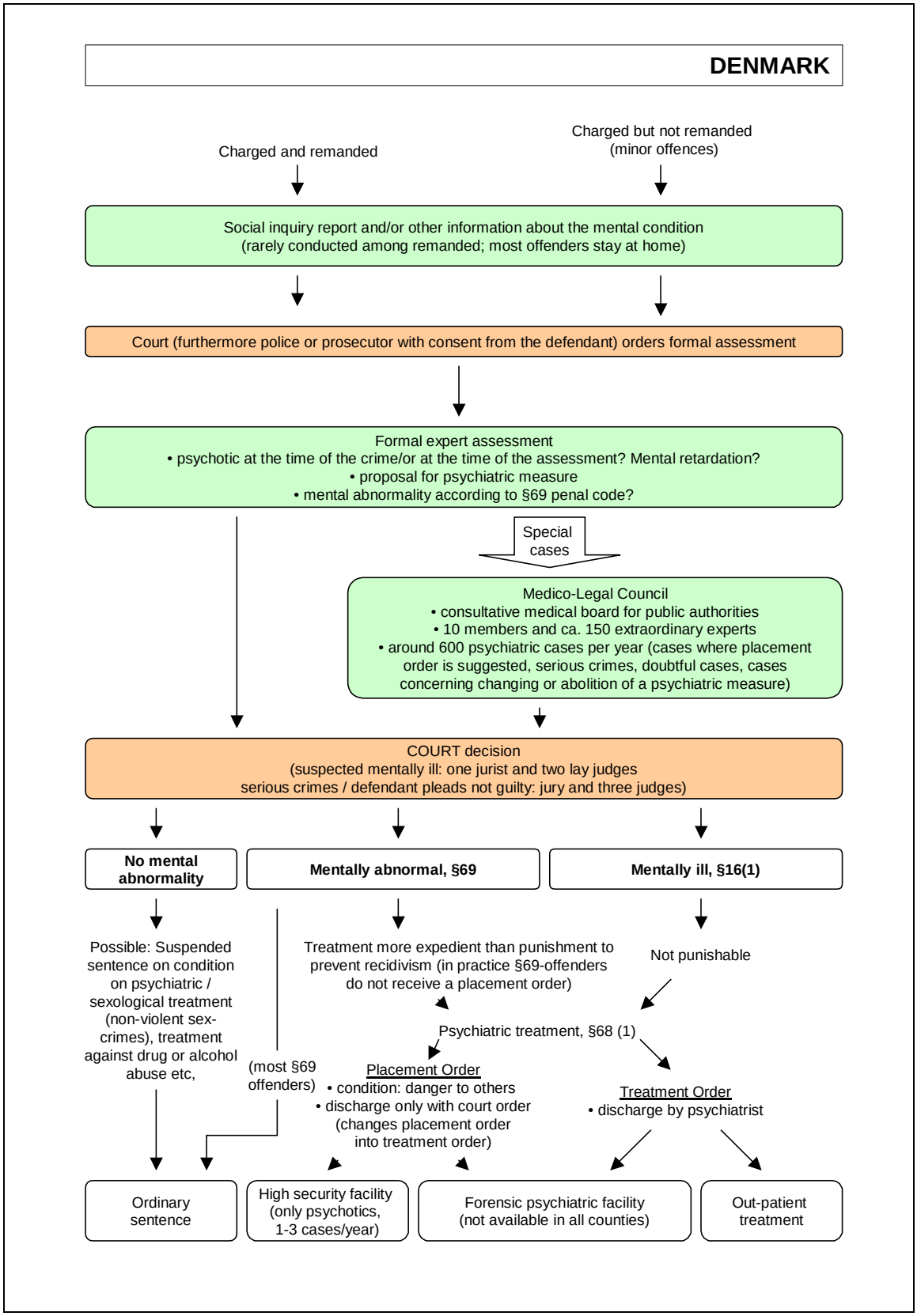
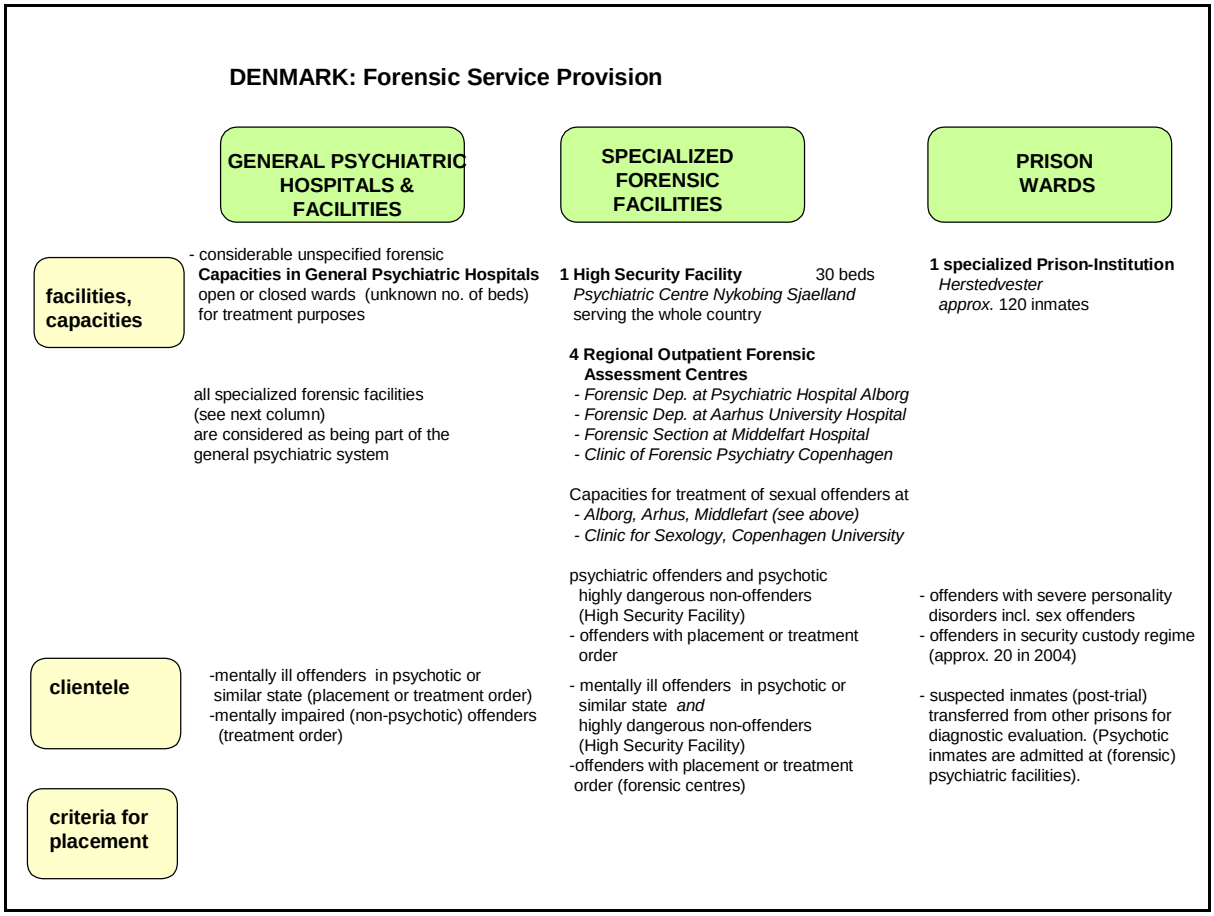


Fig. 17 Forensic Service Provision in Denmark



England & Wales

David James

This chapter concerns legislation and practice in England & Wales. These areas contain 52 million people (88.5% of the total UK population). The law in Northern Ireland (population 1.7 million) is similar to that in England & Wales. That in Scotland (population five million) is rather different.

The chapter concerns 'mentally disordered offenders', a term which incorporates both those suffering from mental illness and those with disorders of personality. The two are strictly differentiated in the United Kingdom.

Overview

Practice regarding mentally disordered offenders in England & Wales differs from that in most European countries in the following respects:

- The issue of criminal responsibility is absent, except in cases of homicide.
- Treatment in hospital is through a sentence of the court, after a finding of guilt is made. Although provisions for defences of 'not guilty by reason of insanity' exist, they are very little used as they are not necessary for a court to adopt a hospital disposal of a criminal case.
- The sentencing court plays no further part in the case after a person has been sent to hospital.
- The court cannot sentence a person to hospital treatment unless the intended hospital and treating physicians agree to provide a bed for a patient.
- The main expert in giving advice about the need for hospital treatment is in all cases one of the psychiatrists from the hospital which will be treating the patient. There is no division of psychiatrists into experts and treating physicians.
- The court does not determine which hospital a sentenced person is treated in. This is determined by the domicile of the defendant and the psychiatrists' opinion as to the level of security needed.
- There is no strict division of hospitals, or wards within hospitals, into forensic and non-forensic. Local psychiatric hospitals treat both, and forensic patients may be treated in the same wards as general patients.
- All forensic facilities for the mentally ill are part of the National Health Service: there are no forensic hospitals within the prison service.
- The forensic psychiatric system is focused on the treatment of people with serious mental illness: until recently, there has been little attention given to those with disorders of personality.
- There is a well-developed psychiatric sub-speciality of forensic psychiatry, with its own full-time higher training programmes, which are strictly regulated by a national body. There is a minimum of three years higher training in the speciality, after basic post-graduate psychiatric training and examinations have been completed.

Criminal Law in England & Wales

England and Wales differ from most other European countries in that the system of law is not closely based on Roman law. There is no Criminal Code in English law. Criminal law has two sources: common law and legislation.

Common law is that part of English law which is not the result of legislation. It originally developed from the decisions of judges which were based in tradtion, custom and precedent. Decisions on individual cases in the appeal courts act as a binding precedent and in effect modify the law (statute as well as common law) in a manner which influences the outcomes of future cases. There are some offences which exist in common law only. For instance, murder is a common law offence: there is no statutory law against murder, although the penalty is set by statute.
Statute law: the vast majority of offences are defined and regulated by statutes, i.e. Acts of Parliament which have duly been passed through both Houses and received the Royal Assent.

The Criminal Courts in England & Wales

Criminal cases are investigated by the police. Prosecutions are undertaken by a separate independent prosecution agency, the Crown Prosecution Service. In other words, the police do not prosecute cases, and there are no examining magistrates. The functions of investigation, prosecution and judging of cases are entirely separate.
The lowest criminal courts are the Magistrates' Courts, which deal with minor offences. They are less formal than higher courts. Cases are heard by magistrates, who are either trained lawyers sitting alone, or members of the public who have become 'Justices of the Peace' and usually sit as a triumvirate, supported by a legally-trained clerk. More serious cases are heard in the Crown Court, in front of a judge and jury. The Crown Court also hears cases appealed from the Magistrates Courts on factual points.
Cases are appealed on points of law to the High Court (Queen's Bench Division). Appeals against conviction and sentence are to the Court of Appeal (Criminal Division). The House of Lords is the supreme court of appeal. Its judicial functions are separate from its legislative work. Cases are heard by up to thirteen senior judges known as Law Lords.
As a Member State of the European Union, the United Kingdom is obliged to defer to the European Court of Justice on matters of European Union law and as a signatory of the European Convention on Human Rights, the United Kingdom is answerable before the European Court of Human Rights in Strasbourg. The enactment of the Human Rights Act 1998 conferred new powers and duties on the English Courts.

Laws Concerning the Placement and Treatment of Mentally Disordered Offenders

Mental health legislation in England & Wales is comprehensive, detailed and relatively sophisticated. Its emphasis is on the patients' best interests in terms of their health. The legislation does not prevent psychiatrists or the courts from imposing compulsory treatment in hospital where this is thought necessary. Such powers are balanced by a comprehensive system of safeguards and independent checks on their use and an emphasis on ensuring patients' rights.

Mental Health Act 1983

Nature
One Act of Parliament regulates compulsory admission and treatment of both civil patients and those concerned in criminal proceedings or under sentence – the Mental Health Act 1983. Part III of the Act deals with those concerned in criminal proceedings or under sentence. Those parts of the Act concerning compulsory treatment and appeals procedures apply to both groups.

The 1983 Act determines that the Secretary of State (in effect the Department of Health) prepare, and from time to time revise, a Code of Practice to offer practitioners guidance on how to carry out their functions under the Act. The Code of Practice is published as a substantial volume which details good practice in terms of procedures for compulsory detention and treatment, but also covers in detail areas not dealt with in the primary legislation, including restraint, seclusion, and after-care. The Mental Health Act does not impose a legal duty to comply with the Code, but as it is a statutory document, failure to follow it could be referred to in evidence in legal proceedings. In practice, it is used as the standard by the independent commission which monitors the implementation of the Mental Health Act in individual hospitals. As such, it is for the most part rigidly adhered to.

The interpretation of the meaning of sections of the Act is regularly redefined or modified by decisions in the courts, which act as precedents for future cases. An increasing number of cases are being decided by reference to the European Convention of Human Rights, which was incorporated into UK law by the Human Rights Act of 1998. The annotated version of the Mental Health Act, including notes on interpretation and case law, relevant rules and government circulars and the Code of Practice, now runs to 850 pages in small font (Jones, 2003).

Scope
The legislation concerns people with "mental disorder", and applies to any age. Mental disorder comprises four categories: "mental illness" (which is not further defined); "arrested or incomplete development of mind (mental impairment)", "psychopathic disorder' (in effect, personality disorder), and any other disorder or disability of mind". The definitions of "mental impairment" and of "psychopathic disorder" specify that there must be "abnormally aggressive or seriously irresponsible conduct" for the persons concerned to fall within the scope of the Act.

Specifically excluded from the scope of the Act are "immoral conduct, sexual deviancy or dependence on alcohol or drugs".

Provisions
The Act includes provisions for the transfer to hospital of remand prisoners for assessment or treatment. It also includes provisions for the transfer to hospital of serving prisoners who have become ill in gaol.

Treatment as a Sentence
The main treatment order, that dealt with under *section 37* of the Act, concerns those that have been found guilty of any criminal offence for which the law would potentially allow a custodial sentence. Being sent to hospital under this order constitutes a sentence of the court. It should be emphasised that this follows a finding of guilt, and that concepts of criminal responsibility are irrelevant, except in cases of homicide. For such an order to be imposed, the court must be satisfied, on the written or oral evidence of two medical practitioners (at least one must be a psychiatrist) that:

1) The person is suffering from a mental disorder “of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment”.
2) In the case of ‘psychopathic order’ (in effect, personality disorder) or mental impairment, that “such treatment is likely to alleviate or to prevent a deterioration of his condition.”
3) That this is the most suitable method of disposing of the case, given the nature of the offence and the record of the offender. (In other words, that community treatment or other disposal would not be preferable).
4) That, on the evidence of the psychiatrist who will be treating the patient or of any other representative of the hospital management, that the hospital in question agrees to treat the patient and will offer a bed within 28 days.

Compared with many other European jurisdictions, the criteria for hospital disposal can be seen as almost wholly medical in nature, although the legal terminology used to describe mental disorder does not coincide exactly with modern medical terminology. “A hospital order is not a punishment…. Questions of retribution or deterrence are immaterial. The sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation that the result will be to avoid the commission by the offender of further criminal acts” (v. Birch, 1989).

For most people put on such an order, their position becomes almost exactly the same as if they were a civil patient. The patient in effect passes out of the penal system and into the hospital system. The courts retain no powers of any kind. Leave and discharge are the decision of the treating psychiatrist and are not reviewed by any other authority. The psychiatrist may discharge the patient at any time, as may the managers of the hospital. The patient may only be detained for six months, unless the order is renewed by the treating psychiatrist. This can only be done if certain conditions, which resemble those which were satisfied when he was admitted, are fulfilled.

The court may also impose a 'guardianship order' under section 37, in cases where treatment in the community would be preferable. This requires the patient to live at a certain address and to attend appointments with a psychiatrist and social worker. It cannot enforce pharmacological treatment in the community.

Restrictions on Release

Where a person has been convicted of a serious offence, a Crown court has the power to add to a treatment order under section 37 a so-called 'restriction order' under section 41 of the Mental Health Act. This has the effect of removing from the treating psychiatrist the power to release the patient from hospital. Release is determined by the Interior Ministry, or by an independent Mental Health Review Tribunal. The decisions of the Tribunal are based on strictly defined legal criteria set out within the Mental Health Act. There is no concept of 'tariff', or the patient remaining in hospital for longer for more serious offences.

In order for the Court to impose a restriction order, it must be the judgement of the court that the imposition of the order is necessary "for the protection of the public from serious harm". This is therefore a provision based upon considerations of public safety. The decision to impose a restriction order is however not based on the gravity of the offence as such, but upon a judgement as to dangerousness and prognosis, based in part upon the defendant's previous record, both in terms of offending and in terms of co-operation with treatment. It remains possible (and indeed not unusual) both for patients to be released from hospital after a relatively short period, despite having committed a very serious offence; and also for patients to be kept in hospital for longer periods that they would have served, if they had been given a prison sentence. This is because discharge is determined principally by medical outcome.

The imposition of a restriction order also has two further consequences. Firstly, it deprives the psychiatrist of the power to give a patient leave in the community without the approval of the interior ministry. Secondly, it provides for the conditional discharge of patients. This means that patients have to comply with conditions imposed by the Mental Health Appeal Tribunal. Failure to comply may result in recall to hospital, if there is any deterioration in mental state. The most common conditions to be imposed are attendance at a psychiatric clinic and taking medication; keeping in contact with a social worker; and residing at a specific address. A conditional discharge from a restriction order is the nearest thing in the current mental health law to a form of compulsory treatment in the community. The necessity for such an aftercare provision in a given case is a common reason for a psychiatrist to recommend to a court that a restriction order be imposed.

Trial of treatment post conviction

Under section 38 of the Act, it is possible for a person to be sent to hospital for a trial of treatment. This is often used for those where the diagnosis is in doubt. It is also usual for the relatively few cases of personality disorder disposed of under the Act to undergo such a trial of treatment in order to decide whether or not a section 37 treatment order should be recommended.

Treatment before Trial

The most common form of transfer to hospital before trial in cases of violent offending is a Home Office transfer warrant under section 48 of the Mental Health Act. This is an order made by the Interior Ministry for transfer to hospital (there is no Ministry of Justice in the UK). It is based upon the recommendation of two doctors, one of whom must be the future treating physician or another psychiatrist from the relevant hospital.

It is possible for the Crown court to use powers under section 36 to transfer a person to hospital for treatment, the mechanism being not dissimilar to an order under section 37. In practice, this provision is rarely used, mainly because there is a twelve-week limit on the power and this is rarely long enough.

In less serious cases, where the court process will be completed rapidly, it is usual to move straight to trial. A section 37 hospital treatment order may then be imposed after conviction, based on psychiatric assessments made in the remand prison or in the cells at court.

Assessment before Trial

Most assessments of defendants will occur by psychiatrists visiting the defendant in prison. Many of these will lead to transfer to hospital for treatment before trial. It is possible for a court to remand a

person to hospital for reports under section 35 of the Act. The only advantage to this provision is that it only requires the recommendation of the treating psychiatrist, or someone acting on his behalf. The disadvantages are that the order does not allow compulsory treatment, and that a bed has to be provided within seven days of the order being made, a difficult task when there is a shortage of beds. For these reasons, the order is little used.

Other Modes of Compulsory Treatment
Defendants can also be sent to hospital for treatment, either pre-trial or post-trail, under the civil provisions of the Mental Health Act. A system of so-called psychiatric 'diversion schemes' has been set up in the last 15 years at magistrates' courts in England & Wales. This involves psychiatrists and psychiatric social workers examining defendants in the cells at court, and making recommendations for civil or forensic orders, in order that the person can be admitted directly to hospital without any delay (James et al, 2002).

Transfer to Hospital of Sentenced Prisoners for Treatment
Prisoners serving a sentence can be transferred to psychiatric hospital for treatment under an Interior Ministry warrant under section 47 of the Mental Health Act. This requires the recommendations of two doctors, one of whom must be a psychiatrist from the treating facility. The circumstances for such transfer are similar to those for compulsory hospital admission from the community. After successful treatment, the patient/prisoner can be returned to prison to continue with their sentence. In practice, such a return is often counter-productive, and many patients will instead stay in hospital until such time as their earliest date of release from their sentence is reached.

Criminal Procedure (Insanity and Unfitness to Plead) Act 1991
This Act incorporates provisions that can be used for cases where a person is unfit to plead or where a person fulfils the antiquated criteria for a verdict of not guilty by reason of insanity.

Fitness to Plead
Opinion as to fitness to plead is provided by medical practitioners, but the criteria upon which fitness is decided are legal ones, based largely upon case law and not defined by legislation (James et al., 2001). With distant origins in medieval concerns about muteness, and shaped by defining nineteenth century judgements along lines of intellectual capacity and comprehension, the criteria are now principally applied to mental illness, the largest category in unfit findings. Variously set out in expanded or condensed form by different authorities, the criteria concern a series of capacities and comprise the following. Does the person understand the nature of the charge? Does he understand the meaning of entering a plea? Does he understand the consequences of his plea? Is he able adequately to instruct his solicitors? Can he understand the details of the evidence? Can he follow the proceedings of the trial so as to make a proper defence, for instance challenge a juror? Legally, only one of these questions need be answered in the negative for a finding of unfitness to be made.

The procedure for dealing with fitness to plead under the Criminal Procedure Act 1991 involves a complicated process, with the empanelment of two juries in a Crown Court, one to make a decision as to fitness to plead, after hearing medical evidence, and the other to decide on a 'trial of the facts' (in other words whether, under the balance of probabilities, the defendant did the act leading to the charge), where the defendant is deemed unfit. This procedure is rarely resorted to. It has few benefits. The disposals available to the court after a finding of unfitness are similar to those available to the court after a finding of guilt. And a person deemed unfit may be returned to court for trial, should they later become fit with treatment, although there is no obligation to return them to trial. In practice, use of the Criminal Procedure Act for cases of unfitness is avoided where possible. Unfit defendants are treated in prison pre-trial under the Mental Health Act, so avoiding all the complications mentioned above.

Not Guilty by Reason of Insanity
In practical terms, the existence of an insanity verdict is something of an irrelevance and only a few such findings are made each year. The disposals available to the court after an insanity finding are virtually the same as those that are available if the person pleads or is found guilty of the offence with which he is charged. The only benefit from going down the insanity route, therefore, is to avoid a

conviction being recorded on the individual's criminal record. It is simply not necessary in facilitating hospital disposal.

In order to qualify for an insanity defence, it has to be proved that "at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know what he was doing was wrong." These Victorian legal terms have little to do with modern clinical reality. In any case, they are so restrictive that many floridly psychotic individuals would not fall within them.

Homicide

There is only one sentence that can be imposed for the sentence of murder, and that is life imprisonment. This was introduced for political reasons upon the abolition of capital punishment, and appears to many an illogicality, as it does not allow the sentence to reflect the circumstances of the crime. It also presents difficulties, should someone who is mentally ill be found guilty of murder, as it does not permit a disposal direct to hospital, necessitating instead the complexity of transfer to hospital as a convicted prisoner.

Where someone who is mentally ill is accused of murder, there is usually a defence available of diminished responsibility available to them under section 2 of the Homicide Act 1957. This reduces the category of crime from murder to manslaughter. On conviction for manslaughter, the judge can impose a wide variety of sentences, including hospital disposal under the Mental Health Act. This defence applies, in the words of the Homicide Act, "if he was suffering from such an abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent cause or induced by disease or injury) as substantially impaired his mental responsibility for his acts." This is decided by a jury. The terms in the Act are legal ones, rather than medical. Their scope is potentially very wide, and successful diminished pleas have occurred in cases of relatively minor abnormalities, including pre-menstrual tension.

The provisions of section 2 of the Homicide Act were relevant when the sentence for murder was death, in that they provided an easier means than the insanity defence of avoiding sentencing the mentally ill to death. The provisions would not now be necessary at all if the mandatory life sentence for murder were abolished. This seems unlikely to happen because of base political considerations. The problem with the Act remains that the concept of diminished responsibility is a legal one. Although decided by a jury, it entails psychiatrists giving their opinion on matters of responsibility, which most would see as inappropriate.

The Infanticide Act of 1922

This is of relevance only in cases where women kill their children in the first year of life. It is a historical curiosity from the days when capital punishment still existed. If a woman "causes the death of her child under the age of twelve months, but at the time of the act…the balance of her mind was disturbed by reason of not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent on the birth", a finding of infanticide will be made. The law is used in a handful of cases each year. The commonest sentence is a probation order.

Proposed Changes to Mental Health Law

The government is proposing the introduction of a new Mental Health Bill, which would make major changes to the provisions for civil detention. Its aim is to allow compulsory treatment orders to apply both in the community and in hospital. The Bill was drawn up without any form of meaningful consultation with the medical profession. The proposals have been heavily criticised by the psychiatrists' professional body, by civil liberties groups and by mental health charities. The introduction of the bill has now been delayed.

The Bill, in its current form, would affect the treatment of mentally disordered offenders less radically than civil patients. However, there are important changes proposed. There are changes to the definition of mental disorder. There would be no exclusions, so allowing the detention of people for alcohol or drug addiction. The stipulation that treatment must be of benefit is removed for those with personality disorders and mental impairment. This would potentially lead to the detention of

untreatable people with personality disorder, and the indefinite incarceration of people with no mental illness simply to prevent offending. In addition, the Bill would allow those placed on community treatment orders in the community and then incarcerated in prison, to continue to be treated compulsorily after being placed in prison. In the view of most psychiatrists, this would be unethical, as coercive treatment and punishment should not become mixed. The standard of prison medical services is currently very poor, and compulsory treatment in prison is not currently permitted. Any change to this, apart from the ethical considerations, would probably be impractical and unworkable. It is anticipated that the government may make substantial changes to its bill before it is introduced to parliament.

Provision for Mentally Disordered People in the Health Care System

The United Kingdom has a National Health Service which is entirely free at the point of delivery. No payments of any kind are made by patients. All provision for the treatment of mentally disordered offenders has been within National Health Service hospitals or in private hospitals, paid for by the National Health Service.

There are three principal tiers of security within inpatient psychiatric provision in the Health Service. All will take both patients detained under civil orders and those detained under forensic orders. The patients are mixed within the hospitals and within individual wards in the hospitals.

1) The first tier is the *general psychiatric hospital*. These facilities used to be located in large asyla, many of them originating in the nineteenth century. Most have now been replaced by small local psychiatric units, often attached to general hospitals. These units will have both open wards and wards where the door is locked ('local secure wards'). Minor offenders will be admitted to general psychiatry wards. More serious offenders are likely to be moved back to general hospitals after periods spent in more secure facilities. It is not possible to calculate how many beds are occupied in such facilities by people originally admitted from the criminal justice system.

2) The third level of secure care is the *high security hospital*. There are three such hospitals, of which the best known, Broadmoor, was opened in 1863. These hospitals have both internal security and perimeter walls. In order to gain admission to these hospitals, patients have to pose a grave and immediate danger to the general public. This is a very high standard to meet, and would not include most homicide cases. The numbers in these hospitals are now being reduced and there are currently around 1,200 patients remaining. It is no longer thought appropriate to detain women in such facilities. The average length of stay in such facilities is seven to eight years.

3) Until the 1980s, there were no facilities other than the general hospitals and the high security hospitals. Since that time, an intermediate tier of facilities has gradually been built. These are known as *medium secure* facilities. Whilst they have good staffing levels and internal locks and limits on movement, they do not have any walls or perimeter security. To this sort of unit will be admitted most cases of homicide or serious wounding. The units will also take patients on civil orders whose behaviour is so disturbed that they cannot be contained in general psychiatry wards. There are around 2,000 medium secure beds in England and Wales, which is an insufficient number. A building programme is underway, hampered by a shortage of fully-trained forensic psychiatrists. There are said to be an equivalent number of medium secure beds in the private sector, which contain patients being paid for directly by the National Health Service. Whilst many contain longer-term forensic cases, there is a greater representation of civil cases, reflecting the shortage of low secure beds (in particular, long-term low secure beds) in general psychiatric units. In most medium secure units, the average length of stay is two to three years. Longer-term units are now being built for patients whose illnesses are refractory to treatment.

Medium secure units differ from general psychiatry units by being better-appointed in terms of buildings and facilities, and far better staffed. The maximum recommended number of patients for any consultant (senior psychiatrist) is between twelve and fourteen. Each consultant works with a team including a psychologist, a social worker, an occupational therapist and one or two junior doctors.

Medium secure and high secure units are staffed by forensic psychiatrists. Forensic psychiatry is a high-status sub-speciality. In order to become a forensic psychiatrist, doctors must first qualify in

basic psychiatry. This takes a minimum of three to four years, and involves passing two sets of examinations. Thereafter, would-be forensic psychiatrists need to spend a minimum of three years in specialist forensic psychiatry training rotations, before they are qualified to apply for substantive posts. There are currently approximately 200 consultant forensic psychiatrists in the country. The number thirty years ago was six. There is a projected need for 460 by the end of 2006, which it is unlikely that it will be possible to meet.

Each area has a tertiary forensic psychiatry service, usually based in a medium secure unit. This will usually provide a range of other services: consultant sessions in local prisons; specialist aftercare teams which aid in reintroducing patients to general psychiatric community care; diversion schemes in magistrates' courts and/or police stations; and an assessment service to local hospitals and to distant prisons. The psychiatrists will also provide psychiatric reports to courts on all cases domiciled in the area for which they are responsible.

There is a nationwide lack of inpatient forensic beds for adolescents. At present, most adolescents are treated by default on adult wards. This inappropriateness of this situation has been recognised and there are plans to built adolescent forensic facilities, when sufficient funds become available.

Until recently, all wards except in high security hospitals, have been mixed in terms of gender. There are now moves to provide some female only facilities, especially for acutely ill patients. The development of specialist forensic facilities for women is envisaged. However, such developments will be limited by their disproportionate cost, and the difficulty in finding staff who wish to work in them.

The government is in the process of introducing a new initiative for the treatment of people with personality disorder. Currently, very few such people are admitted to general hospitals or to medium secure units from the courts. Some cases are admitted to high security beds. The law restricts the treatment of people with personality disorders to those who psychiatrists deem treatable. These are few in number. The government is now introducing experimental assessment and treatment centres for people with personality disorders. Most of these are in prisons, and are the province of psychologists, not psychiatrists. There is also a new unit being developed in a high security hospital. Many psychiatrists are suspicious of these developments and do not view the inpatient treatment of those with primary personality disorders as the role of medicine. There are also concerns that the government, with the legal changes proposed in its Mental Health Bill, will try to use mental health legislation to accomplish the indefinite preventive incarceration of people with no mental illness who have committed no offence and who are not amenable to any form of medical treatment.

The System in Practice

Admission to hospital

The pathways from the criminal justice system into psychiatric care are illustrated in the accompanying flow diagramme. They are as follows:

1) If a policeman finds someone in a public place and they deem them to be "in need of care or control", he may take them to a psychiatric hospital where they may be detained for upto 72 hours to allow them to be assessed for detention under the civil sections of the Mental Health Act. This applies whether or not the person has committed a criminal offence.

2) A person arrested by the police may be examined by a psychiatrist at the police station and admitted to hospital under a civil order or on a voluntary basis. In such cases, the person is given police bail. The police may chose to continue with criminal charges, if this is thought to be in the public interest.

3) A person who is arrested and held in custody by the police, must be brought before a magistrates' court within 24 hours. Where there is a psychiatric diversion scheme at the court, it may be possible to divert the person to hospital for assessment or treatment under the civil or the forensic provisions

of the Mental Health Act. This can occur whilst the case still continues: the person will be bailed to hospital. Or the case can speedily be dealt with, and transfer to hospital can be as a sentence after a finding of guilt.

4) An accused person may be remanded in custody by the magistrates' court and sent to a remand prison. If the person appears ill, the court may ask for a psychiatric report. If the person appears ill at reception into the prison, the Prison Health Service is likely to offer a voluntary report to the court. Where the prison doctor thinks that a person may need hospital treatment, a consultant general psychiatrist from the hospital responsible for the prisoner's domicile will be asked to come to the prison, examine the prisoner and give a report. If that consultant believes that the person needs a higher level of security than he can provide, the case will be passed on to the forensic consultant responsible for the domicile in question. The psychiatrists can quickly arrange the transfer of some one to hospital by:

- using a Home Office transfer warrant under section 48,
- inviting the court to make the appropriate pre-sentence order or to sentence the person to hospital after a finding of guilt.

There are three important points to note:

i) The report has to be provided by the psychiatrist who will be treating the person in hospital (or by one of his colleagues from the same hospital).

ii) The courts are usually delighted to be able to send someone to a psychiatric hospital. The opinions of the psychiatrists in terms of Mental Health Act orders are not questioned or contested.

iii) Delays in admission to hospital are common, owing to a shortage of beds. People may have to wait in the remand prison until a bed in the health service hospital becomes available.

5) Where the case involves a serious offence, it will be sent to the Crown Court for trial or sentence. The same range of possibilities exists as in 4) above. In addition, the Crown Court can impose a restriction order under section 41 of the Mental Health Act. It can also hear fitness to plead cases, and insanity defences. In contrast to the situation with Mental Health Act disposals, the Crown Prosecution Service and/or the Court may order independent psychiatric reports from forensic psychiatrists, who need not be working in the hospital responsible for the domicile of the patient. Contested cases may arise, with psychiatrists giving contradictory evidence. The same may occur with defences of diminished responsibility in murder cases. If the experts all agree, then the matter tends to be processed quickly and without undue delay.

6) Sentenced prisoners who develop psychiatric illnesses will be transferred to local general or forensic psychiatric hospitals using Home Office transfer warrants under section 47 of the Act. The process involves the psychiatrist from the treating hospital and is unproblematic apart from problems with bed shortages.

Once the person is sentenced to hospital following a finding of guilt, a finding of unfit to plead or an insanity verdict, the court has no further role in the case and it passes into the control of the health service. As state above, the patient's position becomes virtually the same as that of a civilly detained patient, unless the court has imposed an additional restriction order.

When a person no longer needs the level of security at which they have been detained, they will be passed down the chain, for instance from high security to medium security or from medium security to a general psychiatry ward. Movement from one level to another is based upon clinical need. Most patients admitted to forensic facilities through the courts will eventually be looked after in the community by the general psychiatrists responsible for the area of their domicile.

Leave Arrangements
The psychiatrist responsible for the patient's treatment has the power to allow leave into the hospital grounds or into the community, unless the patient is subject to a restriction order. In the latter case, the psychiatrist may allow the patient into the hospital grounds, but needs the permission of the Home Office to allow the patient out into the community. It is standard practice for patients to be allowed escorted community leave, followed by unescorted community leave, as their condition improves.

Alcohol and Drugs
Addiction to alcohol or drugs is an exclusion criterion from the provisions of the Mental Health Act. These conditions cannot therefore be treated compulsorily. Addicted prisoners will be detoxified on admission to prison. There will be limited voluntary participation in group work concerning addiction whilst they serve their sentence in prison.

Sex Offenders
Disorders of sexual preference or behaviour are excluded from the Mental Health Act. Most sex offenders who are not suffering from mental illnesses will be given prison sentences. A very small number, who have treatable personality disorders, will be admitted to high security hospitals. In prisons, sex offenders may choose to attend sex offender treatment programmes, led mainly by probation officers and prison psychologists.

Patients' Rights Issues
Patients' rights are relatively well protected in England & Wales.

Compulsory Treatment
All compulsory orders, except for one assessment order, permit treatment as well as detention. Exceptions are for ECT, where either consent or permission from an independent "second opinion" psychiatrist is required: and for psychosurgery and the surgical implantation of hormones, for which both consent and a second opinion are required. In addition, in all people involuntarily detained, after compulsory treatment has been administered for three months, a second opinion as regards the desirability of treatment must be obtained before it is continued, unless the patient consents to treatment.

Appeal Procedures
Patients may appeal against detention either to the hospital managers or to an independently constituted Mental Health Review Tribunal. The latter will include an independent psychiatrist who will examine the patient. Both bodies will receive written reports from the treating psychiatrist and social worker (who are unlikely to be the same as those involved in the original detention). The appeal bodies may also hear evidence from these professionals and from the patient, whose case is usually put by a legal representative. The cost of the latter is met by the State. Both appeal bodies have the power to discharge the patient from hospital.

Extension of Treatment Orders
Treatment orders last for six months, and can be extended for a further six months, and then annually. Extension of a treatment order is decided upon by the treating psychiatrist, who must examine the patient and determine that the preconditions for compulsory treatment still apply. The continuation of detention is then examined by the hospital managers at a review meeting, at which the patient and a legal representative may be present, if the patient so desires.

Independent Supervision of the Act
An independent Mental Health Act Commission is charged with the duty of reviewing the use of compulsory powers within the Mental Health Act, of investigating complaints, and of inspecting

facilities which patients are compulsorily detained. A system of regular inspection of facilities and of compulsory detention records is in place. Such inspection is searching, and includes the practice of unannounced visits, some being at night. Other than reviewing the use of the Act, the Commission reviews the conditions in which patients are detained, and compliance with the guidance given in the Code of Practice. Their duties extend to the inspection of seclusion policies and records, and of practices concerning other aspects of practices impinging on patients' rights, such as search policies, the withholding of mail, and restrictions on visitors. Their reports on individual hospitals are made available to relevant agencies, and progress in addressing criticisms of practice is reviewed upon subsequent visits.

Epidemiology

It is not possible to provide exact figures as to the number of people admitted to psychiatric hospital from the courts each year. Provision of figures is hampered by some being provided for England alone and some for England & Wales. Some are published for calendar years and some for the financial year. In addition, the presence of psychiatric diversion schemes has led to patients being admitted from the courts under civil sections. Whilst the number of these may be substantial, there is no way of differentiating civil orders made at courts from civil orders made at any other location.

An additional problem is that patients are often admitted under pre-trial orders and then transferred to post-conviction orders. It is difficult to track the changes in order, and there is a danger of double-counting. It is also unlikely that the figures gathered for non-restricted cases are particularly accurate. There are important inconsistencies between figures gathered by different agencies.

In 2002-03, 5% of all compulsory admissions to hospital in England were from courts and prisons. This was a decrease from the figure of 9% ten years earlier. These figures include pre-trial transfers to hospital. During this period, the overall number of compulsory admissions rose by 20%. (Department of Health, 2003).

In 2002, 657 people were admitted under unrestricted section 37 treatment orders in England & Wales. 204 were admitted with restricted section 37 orders. There were nine restricted admissions after findings of not guilty by reason of insanity. There are therefore probably around 1,000 hospital disposals under the forensic provisions of the Mental Health Act in England & Wales each year. There do not appear to be major changes in numbers from year to year.

At 31st December 2002, there were 2,989 people currently detained in hospital under various forms of restriction order, including sentenced prisoners, pre-trial prisoners and those found unfit to plead or not guilty by reason of insanity. Of these, 1,939 were detained under a section 37 treatment order (sentenced to treatment after a finding of guilt). Of the 2,989, 13% were detained solely under the category of personality disorder. Figures for new admissions show smaller proportions of people with personality disorders, as bed occupancy figures are distorted by their longer length of stay. In 2001, 4% of all restricted admissions had a primary diagnosis of personality disorder. The proportion of unrestricted patients with a primary diagnosis of personality disorder is much smaller.

Current Problems

Bed Shortages

There is a chronic shortage of psychiatric beds, particularly in general psychiatry and medium security. The greatest shortfall is in low secure beds (particularly longer term beds) and in medium secure beds (particularly longer term placements). The system must be seen as a hydraulic one, and pressure at one point in the system will be felt at another. As the numbers of high security beds contracts, the level of offending to achieve admission to medium secure beds increases. This then has a knock-down effect on the level of offending amongst those admitted to general psychiatry beds from the courts. Improved services to prisons result in the identification of greater numbers of people in need of transfer to the health service, and this further increases pressure.

Shortages of Forensic Psychiatrists

The rapid expansion of new forensic psychiatric facilities is hampered by an inability to produce sufficient fully-trained forensic psychiatrists to run the facilities in question. The system of junior doctor training is also insufficiently flexible to allow the numbers of junior medical staff to expand to keep pace with the expansion in bed numbers.

Difficulties at the General-Forensic Interface

The shortage of low secure beds in general psychiatric hospitals is resulting in general psychiatrists placing unrealistic expectations on the forensic services about which patients they will agree to take. This results in friction. The better staffed and better equipped forensic services arouse the envy of the general services. There is beginning to be a consensus that forensic services have expanded far enough and that general services should receive more money. The idea is that many forensic cases represent failures in civil care through service shortage. If these were corrected, then many patients might not come before the courts.

Expanding Prisoner Numbers

Retributive legislation, based on the US model, which has been introduced over the past thirteen years by the current government and its predecessor, has resulted in the near doubling of the prison population. The UK now has the highest number of prisoners per capita of population in the European Union. The government is now beginning to realise that this position is unsustainable. However, it continues to cause problems in terms of services to prisons, given the poor state of prison health care.

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Fig. 18 Judicial and Placement Procedures for Mentally Ill Offenders in England & Wales

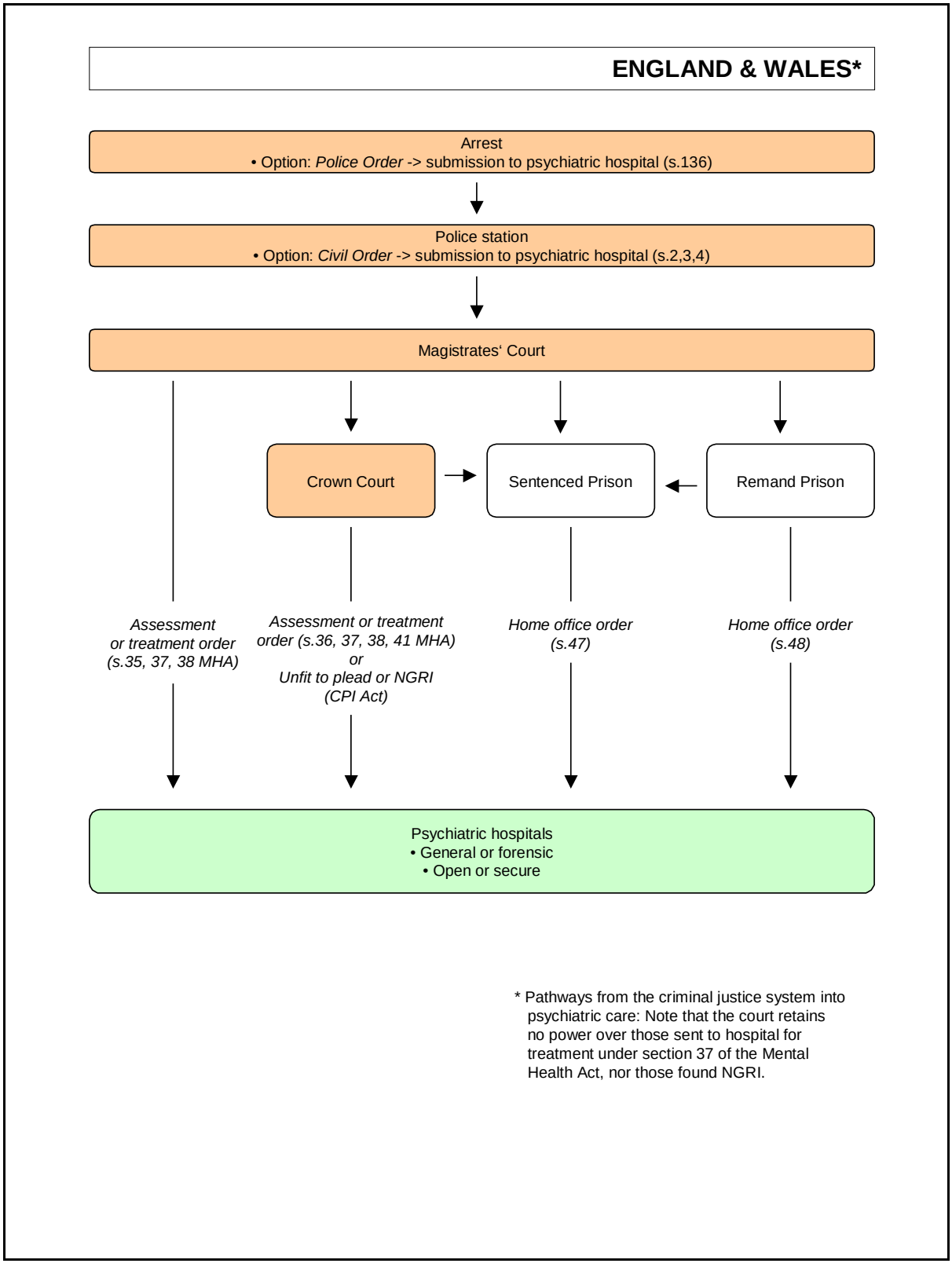


Fig. 19 Forensic Service Provision in England & Wales

ENGLAND & WALES: Forensic Service Provision

The service provision for mentally ill offenders in England & Wales, which is highly developed compared with other member states, provides three tiers of security within inpatient psychiatric provision (high security hospitals, medium secure facilities and placements in general psychiatric hospitals , the latter comprising both open and secure wards). Specialised forensic services run the medium secure and high secure facilities, and provide close liaison with general facilities. All will take both patients detained under civil orders and under forensic orders. The security needs of the patient determine placement, rather than criminological factors. Civil orders comprise a small minority in forensic units. The framework used for describing forensic service provision in the other Member States does not equate with UK developments, but has kept here for reasons of comparability. The system in the UK is pragmatic and focused on illness needs, and it should be noted that hospital disposal as a sentence is standard for those found guilty, but suffering from mental illness. Disposal is not fettered by abstract concepts of criminal responsibility, which survive through historical accident only in cases of homicide. This concept is therefore ommitted in the following description.

	GENERAL PSYCHIATRIC HOSPITALS	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	- unspecified capacities in general psychiatric hospitals or departments in open or closed wards for mentally ill offenders number of beds used unknown Unlimited capacity	**3 High Security Hospitals** - Broadmoor - Ashworth - Rampton approx. 1,200 beds in total for male & female patients average length of stay 7-8 years, reduction in numbers projected Mainly mental illness, some personality disorders are treated in high security hospitals **Medium Secure Facilities** approx 40 facilities, approx. 2000 beds in total average length of stay 2-3 years	No forensic placement of mentally ill offenders in prisons No compulsory treatment allowed in prisons All mentally ill must be transferred to health service placements Sex offenders and offenders suffering from addiction disorders may be given prison sentences due to being not covered by Mental Health Act. Treatment programmes in prison exist for inmates suffering from these disorders
clientele	Clientele: - minor offenders - more serious offenders after periods spent in more secure facilities	Clientele: - mentally ill offenders under forensic orders - patients under civil orders - few cases of personality disorders or sex offenders	

Finland

Riittakerttu Kaltiala-Heino

Legislation

Finnish legislation concerning mentally ill offenders, as well as legislation in general, is national. The Mental Health Act regulates the assessment of offenders assumed to be mentally ill and the treatment of offenders who are mentally ill. Criminal law states the need to assess criminal responsibility by defining certain conditions for lessened criminal responsibility or the lack thereof.

Criminal law (Rikoslaki 1889/39, 3, 4§, 13.6.2003/515) defines general criminal responsibility from the age of 15 years on. Offenders younger than that do not enter court processes. Secondly, the offender who has turned 15 at the time of the criminal act also has to possess criminal responsibility with regard to his /her ability to understand the nature of her/his offence, or its unlawfulness, and the capacity to control her/his behaviour. The law states that an offender can not be held criminally responsible if at the time of the act s/he is not able to comprehend the nature of the act, or to control her/his behaviour, due to mental illness, mental retardation, or severe mental disorder. An offender who is seen as not criminally responsible for a given crime will not be sentenced for that crime. It is possible that an offender might bear full criminal responsibility for one crime but lack understanding regarding another, and thus will be sentenced for one but not be sentenced for the other act. The law also acknowledges the possibility that an offender may be less criminally responsible for an act but not lack complete criminal responsibility. In case of lessened criminal responsibility, the offender will receive a lesser sentence. A state of intoxication, or a similar condition that the offender her/himself has caused, does not lessen criminal responsibility.

If the court does not sentence an offender who is judged to have acted without understanding and with a lack of criminal responsibility, the court has to consider whether the person is in need for involuntary psychiatric care. The decision on this matter is requested from the Authority for Medicolegal Affairs (TEO). Involuntary psychiatric hospitalisation is regulated in the Mental Health Act.
In order to find out whether an offender is mentally ill and perhaps has acted without understanding and may not have criminal responsibility regarding a given crime, the court can request a Forensic Psychiatric Assessment (FPA) from the Authority for Medico-Legal Affairs (TEO). The possibility to order FPA is stipulated in legislation regulating court processes (Oikeudenkäymiskaari 17, 45§). The right to request FPA is given only to the court.

The Mental Health Act regulates the involuntary treatment of the mentally ill. Independent of her/his will a person can be taken into psychiatric treatment if s/he is a) mentally ill, and b) due to her/his mental illness in need of treatment because failure to provide treatment would result in deterioration of her/his mental health, or in harm to her/himself, or in harm to others, and c) no other treatment options are adequate. (Of the three different criteria in paragraph b, 1-3 must be fulfilled). While the Mental Health Act does not further define mental illness, the background material defines that mental illness refers to psychotic conditions, independent of aetiology. Finnish legislation and practice strongly emphasize the need for treatment and the best interests of the patient. In civil commitments, dangerousness to others (harm to others, as it is defined in Finnish law) is hardly ever used as the sole criterion for committing a mentally ill person. In addition to civil commitment, the Mental Health Act regulates FPAs and involuntary treatment of mentally ill offenders who have been given treatment order by TEO.

Forensic Psychiatric Assessments are carried out to assess whether at the time of the crime an offender was mentally ill in such a way that her/his criminal responsibility must be considered lacking or lessened. The essence is the criminal responsibility: Mental illness or a mental disorder not alone is not sufficient for concluding a lack of criminal responsibility (and altering the consequences); rather it must be concluded that the mental state stood in causal relationship to the crime. In assessing criminal responsibility, the expert must consider the extent to which the person was able to understand the factual and legal-moral nature of her/his act, and the extent to which s/he was able to control her/his behaviour. The expert must also consider whether the offender understood the consequences of her/his act for the victim and her/himself, and whether s/he, *at the time of the crime*, could control her/his actions. In addition, it must be stated whether the offender is *now* (at the end of the FPA) in need of involuntary treatment (fulfils the commitment criteria), and whether she/he can be heard at the trial.

The Mental Health Act was passed in 1991. Since then it has undergone minor changes, mainly concerning changes in some decisive bodies, the names of which have consequently been changed in the text of the law, and in 2002, a more major change to clarify the criteria pertaining to the use of coercion during psychiatric inpatient treatment. However, the principles of involuntary treatment and the FPA have not changed.

Assessment of "danger to the public" in Finnish legislation is implicitly incorporated into the Mental Health Act, since one of the commitment criteria is the risk of harm to others (see above). There is no further definition at the legislative level of how the risk should be assessed. The concept of "danger to the public" is not explicitly used, nor does the legislation explicitly mention risk assessment, to say nothing of requiring specific risk assessment protocols. Involuntary treatment after FPA is regulated by the same legislation that regulates civil commitment, with only some exceptions with regard to reassessment intervals and to the decision-making about termination of treatment. In civil commitment, involuntary treatment decisions are reassessed at three months after commitment, followed by a second reassessment six months after the first one. If involuntary treatment is considered necessary beyond nine months, an external assessment is required. The second decision (at three months after the first detainment) is subjected to confirmation by administrative court.
In the involuntary treatment of mentally ill offenders for whom the Authority of Medico-Legal Affairs (TEO) has issued an order for involuntary treatment, the reassessments take place every six months and are always made by the medical experts at the hospital of treatment. Like in civil commitment, the decisions are subject to confirmation by an administrative court. While normally it is medical doctors who decide about termination of treatment, in the case of criminal patients, for whom the Authority for Medico-Legal Affairs (TEO) has issued a treatment order after the FPA, the final decision is made by the TEO.

The topic of mentally ill offenders has not been very intensively discussed in Finland in recent years, nor has involuntary treatment in general been the target of public attention. The discussions that have been going on have not focused on either FPA or the subsequent involuntary treatment. A relevant major discussion and forthcoming change to the law that must be mentioned here is the planned option of psychiatric treatment rather than a penalty in legislation (penal law) concerning crimes carried out as young person (15- 21 years). This would apply to lesser crimes than those that may result in FPA, and presumably adolescents coming to treatment through this route would not classify as “mentally ill offenders”. However, this also illustrates the treatment-oriented philosophy in Finnish legislation concerning norm-breaking behaviour. (Otherwise, after serious crimes such as homicide, adolescent offenders can be assessed with regard to their criminal responsibility in a process similar to that for adult offenders.) Another current issue is that with the modernisation of criminal law, relating a lack of criminal responsibility to "an act committed in state of lunacy, or in lack of understanding because of senility or alike conditions", dating back to the late 1800s, has been changed to describing as a condition for the lack of criminal responsibility the offender's inability to comprehend the nature of the act, or to control her/his behaviour, due to "mental illness, mental retardation, or *severe mental disorder*". This requires a review as to how to interpret "severe mental disorder" as basis for lack of criminal responsibility, since in the Mental

Health Act, the basic criterion for commitment is "mental illness", a narrower concept. The Parliament has set the requirement that the government ensure that Criminal Law and the Mental Health Act fit, so that an option of involuntary treatment is available with regard to those who lack criminal responsibility and thus would not be sentenced, particularly if the offender poses a danger to others. Prompted by this and some other developments and needs in mental health care, the Mental Health Act will possibly be modified, but it is yet too early to predict the outcome of this process. A committee led by the Ministry of Health and Welfare is working on the topic.

Procedures

When a crime becomes known to police, they start primary police investigations. If the crime was serious and it is considered important for safety or for the investigations, the police can detain the suspect(s) or imprison them for the duration of the investigation. The police can decide upon short detainment, while the court orders any longer periods of imprisonment before the final trial. If in this phase it is already obvious that the person suspected is mentally ill, she/he can be committed to a mental hospital according to the civil commitment rules, where she/he, their health providing, would be heard, and from which s/he could come to court trials.

Following conclusion of the police investigations, the prosecutor decides whether or not to prosecute. If a decision is made to prosecute, the case comes before the court. Criminal issues are primarily dealt with by the lower courts (käräjäoikeus). Verdicts by lower courts can be appealed to intermediate courts (hovioikeus), and further to the highest court. If the prosecutor does not prosecute, victim can take the case to the court on their own initiative. The same structure of court responsibility pertains.

If the crime is a serious one, such as a serious violent crime, homicide, a serious sexual crime or the like, the court can order an FPA to determine whether the offender’s criminal responsibility is lessened or lacking. The TEO is responsible for this assessment, which can also be made only on the basis of documents. However, such decisions are rare; usually the TEO chooses the facility where the FPA is carried out as the period of inpatient assessment. The FPA are carried out in the two state hospitals, which are the forensic psychiatric hospitals serving the entire country, and in six other facilities which include the forensic psychiatric wards at certain hospitals, and a prison psychiatric ward. The assessment must be completed within two months of its beginning, although an extension can be requested and granted if there is good reason for that. At the end of the FPA, the expert(s) carrying out the assessment submit a written report to the TEO that concludes the criminal responsibility of the offender, her/his need for involuntary psychiatric treatment, and whether s/he can be heard in court.

The person can not be heard if s/he is unable to attend (a very serious somatic illness), or if going to court would seriously endanger her/his health and safety (a seriously suicidal patient, whose safety could not be guaranteed if the patient were to be taken out of the ward; psychosis alone, on the other hand, is not an absolute obstacle, even though the offender’s court hearing might then not be meaningful.).

The TEO board evaluates the expert FPA and formulates its conclusions for the court. The court decides whether the offender acted in full criminal responsibility, had a lessened criminal responsibility, or completely lacked criminal responsibility. If the court concludes that the offender lacked criminal responsibility, it can ask the TEO to assess the need for involuntary psychiatric treatment. While the decision about involuntary treatment is in process, the court may order that pending the decision the offender be placed in prison. The TEO issues an order for the involuntary treatment of an offender who is currently in need of psychiatric treatment.

There are more decisions stating the lack of criminal responsibility than decisions mandating involuntary treatment. If a person is concluded to have lacked criminal responsibility, she/he will not sentenced to a penalty. If a person is concluded to have had full criminal responsibility for the crime but is now mentally ill and in need of treatment, the penalty may not be actualized but the person will be committed. If the person is mentally handicapped and in need of involuntary care for the

mentally handicapped (Act on Special Care for The Mentally Handicapped), an order for her/his treatment under the relevant legislation is issued.

In obvious cases and regarding lesser crimes, the court may decide upon the lack of criminal responsibility of a mentally ill offender without commissioning a formal FPA. In practice, it is very likely that in such a situation the offender will already have been civilly committed before the trial.

A mentally ill offender for whom a treatment order has been issued will be reassessed at six month intervals to determine whether the criteria for involuntary psychiatric treatment continue to be present. This assessment is carried out by the psychiatrists at the facility of treatment and. focuses on defining whether or not the commitment criteria given in the Mental Health Act (see above) are still fulfilled. Although one of the commitment criteria is the risk of harm to others that the patient would pose without involuntary treatment, the legislation does not otherwise define how such dangerousness should be assessed. The decision made in the reassessment process is subjected to confirmation in administrative court. The patient can appeal the decisions to continue treatment.

The Mental Health Act also defines a possibility for the conditional release of forensic patients for whom a treatment order after FPA has been issued. In order to further confirm that her/his mental health is stable enough to allow final discharge, or to test whether her/his necessary psychiatric treatment in the community indeed is feasible, such a patient can be discharged for a maximum period of six months at a time into the supervision of the specialist level psychiatric unit serving the area where the patient permanently resides.

Practice

The Finnish process for the FPA of offenders suspected to be mentally ill is rather heavy, but the TEO has expressed its satisfaction with the results as to the reliability and validity of the process. The judges have in a recent survey also expressed their satisfaction with the FPA-practices and the written reports they receive for trials.

Over the past decade, the court practices have changed slightly so that the annual number of FPA ordered has somewhat decreased, and further, the courts tend to conclude less lack of criminal responsibility and less lessened criminal responsibility. This has inspired discussions (mainly within the psychiatric profession) as to whether more mentally ill persons now enter the prison system; indeed some research has suggested that there now might be more mentally disordered prisoners than there were earlier. However, most of the disorders detected in prison populations are not psychotic disorders, and the available studies failed to satisfactorily show that the problem would be that greater numbers of offenders who were mentally ill to begin with would be entering prison. Rather, it seems that mental disorders related to substance use and conditions induced by acute detoxification are increasing particularly in the prisons. The psychiatrists emphasize the importance of detecting those mentally ill offenders who should not be sentenced to prison but who should be treated. Less concern is expressed about the possibility that the FPA might produce “false positives”, meaning that persons who are not really mentally ill would not be sentenced but would enter involuntary treatment. This has not been a significant problem in practice, even if it is, of course, a theoretical although unlikely possibility.

The issue of carrying out structured assessments of the risk of violence has been raised by the psychiatric profession, and forensic psychiatric facilities are increasingly using structured risk assessments such as HCR-20 and PCL, although neither the law nor the guidelines for FPA require them to do so. Risk assessments are especially utilized towards the end of the involuntary treatment to help clarify whether and how a person can be discharged from the hospital.

The practice of conditional release after forensic psychiatric inpatient treatment was not initially incorporated into the 1991 Mental Health Act, but added later in 1997. Civil psychiatry does not foresee any kind of compulsory outpatient care. The legislation focuses on FPA, treatment order and reassessments, and discharge, but the practices within the treatment period are left to the

discretion of the units of treatment. Such issues as leaves are thus a matter of the treatment plan like in psychiatric inpatient treatment in general, and are decided upon by the treating psychiatrist.

The main forensic facilities are the two state psychiatric hospitals, Niuvanniemi Hospital and Vanha Vaasa Hospital. They admit patients for FPA and for involuntary treatment as ordered by the TEO, but they also admit especially challenging (violent and noncompliant) psychiatric patients without criminal status, who cannot be safely treated in the psychiatric facilities of the 22 health care districts. The expenses of the FPA are covered by the state, but the costs of the treatment periods are finally paid by the municipality of residence of the patient. Some of the psychiatric hospitals of the 22 health care districts also have their own forensic psychiatric wards. The TEO can order the FPA and also decide to place a mentally ill offender into treatment in the forensic psychiatric wards of the health care districts as well, if it is considered safe enough. The most challenging patients are placed in the state hospitals. If the period of treatment is very long (years), the transfer of the patient to the facility in her/his own health care district after the initial treatment period in the state hospitals is possible if her/his potential for violence has decreased essentially. On the other hand, if necessary, it is also possible to transfer a patient from a health care district's forensic wards to one of the state hospitals.

For minor forensic patients, two new units which serve the entire country have been established since 2000. One of them, the Psychiatric Treatment and Research Unit for Adolescent Intensive Care (EVA), works in Tampere University Hospital, and the other is operating in Niuvanniemi Hospital. These units are designed to meet the requirement that minor forensic psychiatric patients and minor patients with especially challenging (violent and noncompliant) behaviour be treated separately from adult patients. Until now, minor patients with criminal patient status have been treated in adult forensic wards. In the Tampere unit, criminal history is not a requirement for admission, but the Unit admits adolescents in need of intensive care (of whom, however, many have at least a minor criminal history, even if they do not qualify as "criminal patients" or "mentally ill offenders"). The number of under-aged mentally ill offenders (who have gone through FPA and have not been sentenced but for whom a treatment order has been issued), has been very low, mainly zero to three cases per year have been in treatment (this may include the same patients from year to year, since these treatments tend to be long).

The courts, the TEO, and the treatment facilities all appear to be fairly satisfied with the current legislation and practice of FPA and treatment of mentally ill offenders. Judges were surveyed about their opinions in 2003. The Ministry of Health and Welfare has expressed its concern about the expenses of the FPA, and the TEO ordered an evaluation by an expert advisor of the practices and costs in the Nordic countries in 2003. However, the TEO has not exercised great pressure to reduce costs since it wishes to emphasize the reliability and validity of the assessments rather than the economical aspects.

Initiating the process of FPA depends on the courts, and both the political climate and public opinion influence the courts just like any other process in society. It has been observed that the courts currently tend to order fewer FPA than in earlier times. Conditional release from forensic treatment was introduced for mentally ill offenders in 1997 in order to improve the quality of aftercare and reduce risks.

As to the treatment of sex offenders, although some programmes were begun in recent years in prisons, no national programmes or guidelines exist. The National Development and Research Centre for Health and Welfare (STAKES) in now planning to initiate and coordinate treatment programmes for under-aged sexual offenders.

Offenders who have committed their crime under the influence of alcohol and drugs are fully responsible for their crimes and are sentenced according to the crime. There are substance-use treatment programmes in prisons, and prisoners can apply for placement in such a programme. In the community, treatment programmes are available for those who have committed crimes, as well as to all users, but the involuntary treatment for substance-use disorders is not possible in Finland.

Only psychotic conditions (such as delirium tremens, amphetamine psychosis) can be treated on an involuntary basis.

As for minor persons, legislative changes are currently in process to facilitate the psychiatric treatment and treatment of substance-use disorders in minors who have committed crimes, instead of or as part of the verdict. It has been recommended by a committee for the revision of this law that under-aged offenders under certain circumstances receive a verdict mandating substance- use treatment or psychiatric treatment instead of, or as a part of their sentence. This would be a lighter process that the above-described FPA: the practical solutions are currently being discussed.

Patients' Rights

Patient rights in the process of forensic assessment and treatment are well protected in Finland. The criminal law protects mentally ill offenders from being sentenced. The Mental Health Act carefully regulates the treatment decisions and use of coercion during inpatient care. The Patients' Rights Act (passed 1993) is in force regarding offenders for whom an order for involuntary treatment has been issued, as well as with regard to all patients. There have not been any major patients' rights debates in psychiatry or in forensic psychiatry for a long time.

Epidemiology

In summary, the relevant national trends in this context include:

- the decreased in the number of FPA requested by the courts over the past decade, from somewhat above 200 per year in the early 90s to somewhat fewer than 200 per year in the early 2000s (in 2000: 169, in 2001: 195, in 2002: 181, data based on the statistics of TEO);

- the decreased proportion of those judged as having "lessened criminal responsibility" in favour of the category "full criminal responsibility". In 1991-1992, the TEO concluded that 48.4% of those assessed in FPA were fully responsible, 32.9% had a lessened criminal responsibility, and 18.6 % lacked criminal responsibility. In 2000 the figures were 54.4%, 22,5% and 21.9%, respectively, in 2001: 59.0%, 21.5% and 19.0%, and in 2002: 60.8% as fully responsible, 15.5% as lessened criminal responsibility, and 22.7% lacked criminal responsibility (Statistics of TEO).

Data relevant to the study of crime trends and the issue of mentally ill offenders are collected in:

- different registers of the Ministry of Justice and police organisation (figures of crimes investigated by police and brought to court, number of prisoners, main crimes of prisoners, information on how many times the prisoners have been imprisoned (first timers, second, third…)).

- registers of Authority for Medico-Legal Affairs: TEO reports annual number of FPA requested, FPA completed, categories of criminal responsibility concluded, and involuntary treatment orders issued for offenders; after completing relevant permission procedures researchers can utilise the archives more thoroughly, and outstanding research has been carried out based on FPA documents

- National Hospital Discharge Register collects information on all inpatient treatment periods in Finland (in all specialities); for psychiatric inpatient treatments, NHDR provides information on the patient's age, sex, municipality of residence, diagnoses, dates of arrival and discharge, referred by, referred from, discharged to, GAS, mode of entering the hospital (emergency, from waiting list), mode of referral (voluntary, involuntary, for FPA, on treatment order by TEO), coercive measures used (involuntary medication, seclusion, mechanical restraint, physical restraint, restricted leave), carers met during treatment (yes,

no). The data is person identifiable. (NHDR data has been used in structured questions – part of the present study.)

As to mentally ill offenders, no information on the crime is registered in NHDR. Likewise, registers of the justice system do not contain information on mental illness. A more detailed picture of mentally ill offenders necessitates carrying out specific research using FPA documents and register linkages. Permission for research can be obtained via ethics committees and bodies supervising the registers of interest. Guidelines exist for permission policies.

Data security legislation makes it difficult to exchange information even within the health care system unless the patient is co-operative. In carrying out FPA, the expert has a right to obtain information from all public institutions (school, health care etc.) independently of the patient's consent, but for treatment purposes, obtaining information from previous treating agents, not to mention other bodies, requires the patient's informed consent. In general, this is likely to generate unnecessary costs in health care by resulting in repeated laboratory testing and the like.

Public Opinion and Mass Media

Court trials in Finland are generally open to the public and the media, and it is an exception if the court decides to handle a case behind closed doors. This could happen due to details related to the offender(s), or the victim, or the nature of the crime. It is individually decided in each case. It would not be automatically tied to the (assumed) mental illness of the offender, but this could be a reason for closed doors. The media has shown no particular interest in the case of mentally ill offenders, not to mention their treatment. Rather certain crimes gain a lot of attention, such as violent crimes, especially homicides, where the offender is under-age, or the nature of the crime is particularly strange, disgusting, or cruel. In such cases the media and public discussion would carefully follow and present a lot of background material as well, but the point for the interest is not a particular interest in mentally ill offenders: the point is a particular interest in shocking crimes. In such cases, FPA of the offender(s) is often carried out. These have not systematically resulted in the placement to care of the offender(s), rather it is my impression that a prison sentence has been the more common solution.

Finnish research on homicide has characterised that in a typical Finnish homicide both the offender and the victim can be described as a socially very unprivileged man, usually under the influence of alcohol. The victim is usually someone close to the offender, like his peer; another typical victim is the offender's spouse. These incidents do not attract the special attention of the public or the media. The legislation on FPA and the involuntary psychiatric treatment of the mentally ill offenders has not been changed since the Mental Health Act went into effect (the minor changes that have been carried out have not influenced the basic structure or philosophy behind the processes), which also indicates that there have not been any powerful discussions that would have influenced the legislation or even the practices. By and large, discussions on criminal policy have focused on whether it is better to favour treatment and agreement (social care, mental health care, substance-use services; offering a second opportunity, agreeing) instead of, or at least within the penalty system, or whether Finland adopt a stricter line and give longer sentences, higher penalty fees etc, and also emphasize full criminal responsibility whenever possible. One reflection of these discussions seems to be the fact that the proportion of "lessened criminal responsibility" among those assessed in FPA has decreased. On the other hand, with regard to adolescents who commit crimes, treatment options will be increased in the future.

Unlike the UK, for example, in Finland there has been no major public discussion of public safety and mental illness, or of public safety and mentally ill offenders. Public discussions and activities of interest groups focus instead on the mental health domain, on the support to carers, access to care, reimbursements for psychotherapies, etc.

Both psychiatrists and jurists have criticized the routine lesser sentence in cases of lessened criminal responsibility. Examinees concluded to possess a lessened criminal responsibility often suffer from personality disorders and substance dependence, and are especially likely to violently

re-offend. That these offenders are released into the community after a shorter sentence than would otherwise follow after the crime in question seems illogical and irrelevant.

Fig. 20 Forensic Service Provision in Finland

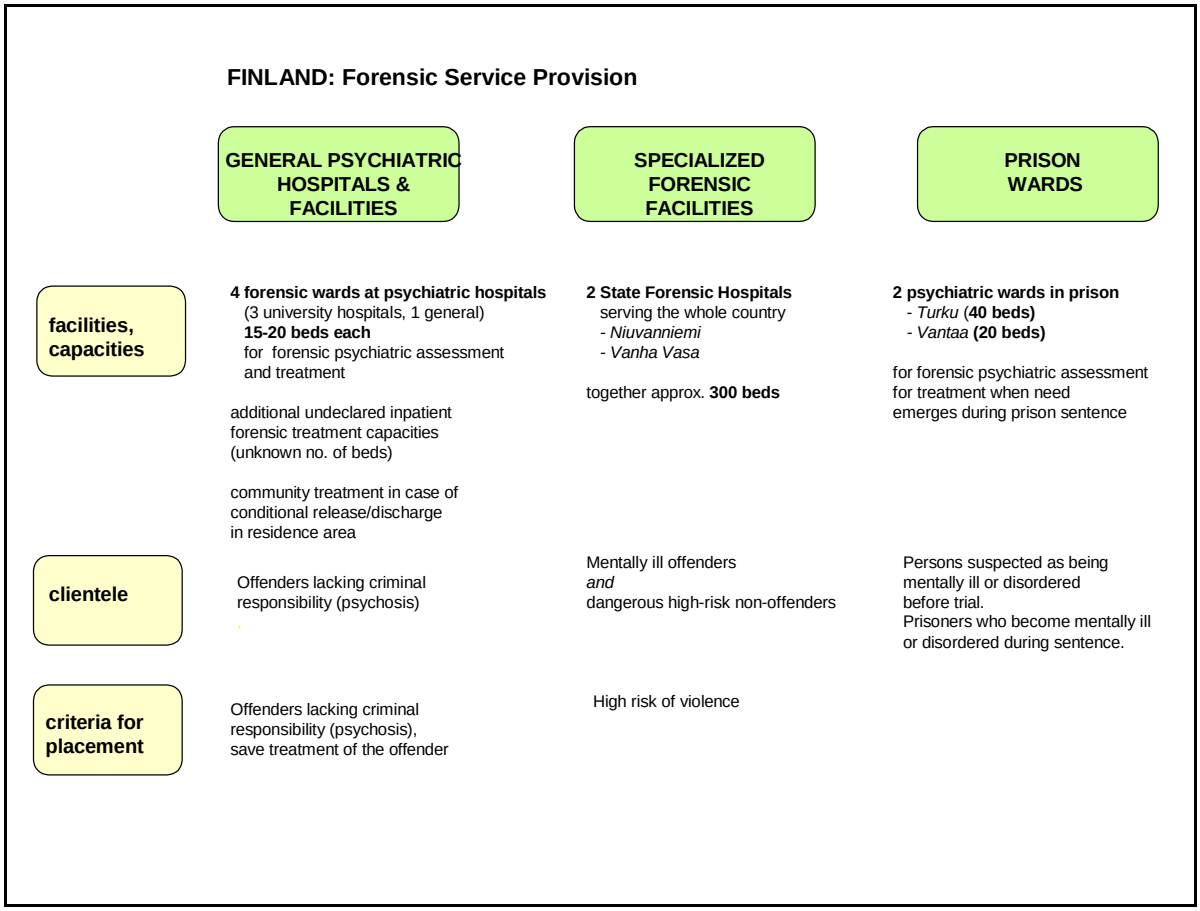
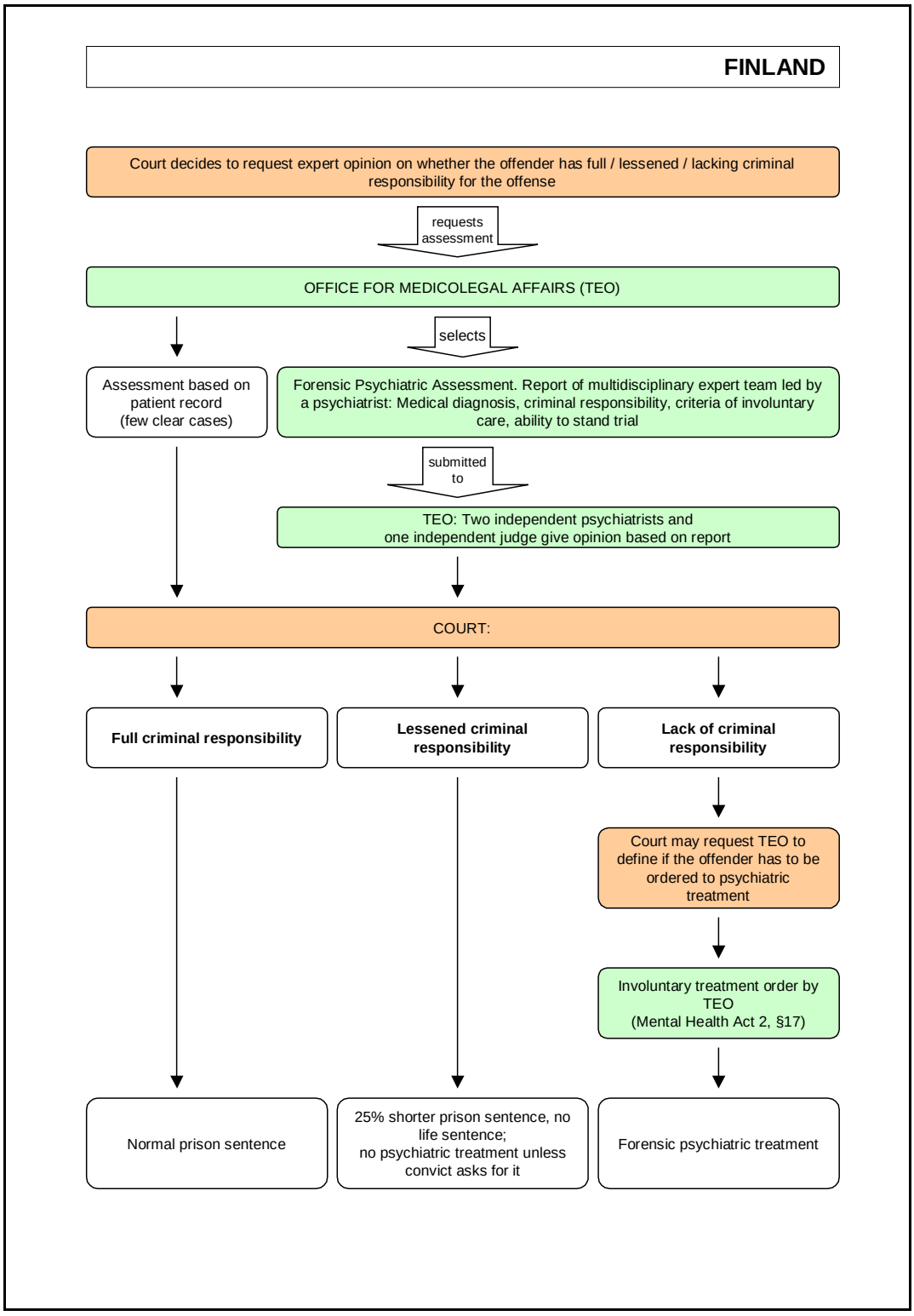


Fig. 21 Judicial and Placement Procedures for Mentally Ill Offenders in Finland



France

Pierre Lamothe & Frédéric Meunier

Legislation

The French Penal Code (CP) contains provisions for cases regarding mentally ill offenders. Each regulation, whether a law or a rule on a lower level, is based on a constant dividing line: the question of criminal responsibility, which is exclusively defined with regard to the ability of discernment and to control one's action. This criterion acts as a clear dichotomy. When a mentally disordered offender is considered (by expert-assessment which might not obligatorily be followed by the judge) as being responsible for his act, his case is practically treated as if he was not mentally ill.

The new CP from 1994 changed the definition of criminal responsibility. The present legislation comprises full criminal responsibility or total lack of criminal responsibility. Any partial or diminished responsibility is not included into the concept. However, the law defines more the lack of responsibility than the concept of responsibility itself. Article 122-1 of French Penal Code (CP) states:
"Any person experiencing mental or neuro-psychiatric problems abolishing his discernment or the control of his action during the time at which the incident took place is not responsible in the sense of penal justice. A person experiencing mental or neuro-psychiatric problems abolishing his discernment or the control of his action during the time at which the incident took place which have altered his discernment or hampered the control of his action remains punishable. However, the jurisdiction takes into account this circumstance when determining the sentence and setting execution modalities." (cited by the authors, due to unavailable official translation)

The terms "mental problems" or "neuro-psychiatric problems" are not defined, however, and the interpretation and evaluation are left to experts or judges as well. They are not related to any particular diagnosis.

The second paragraph of article 122-1 of the CP, which is very short, leaves open most of the crucial questions for holding trials against mentally ill offenders and puts the responsibility on judges and courts to cope with any specific cases. One could understand that this article is expected to reduce sentences or open the way to adequate care measures under probation. But in reality, the evocation of Article 122-1, 2 of the CP leads to the opposite, resulting in longer sentences.
The concept of unfitness to plead is not specifically defined. Thus it happens that offenders showing clear symptoms of severe mental illness are tried and judged. Sometimes a trial is suspended "sine die" after assessment (which is not mandatory) ordered by the court on request of the defence or jurisdiction itself. The prosecution might not be withdrawn even when the mental state of the person concerned is disturbed for years. Additional assessments may be requested by the prosecutor supplementary to regular reviews of the detention order which are stipulated by the law.

More than elsewhere in Europe or the western world, new care strategies can be observed in France that risk relying on prison-placement instead of placement in public psychiatric hospitals to cope with behavioural problems of the persons concerned or to fulfil requirements of public safety. Public psychiatric hospitals in France operate today almost completely with open ward-policies to provide adequate care for consenting patients, whereas closed wards offering adequate and secure environments are lacking. Appropriate wards or beds for long-stay detainees

are scarce. Rather common are small cells for dangerous or agitated patients that are usually without access to secured yards

So instead of being conducted in hospitals under temporary involuntary placement conditions, medical or psychiatric examinations of offenders suspected of being mentally ill are regularly carried out in prison under provisional detention-regimes as a safety measure. Being a part of clinical files, the results of these preliminary examinations very often determine conclusions on the mental state of the person concerned in terms of an expert-assessment prior to any judicial decision. Actually there is a general trend in France to send even severe psychotic patents to trial. The conceptual or ideological background might be the idea that confrontation with the judicial system might have a therapeutic effect. In the year 2000, less than 2% of people having committed an offence eligible for prosecution were found irresponsible due to mental problems.
When considering study results estimating 3% of the population at large and 7% among delinquents as suffering from schizophrenia, it could be concluded that mentally ill offenders in France are not adequately recognised and most often are treated like non-disturbed persons. A Senates Commission officially stated that 0.47% mentally ill offenders were found to be non-responsible for their acts. However, this is the proportion of cases seen by investigational judges ("judge d'instruction"), whereas many minor crimes are handled directly by a prosecutor or are returned to immediate hearing ("comparution immediate"). So the real figure might be higher, probably estimated at a maximum of 2%.

Both the public and professionals often object to the present legislation which allows for suspension of prosecution under Article 122-1 of the CP, ignoring the interests of the victims and their families, as well as those of the community. However, in 1995 there was a change in legislation concerning the possibilities of appeal against a non-suit decision which can be brought before the "chambre d'instruction": On request of the victim, a defendant may appear at the hearing of the court if he has the medical and mental capacity to attend. The experts have to be heard personally as well to affirm their evaluation (Article 199-1 of CPP). But "chambres d'instruction" do not have the power of a court trial, and all evidence or facts are not disputed as done at court.

Recently a working group has been established to analyse the issue of implementing special trial procedures for mentally ill offenders lacking criminal responsibility. Attendants should comprise victims for a better understanding the basis of court decisions resulting in on-suit verdicts. The recommendations of this working group have not led to any modification of the legislation. However, many experts fear that respective changes would narrow the rights of persons concerned and that these would encourage proposals for implementing registers for mentally ill offenders.

Assessment

At every stage of the judicial procedure an assessment of the mental state of the person concerned might be ordered (first by the prosecutor during the pre-trial period, then by the judge in charge of the investigation and finally by the judge chairing the trial). Mandatory questions of the assessment focus on criminal responsibility, which means the defendant's ability of insight and his ability to control his action. Additional fields are at the discretion of the court and may include public safety and risk assessment.

An assessment is mandatory in the case of major offences listed in the CP as crimes judged by the "court d'assises". But during the pre-trial investigation by the "juge d'instruction", an assessment can be conducted in order to prepare for the trial. An assessment of the mental state of the defendant can be ordered for smaller offences, also on request of the defence or the victim of the offence.
It is routine practice to assess the defendant if he holds a certain record, if he exhibits certain behaviour or if he has committed a serious or unusual type of crime with minor benefit for the offender.

The defence or the prosecuting parties can only request an assessment which always must be ordered by the court or the judge. The appointment of the expert is also at the discretion of the

court or the judge. Each court of appeal maintains a list of official experts pre-selected on the basis of complex or undefined criteria (e.g., reputation, titles, function). An expert who is not pre-selected may be admitted to court but must swear an oath for each particular case.

Placement of Mentally Ill Offenders

Most mentally ill offenders who are found to lack criminal responsibility receive forensic care. However, lack of criminal responsibility does not obligatorily lead to forensic care and the mentally ill offender who is held not responsible for his act may benefit from a non-suit decision and can be acquitted without further consequences!

If a mentally ill offender meets the criteria for the so-called “hospitalisation d’office (H.O.), which is originally a civil detention regime whose major criterion is public threat, he will be placed under Article L3213-7 of CSP. However, this placement cannot be ordered directly by a judge. It has to be submitted for administrative decision, which is taken by the “Prefet”, the authority of each regional “department” representing the government.

The assessment itself may not be sufficient as usually the delay between the examination by an expert and the trial is too long, so that an additional more recent certificate is required, confirming that the criteria for involuntary placement are still fulfilled.

If a mentally ill offender is found not to be a public threat but to meet the criteria of the “hospitalisation à la demande d’un tiers”-regime (H.D.T.) which applies on the request of a third party in case of an obvious need for care and inability to consent, he will be placed under this rule. In this case a discharge will not require a mandatory assessment, instead the recommendation of the treating physician as part of the required monthly report will be sufficient. This patient placed against his will has no peculiar obligation towards justice.

This non-suit decision ends any right of disposal by the court, changing the legal status of a mentally ill offender to that of a civilly committed patient. The only difference refers to the modality of discharge. Here, the recommendations of two different experts resulting from two separate assessments are necessary (Article 3213-8 of CSP).

If an offender has been found responsible for his act, regular penal procedures will apply. In case of deterioration of the mental state after the assessment and if, in this case, this altered state meets the conditions for placement, the person concerned will be admitted to a psychiatric hospital under the conditions of the general mental health law. Only public hospitals enlisted and certified are legally allowed to admit these patients.

When a mentally ill offender is detained in prison, the provisions of a possible placement are regulated by Article D398 of the Code de Procédure (CPP) which states that no detainee should be “mentally deranged” and maintained in prison. Therefore this person should be committed to a public psychiatric hospital under civil law until he eventually recovers. This article, which was not formulated very precisely and is therefore not easy to apply; unfortunately was restricted in 1998 by an amendment stating that a detainee must meet the criteria of Article L3213-1 of the CSP (Code de la Santé Publique, Mental Health Act of 1990) which supposes predictable dangerousness. Thus many mentally ill offenders who are really disordered and suffering but are not estimated as dangerous are left in prison without the benefits of Article D398 and are not transferred to public psychiatric hospitals.

Service Provision

Currently available institutions in France do not provide any specific facilities for mentally ill offenders. There are four security units in psychiatric hospitals (”unités pour malades difficiles” UMD), which all together offer 400 rooms for males or females) that are not considered to be forensic wards; they are simply supposed to provide space for very dangerous or very difficult

patients. Thus, most mentally ill offenders are put into prison when found responsible for their acts. Legal criteria are defined broadly enough to do so.

Usually mentally ill offenders are admitted to so-called regional medico-psychological services which are implemented in 26 of the main prisons in France. However, these facilities are not supposed to care for detainees serving long-term sentences. Only one prison (Chateau-Thierry) is prepared for these specific clientele. Thus, sentenced mentally ill offenders often stay for years in non-suitable wards even when suffering from severe mental problems affecting their personality or behaviour.

Currently, the French Government is conducting an assessment regarding the possible implementation of special units for prisoners with mental problems (e.g., chronic psychotic patients), who most often receive inadequate psychiatric care. A potential opening of such units might be in 2006. These units will be integrated in public psychiatric hospitals, but custody might probably be the responsibility of penitentiary administration. At the moment there is no special security staff available in psychiatric hospitals. Prisoners treated in general hospitals are in the custody of the police.

Criminal Responsibility in Routine Practice

As the term “lack of criminal responsibility” is not precisely defined by law, psychiatric experts are left alone without any guidelines on how to conduct assessments and draw conclusions. In routine practice, each expert applies his own criteria, often adopting those of the judge by whom he has been appointed.

Overall, there are two different schools of thought or ideological positions prevailing. The one that might be dubbed “latin” is based on a dichotomy of psychiatric diagnosis and a determination of responsibility. One mentally ill offender might be schizophrenic or paranoid and be considered criminally responsible, whereas a second person with the same diagnosis might very well be held non-responsible. This view assumes that psychiatrists would be able to get specific clinical data (from interviews, medical or criminal files etc.) enabling them to conclude on or answer the question of the patient’s discernment and ability to control his actions.
Some psychiatrists are convinced that this exceeds the specific psychiatric domain and will dangerously extend to a moral concept of behaviour. The key question here is whether a psychiatrist should be allowed to declare a mentally ill offender competent to decide “right from wrong” and to apply this concept to confirming criminal responsibility.

Quite different from this view is the approach of experts who consider mentally ill offenders per se as being non-responsible for their acts when they are suffering from a severe mental disease (usually psychotic problems) and offence and pathology are linked. This view follows more or less the rules and practice of the Anglo-Saxon legal tradition. In this case, a diagnosis may be put against a defendant’s intention to be sent to court to claim his responsibility. The evaluating expert may consider this claim itself to be part of a delirious state.

Compulsory Forensic Treatment

At present, French law does not specify treatment modalities for mentally ill patients but only regulates conditions of involuntary placement.
There is an ambiguity in the present legal regulations which reoccurs in daily practice: When a detained dangerous mentally ill patient, regardless of whether or not he is an offender, refuses medical treatment, there are no clear regulations that would allow physicians to impose this treatment, even in locked psychiatric wards.

Patients’ associations often claim that placement does not automatically imply treatment. Most psychiatrists, however, would seriously consider applying treatment against the will of a patient when a patient is detained under the Mental Health Law. This discrepancy clearly underlines the

lack of a clear legal regulation. Currently, coercive or forced treatment already is a topic of debate in France, independent of the modalities of placement.

Compulsory treatment in prison is not applied. In no case would a treatment applied beyond the medical domain be mandatory. There is a clear dichotomy between justice and medicine in this regard. So even if a mentally ill offender who has been sentenced with a complementary "obligation de soins" (which is a very soft measure, where the presumed patient is just supposed to produce a certificate issued by any doctor confirming his presence) is eventually detained for something else, his obligation is denied during his prison stay.

The only legal stipulations for mandatory forensic treatment that can be ordered by the judge are defined by the law of June 15th, 1998, which disposes that sexual offenders can be sentenced with an "injunction" of care (not treatment) under the control of a new kind of medical profession called "coordonateur". A coordonateur is neither an expert nor a therapist but an individual who will evaluate the effectiveness of care. This injunction may be an alternative to a prison sentence or a complementary measure after the sentence has been served. However, it can not be imposed against the patient's will. The person concerned is able to refuse treatment and is able to opt for a supplemental prison sentence. The "injunction of care" does not concern the prison time, during which any treatment must always be applied with the detainee's consent.
This consent is also a delicate issue since the revision of the CPP in December 1998. As ruled by Article 362, it has been added that a detained person must not be treated without his consent "except if he is not competent to consent"! Thus, emergency treatment is legal in prison and probably even measures exceeding the actual state of emergency, underlining a rather subeffectively regulated environment which might be appreciated by some players in the field and complained about by others.

When the physician in charge of treatment also has to determine the patient's competence to consent, he is always at risk of either disclaiming all responsibility or of abusing his medical power. Most of the time, psychiatrists, who are always subject to criticism by the mass media or possible prosecution in case of spectacular consequences of their decisions, choose to reject this responsibility and leave mentally ill offenders without the needed care or medication. Frequently, this may result in behaviour problems on the part of the person concerned and subsequent disciplinary or penal consequences.

The question of appeal against a placement order or its duration is well defined in the French Mental Health Law. Different appeal procedures are possible, either through the court or a court-like body. However, there is no option to appeal against placement in a psychiatric prison-ward. Thus, despite the fact that the inspection of psychiatric services in prisons is the responsibility of the health administration and not of the penitentiary administration, it is rather difficult for psychiatrists to act on behalf of the well-being of incarcerated patients with equal respect for their rights and their informed consent.

Fig. 22 Judicial and Placement Procedures for Mentally Ill Offenders in France

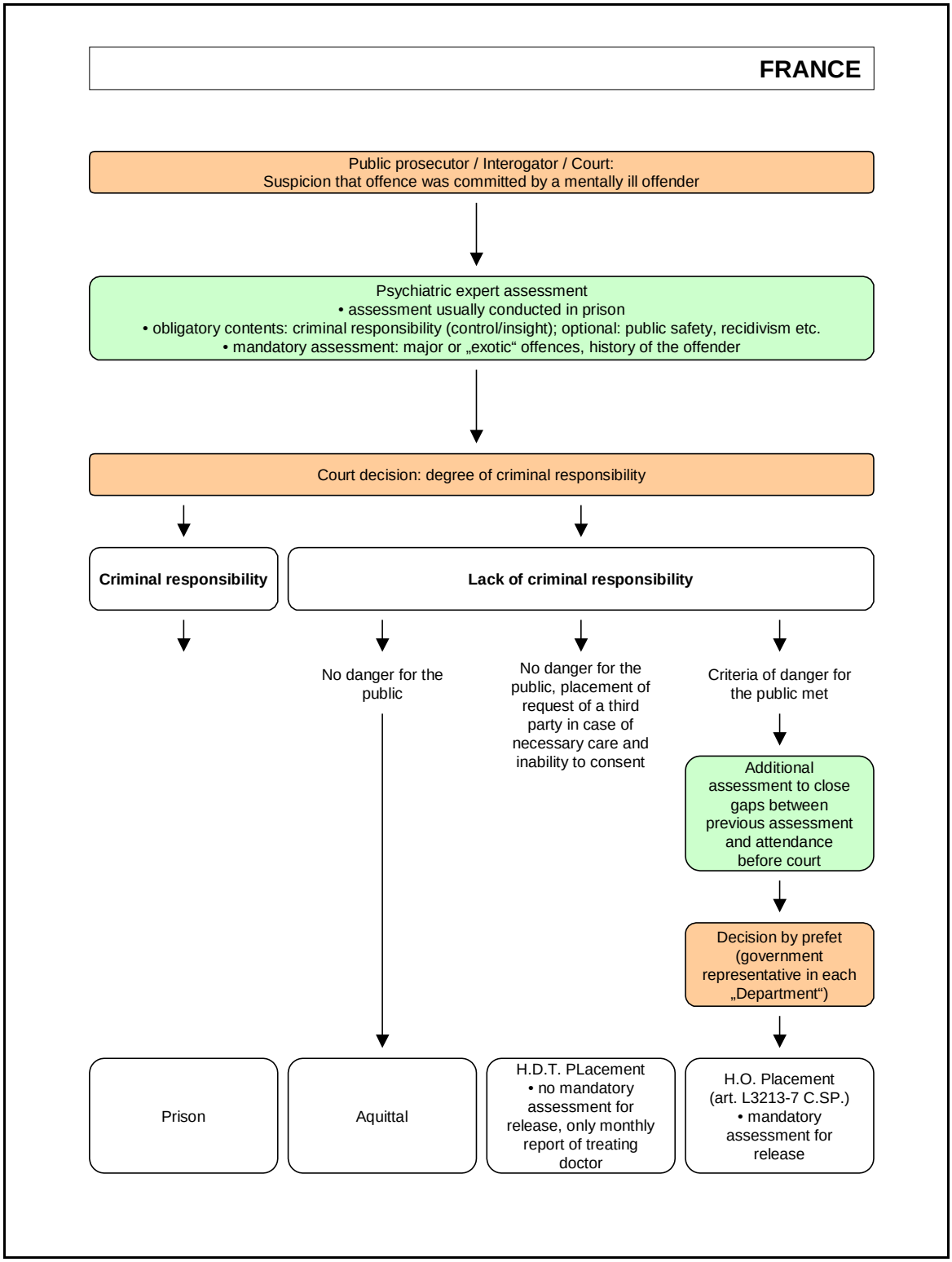
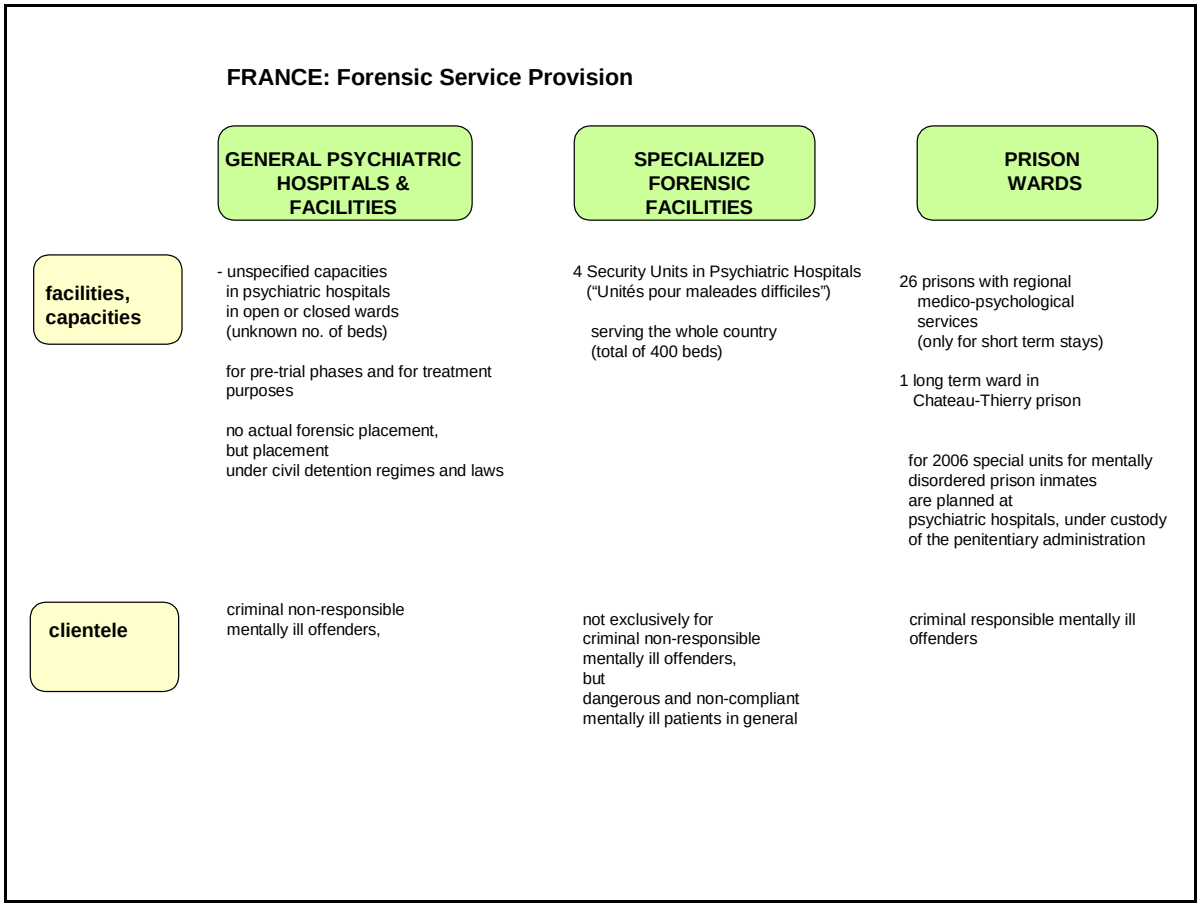


Fig. 23 Forensic Service Provision in France



Germany

Michael Osterheider & Bernd Dimmek

Structure of the Legal System

In German criminal law the question of the guilt of an offender is of central significance: According to § 46 of the German Penal Code (StGB), “the guilt of the offender constitutes the basis for determining the punishment." The basis of this guilt-oriented criminal law is the assumption that only a person who is to be regarded as having been able to be motivated by unlawful norms at the time of the offence deserves punishment under criminal law. This means that only a person who was aware of the unlawfulness of his actions at the time and who was free to decide not to commit the offence can be blamed for his actions. This awareness and the freedom of decision are considered as preconditions for guilt in the actions. Only when the offender can be regarded as "responsible" for his actions can a punishment appropriate to the individual guilt for the offence be imposed. For this reason, the law provides for restrictions of the responsibility for juvenile (aged between 14 and 18 years) and for adolescent (aged between 18 and 21 years) persons that are oriented to the absence or partial presence of the ability to recognise the unlawfulness of the actions. Children under fourteem years of age can not be punished under criminal law for offences which they commit.

A decrease in or a loss of responsibility can also result from mental disease: If, at the time of the offence, the offender was unable to recognise the wrongfulness of his action or was unable to act in accordance with this understanding as a result of such an illness or disturbance, then he cannot be regarded as guilty of his action in this specific legal sense. As a result, it is not possible to impose a punishment - the offender will be acquitted of guilt.
Particularly when the offender has already committed offences in the past, the acquittal without punishment of offenders with an absence of responsibility comes into conflict with the demands of society for effective protection of the legal state. Thus it was more considerations of criminal policy that led to the so-called "two-track" criminal law system which is applied today in Germany. This means: Temporally limited detention sentences are imposed upon offenders who were conscious of their responsibility, and temporally unlimited detention upon offenders who were unconscious of their responsibility but who represent a potential source of danger. On the one hand, this system opens up the possibility of an offender-oriented treatment and improvement instead of an offence-oriented punishment, whilst at the same time ensuring the protection of society from further offences.

The start of this two-track system dates back to the "Prussian General Law" of 1794 (Blau, 1984); it was taken up by the legislators in almost all the European nations at the beginning of the last century. This system was incorporated into German criminal law with the passing of the "Act against Dangerous Habitual Offenders" in 1933 which, before being perverted under National Socialism, permitted for the first time that mentally ill and addicted offenders be committed to psychiatric institutions (concerning these considerations see: Aschaffenburg, 1912).

The objective of compulsory commitment to a psychiatric hospital is not to punish the offender but to allow him to be treated and to enable an improvement in his condition to take place, whilst at the same time protecting society. In the German Penal Code the regulations on the placement and treatment of mentally ill or disturbed offenders in a psychiatric hospital, respectively in a detoxification centre, are subsumed under the section "Measures on Improvement and Safety". § 63 StGB provides for the temporally unlimited commitment to a psychiatric hospital. In accordance with § 64

StGB, addicted offenders can be committed to a detoxification centre for a period of up to two years.

These compulsory measures are primarily individual preventive measures and not criminal punishments. They relate to the future potential danger of the offender; they are not linked to an offence in the past. In order to clarify it by the example of § 63 StGB: A precondition for imposing this measure is that the offender at the time of the offence was suffering from a pathological mental disorder, a profound disturbance in consciousness, a mental deficiency or some „other serious mental aberration" that prevented him from recognising the unlawfulness of his actions or from acting in accordance with this understanding. These entrance criteria of a missing or decreased criminal liability are designated in §§ 20 and 21 StGB. At the same time, it must be foreseeable that the offender will commit further substantial illegal acts due to this illness or disturbance. This means a prognosis according to which further acts are not only to be expected as possible, but also as justified.
The admittance in accordance with § 63 StGB takes place without a given duration. The reason for the admittance is the danger of the patient; it is at the same time the criterion for the continuation of the accommodation. Accordingly, it is the goal of the treatment to cure the patient of his disorder or to improve his condition such that he is no longer dangerous (§ 136 of the Execution of Sentences Law - StVollzG). A similar regulation exists for the admittance of addicted persons (§ 137 StVollzG). This purpose of the compulsory measures was underlined in the course of the 2nd Penal Reform in 1975, when the earlier formulation „Measures on Safety and Improvement", was altered to „Measures on Improvement and Safety"

After the penal reform in 1975, the time frame of the accommodation also was redefined. Up to then the legal default was: "Placement continues for as long as it is required by its purpose". Now § 67d section 2 StGB determines: "If no maximum period is provided or if a provided period has not yet expired, then the court suspends the further execution of the measure on probation as soon as it can be answered for to test whether or not the accommodated person will commit more illegal acts outside of the measure of execution". Also, due to a misleading perception of this formulation by the public, a new formulation was defined within a change of law in the year 1998: „...the court suspends the further execution of the measure ... if it is to be expected that the accommodated person will commit no more illegal acts outside of the measure of execution"

While the arrangement of the measures, just like their completion, is essentially regulated by Federal Law, their implementation depends on state laws (§ 138 Section 1 StVollzG). Appropriate state laws, which put into concrete terms the legal area unsettled until then, were adopted relatively late, however, starting in the late seventies. Some of the German Federal States integrated the legislation concerning the placement and treatment of mentally ill offenders into the general laws for mentally ill persons (e.g., Schleswig-Holstein, Bavaria, Baden-Wuerttemberg), while other Federal States adopted their own laws on the measure of execution (among others Lower Saxony, Hessia, North Rhine-Westphalia).

During the last 20 years, the discussion on the goals of the measures was particularly characterized by three developments:

1. the development of new legislation in the East German states of the Federal Republic after reunification,
2. the further arrangement and adjustment of existing measure of execution laws to the scientific level of knowledge (in particular by consideration of the requirements of qualified aftercare for dismissed patients) and
3. a more restrictive handling and/or tightening up of the legislation for the placement of offenders who have committed violent crimes and sexual offences - this caused in particular by those offenders, who committed renewed criminal offences after the completion of a term of imprisonment or a measure. In particular, a new regulation must be mentioned here that was newly introduced in the year 2002, according to which a psychiatric appraisal must be carried out before a release from the forensic psychiatric hospital can take place (§ 454 Abs. 2 StPO).

Pre-trial Procedures

During the preliminary investigation in particular, two regulations of procedural law are used: If there are urgent reasons for the presumption that the offender acted in a condition of missing or diminished criminal liability and that the admission to a psychiatric hospital or to a detoxification centre will be arranged, then the court can arrange a provisional accommodation in such an institution. A condition is that such a provisional accommodation is required for reasons of public security (§ 126a StPO). For the preparation of an expert assessment of the mental state of an accused individual the court can arrange that the accused be brought into a public psychiatric hospital and observed there. A condition is that the accused person is urgently suspicious and the arrangement does not stand except in relationship to the punishment or measure which can be expected (§ 81 StPO). In all cases in which an accommodation in a psychiatric hospital, in a detoxification centre or a preventive detention in a prison is to be expected, an expert must be heard at trial. He has to give information about the mental condition of the accused and about the prospects of treatment (§§ 246a, 415 Abs. 5 StPO).

The assessment will be carried out by an expert assigned by the court, usually during the provisional accommodation in the psychiatric hospital. In such cases in which there is no direct danger to public safety and no further reasons exist against the whereabouts of the accused at liberty, an ambulatory assessment is possible. The duty of the experts includes three steps:

1. the assessment of whether the prerequisites of a missing or decreased responsibility as specified by the law have been present,
2. the assessment of whether the offender for the reasons mentioned was unable to recognise the unlawfulness of his action or to act in accordance with his insight (absence of responsibility in accordance with § 20 StGB) and/or whether his ability was substantially decreased (decreased responsibility in accordance with § 21 StGB), and
3. the prognosis of whether further substantial criminal offences are to be expected due to the illness or disturbance.

Trial Procedures

The expert has to report the results of the assessment during trial. If the court comes to the conclusion that the offender was acting in a state of an absence of or in a state of decreased responsibility due to a mental illness or mental disorder or due to an addiction, and that further substantial criminal offences are to be expected due to this condition, then the prerequisites are there for a court order in accordance with § 63 or 64 StGB. In the case of an absence of responsibility, the offender is acquitted of the charge and his admission to a hospital is arranged at the same time. In the case of a decreased responsibility, the court can sentence the person to additional imprisonment, which is to be executed after the measure.

Practice

In Germany, special accredited psychiatric hospitals (special forensic hospitals) or the psychiatric departments of general hospitals are usually designated for the involuntary placement or treatment of mentally ill patients. Hospital services for mentally disordered offenders exist across a range of levels of security. At the maximum security end of the spectrum, there are high-security standard hospitals (e.g., Westphalian Centre for Forensic Psychiatry at Lippstadt or the Bavarian Centre for Forensic Psychiatry at Straubing). In a few cases, patients also might be admitted to nursing homes and rehabilitation centres. Involuntarily placed patients are not usually separated from voluntary patients. Whether or not common wards are open or closed depends on various local circumstances (with the exception of high-security standard hospitals; see above). Although both options are possible in principle, an open-ward policy is preferred in some regions of Germany, indicating a rather liberal philosophy in routine care.

Special hospitals take the most serious offenders (including a small number of women) who are considered to be a grave and immediate risk to the public, and rely on a high degree of both perimeter and internal security. The nursing staff are not only trained in control and restraint techniques, but also know how to deal with dangerous untoward incidents such as hostage-taking. The special hospitals have increasingly begun to offer treatment focussed on particular problems (e.g., long-stay-departments, departments for psychopathic patients) and there are expanding forensic psychotherapy departments also with academic and clinical interests. Most of the hospitals also have excellent workshops, training and education facilities. In the past, conditions in the special hospitals, and the treatment provided to their patients, were heavily criticized. But much was undertaken in the late 1990s to improve outmoded practices such as the over-use of seclusion and to reduce professional isolation.

Although many regions in the Federal Republic of Germany provide good standards of community-based mental health care, there is statutory stipulation of the least restrictive settings for involuntary regimes as well; State Acts do not mention any option of compulsory outpatient treatment. However, most of the State commitment laws suggest aftercare following involuntary inpatient episode, and the role of the social psychiatric services is emphasised in this process. In some Federal States patients are referred automatically to community services upon discharge from involuntary inpatient stays. Moreover, four State commitment laws stipulate a referral without the patient's consent, even when the involuntary status does not prevail after discharge. Commitment laws in fifteen Federal States explicitly permit the interruption of involuntary episodes for defined periods and certain purposes, including vacation.

Some forensic intensive care units are situated within district general hospital psychiatry units. They are designed to manage patients with „challenging behaviour", who may or may not have a criminal history or be facing current charges. These smaller, low-security units are not ideal for patients who require a long stay as they often lack large day areas on the grounds in which the patients can be taken out on parole. On the other hand, they are likely to be nearer to the homes of partners and family, thus making visiting, and if indicated, joint work, more practicable.

At maximum and medium levels of security, and frequently on intensive care units, patients are managed by a multi-disciplinary ward team with special forensic expertise. Forensic psychiatrists and psychotherapists work alongside with forensically trained nursing staff, social workers and occupational therapists. The approach to assessment and treatment is, and has to be, eclectic, since for many patients, both biological and psychological problems are aetiologically significant. Most are treated with a combination of medication, cognitive-behavioural techniques, and group or individual interpretive work, in which at least one of these professionals usually has a special training and interest. Often overlooked, but equally important, is the „milieu therapy" that is offered by forensic in-patient facilities. This term refers to the beneficial effects of an environment that emphasises containment, structure, involvement and a practical orientation to individuals whose lives have hitherto been chaotic and unpredictable.

Patients Rights

From a legal as well as a procedural point of view, patients' rights in Germany are safeguarded in many ways.

- Continuous reforms of the mental health acts have increasingly emphasised basic human and legal rights.
- The basic distinction between involuntary placement and treatment, requiring the patient's consent for most therapeutic interventions, strengthens the autonomy of the persons concerned, although this might limit their chances for adequate treatment.
- The independent decision by a court or a judge guarantees compliance with the most basic democratic principles during all stages of the procedure.

- Patients have the right to appeal to courts at any stage of the procedure. Patients have to be heard. Patients' advocates are approved during all stages.
- Control commissions supervise quality standards at various levels (procedures, facilities, treatments etc.).
- Coercive measures have to be strictly recorded.

Epidemiology

In the Federal Republic of Germany no continuous nationwide collection and evaluation of data concerning the accommodation and treatment of mentally ill or addicted offenders takes place. Only as a part of the general crime statistics are some data available on the type and frequency of the placements in forensic psychiatric institutions. However, these data are limited to the old West German states (since 1996 including East Berlin) and they are limited to a few selected characteristics, representing an absolute minimum. There is no information about diseases, duration of accommodation or other epidemiologically relevant data.

Tab. 50 **Number of Criminally Non-responsible Mentally Ill Offenders in Custody in Germany** (data excludes East German Federal States in the former German Democratic Republic, where information is not registered. Data source: National Statistical Office, Wiesbaden)

Year (Census Data, March 31)	in forensic hospitals (§ 63 StGB)	in detoxification centres (§ 64 StGB)	Total
2003	5,118	2,281	7,399
2002	4,462	2,088	6,550
2001	4,297	1,922	6,219
2000	4,098	1,774	5,872
1999	3,632	1,596	5,228
1998	3,539	1,529	5,068
1997	3,216	1,363	4,579
1996	2,956	1,277	4,233
1995	2,902	1,373	4,275
1994	2,739	1,418	4,157
1993	2,719	1,343	4,062
1992	2,657	1,269	3,926
1991	2,473	1,127	3,600

The available surveys show a clear increase in the admissions to a psychiatric hospital and/or to a detoxification centre since beginning of the '80s. Therefore, the number of approximately 3,600 patients accommodated in a forensic psychiatric institution in the year 1991 had increased almost continuously to approximately 7,400 in 2003.

The increase in the accommodations concerns both the mentally ill or disturbed offenders in accordance with § 63 StGB, as well as addicted offenders in accordance with § 64 StGB. Within the group of addicted offenders, however, certain differences exist: While the number of the accommodated alcoholics is constant at a relatively high level (in the means of the last ten years approx. 850 per year), the number of drug-dependent offenders has clearly increased, and since the year 2001 has continued to exceed the number of alcohol-dependent offenders (von der Haar 2003).

The majority of the available data originate, however, from the few nationwide research projects (e.g., Leygraf, 1988; Dessecker, 1997), and are limited to the situation within individual States of the Federal Republic (e.g., Seifert & Leygraf, 1997) or they were collected as stock-takings with regard to specific questions due to inquiries from politicians (Federal State Parliament North-Rhine/Westphalia, 2000).

Only recently have some initiatives by individual professional associations and forensic hospitals systematically extended the state of knowledge about general developments of the measure of execution and also about epidemiological questions. Worthy of particular mention is the working group „Forensic Psychiatry", a subgroup of the „Federal Conference of Medical Superintendents". In the year 1994, this group initiated the first nationwide annual survey of addicted offenders according to § 64 StGB.[1] A comparable survey of mentally ill or disturbed offenders accordance with § 63 StGB has been carried out since 2000[2].

Public Opinion and Mass Media

The psychiatrist as an expert witness in court and at important trials is always a focus of great media and public interest. Such trials offer a good chance to have a look at forensic psychiatry. But this is also the chance (and a risk) for forensic psychiatrists to inform the public about their work, about the treatment and about the therapeutic limitations. Activities of interest groups (such as the DGPPN in Germany) may help to focus the public interests on the objectives of the field of forensic psychiatry. Some "key-cases" and the subsequent reaction from the public may have consequences for care and legislation! For this reason, some forensic hospital departments in Germany initiated a "pro-active media-work" effort to inform the citizens, the public and also the political authorities about the needs and aims of the work of forensic hospitals.

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Statistisches Bundesamt Wiesbaden: Fachserie 10, Reihe 4.1 Strafvollzug - Demographische und kriminologische Merkmale der Strafgefangenen, Jahrgänge 1991 bis 2003

[1] Dr. Michael von der Haar, Fachabteilung Bad Rehburg des Niedersächsischen, Landeskrankenhauses Wunstorf, Friedrich-Stolberg-Allee 5, D-31547 Bad Rehburg

[2] Dr. Klaus Leipziger, Bezirkskrankenhaus Bayreuth, Nordring 2, D-95445 Bayreuth

Fig. 24 Judicial and Placement Procedures for Mentally Ill Offenders in Germany

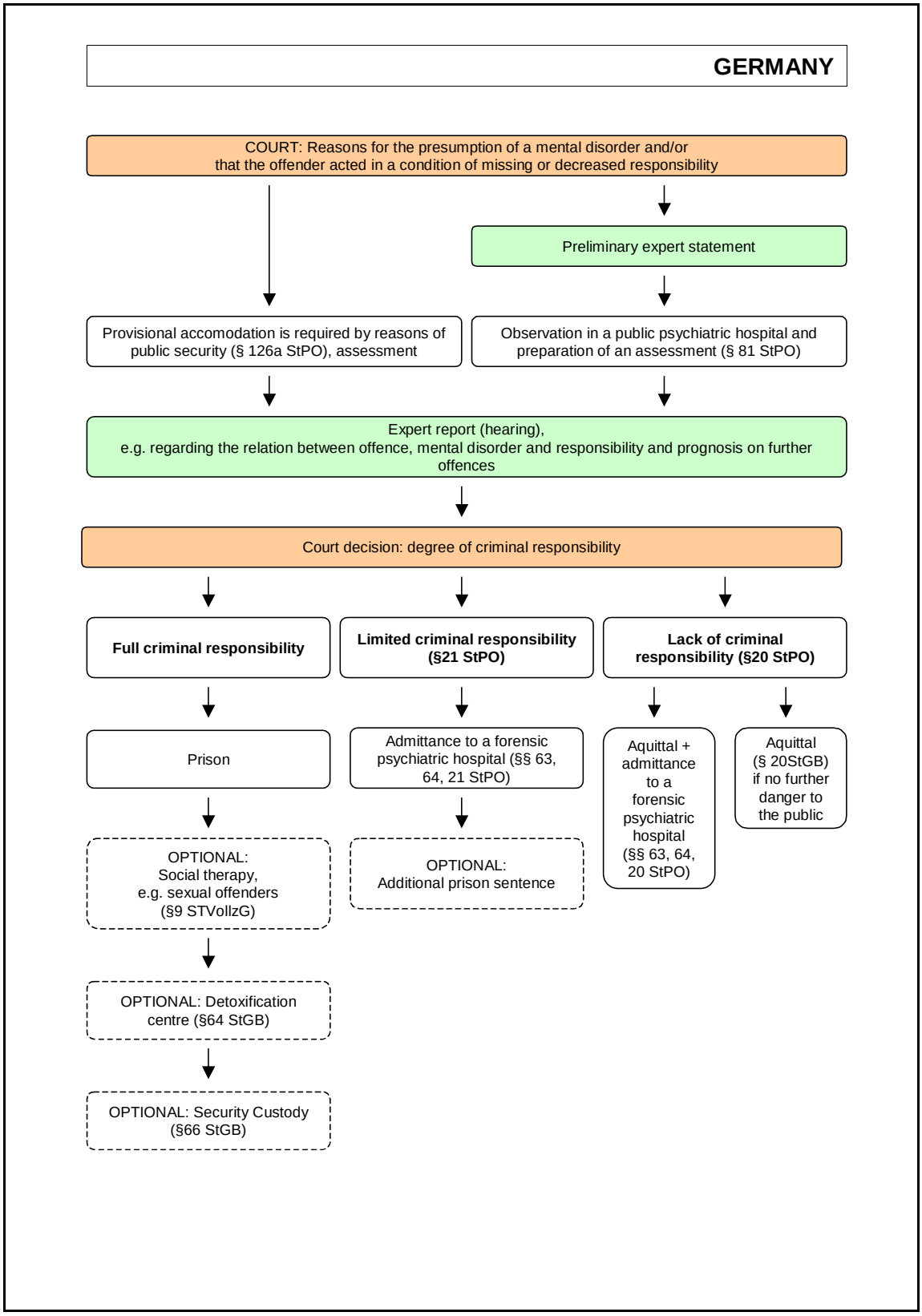
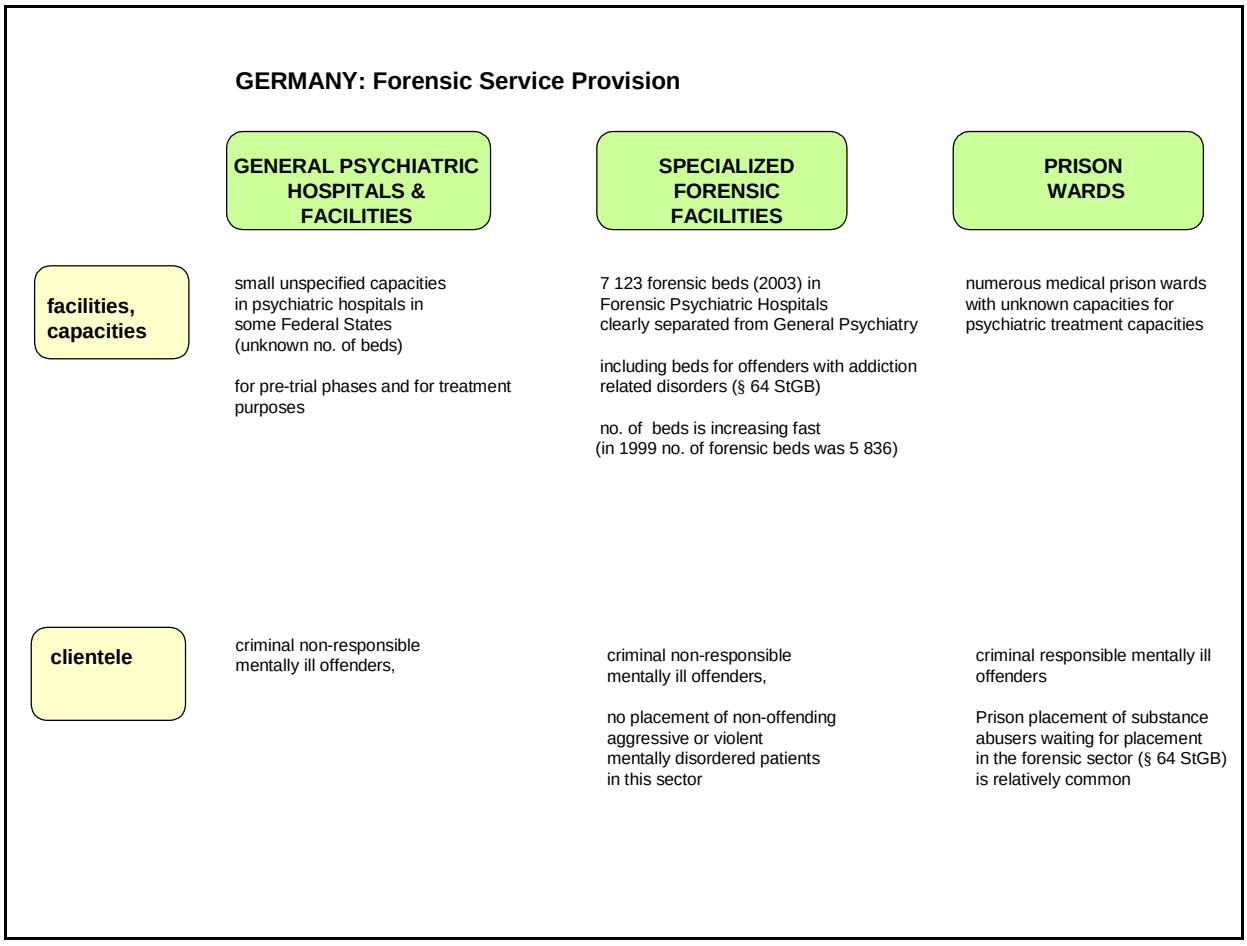


Fig. 25 Forensic Service Provision in Germany



Greece

Giorgos Alevizopoulos, Markos Skondras & Konstantinos Zacharakis

Legislation

The social and legal confrontation of mentally ill offenders has existed in Greek literature since the 5th century B.C. in the tragedies of Sophocles and later in the psychological works of Aristotle. Some of those opinions, such as that of guilty intoxication, have remained immutable until the present day. In Greek penal law, the notion of incompetence was reported for the first time in article 86 of P.L. of 1870, where a person was considered “incompetent” who suffered from fury, complete or partial lunacy, or from any damage to the brain, or mental illness, the free use of logic totally excluded (Striggaris, 1947).

Currently, there is no special mental health care act in Greece for mentally ill offenders but some of the articles in the general penal legislation cover the relevant issues. Articles with regard to mentally ill offenders are included in the penal law (penal code p.c.) and the procedural law that has remained in force with minor additions since 1950. To our knowledge, there are no plans for any reformation of the laws and regulations, although the small numbers of psychiatrists in Greece who practice forensic psychiatry are pressing the government to draw up a special act for mentally ill offenders. The basic philosophy of the existing law emphasises aspects of human rights as well as public safety issues.

The committee of N.D. 1947 worked out the penal law, which in 1950 became the law of state, Law 1492/17-8-1950 of "Ratification of Penal Code". The p.c. of 1950, even if it remains immutable, is compiled in the Greek common language (demotike) by the committee of article 36 §1 of L. 1406/83 and has been in effect since 1985, according to the presidential decree 283/Official Journal of the Hellenic Republic 106, copy first, 31st May 1985. The laws 1160 of 1972 and 410 of 1976 revised some of the articles of the procedural law of 1950 (Dragatsis, 1997). The major articles of the penal and procedural laws, as well as the general philosophy behind the criminal legislation are described briefly in the following: With regard to the penal character of the criminal actions, the p.c. foresees immunity for criminal actions by deaf-mutes and by individuals who have disturbed intellectual functions or conscience.
Article 33: *§1. The action that took place by a deaf-mute is not ascribed, if he is judged as not having the required intellectual ability to conceive of his action as unfair or to act according to his perception of this unfair deed. §2. If it is not a case of application of the previous paragraph, the deaf-mute is punished with a decreased sentence.* Article 34: *The action is not ascribed to the perpetrator if, when he committed it, due to morbid perturbation of intellectual functions or perturbation of conscience, he did not have the ability to conceive of his action as unfair or to act according to his perception of the unfair deed.*

Limitations of these general principles that concern criminals with a circumstantial mental disturbance are described in the subsequent articles. Also determined is the place of detention of perpetrators that belong in these categories:
Article 35.: §1. *An act that someone has decided upon in a normal mental situation, but which to perform it has brought himself into a situation of disturbed conscience, is ascribed to him as if it took place with deceit. §2. If the action that took place in such a situation is other than the one that had been decided, the guilty person is punished by a decreased sentence. §3. An act that the guilty (person) foresaw or could foresee that it would probably take place, if it results from a situation of perturbation of conscience; is ascribed to him as an action that has taken place by negligence*.

Article 36: §1. *If, due to the mental situations that are reported in article 34, (the person) was not completely incompetent, however, the competence to be charged, that is required by this article, was decreased considerably, the sentence imposed is decreased. §2. The provision of the previous paragraph does not apply in the case of guilty intoxication (A. 35).* Article 37: *When the situation of the individuals is that provided for by article 36, of a diminished criminal responsibility for being charged and imposes particular treatment or concern, the sentences that are imposed are executed in forensic psychiatric facilities or departments of prisons.*
Article 38*: §1. If the person who, according to article 36, has diminished criminal responsibility due to perturbation of intellectual functions or according to article 32 §2 is a deaf-mute dangerous to public safety and the action that took place is a felony or delinquency for which the law threatens a sentence longer than six months, the court condemns him to detention in forensic psychiatric facilities or departments of prisons in accordance with article 37 §2. In the decision, only the minimal limit of the duration of detention is determined, which can not exceed more than half the maximum according to the article 36 § 1 limit of the sentence for the action that has taken place.*
Article 39: *§1. After supplementation of the minimal limit that the decision fixed according to article 38 §2, the case is examined every two years, either upon application by the detainee or upon ex officio appointment, to determine whether the person can be released. The magistrate's court (plimelliodikio) in the region in which the sentence is executed decides the case after consultation of special experts. § 2. The discharge is always granted under the term that it can be recalled according to the terms fixed inn article 107 (retraction of discharge when the person does not comply with any detention measures) ·The discharge becomes final, if in five years it is not recalled according to the provisions of article 109 (consequences of non-retraction of sentence). §3. In any case, after supplementation of the minimal limit that fixed the decision, the detention cannot continue beyond ten years for delinquencies or beyond fifteen years for felonies.*
Article 40: *The court that is foreseen by the previous article can at any time, on application by the public prosecutor and afterwards in the consultation of special experts, decide the replacement of detention, with a sentence of imprisonment or imprisonment that was determined according to §3 article 38, if it judges that the detention of the convicted person in forensic psychiatric facilities or departments of prisons is not necessary. In this case, the time that was spent in the forensic psychiatric facilities or departments of prisons is deducted from the sentence that has been imposed.*
Article 41: *§1. If the person who was condemned according to article 38 to detention in forensic psychiatric facilities is judged according to articles 90 and 91 as a recidivist criminal, the minimal limit of the duration of detention is determined in the limits of the sentence according to article 89 (sentence after recidivism). If the law on the action that was taken place foresees the death or lifelong imprisonment, lifelong imprisonment is imposed. §2. The court can change at any time the terms according to the previous article of the detention order in the sentence of vague imprisonment foreseen according to the articles 90 and 92.*

Completing the relative legislation with regard to the penal code for the placement mentally ill offenders we shall refer to two other articles regarding the guardianship of "insane" criminals.
Article 69: *If someone due to morbid perturbation of intellectual functions (article 34) or by reason of being a deaf-mute (article 33 § 1), is acquitted from the sentence or the prosecution for felony or delinquency, for which the law threatens a sentence of more than six months, the court orders his guardianship in a public therapeutic facility, provided that it judges that he is dangerous to public safety.*
And Article 70: §2. *The guardianship is continued as long as (the person) imposes a danger to public safety.* § 3. *Every three years the magistrate's court in the region in which the guardianship is executed decides if guardianship should continue. The same court can, however, whenever upon application by the public prosecutor, or address of the authority of the therapeutic facility, order the discharge of the incompetent criminal.*

Procedures

In usual practice, when an individual for whom there is sufficient evidence that he/she suffers from mental illness, is arrested and after the police submit him/her to the preliminary investigation, he/she is referred to regular interrogation. During this phase the interrogator can, at his judgment,

order a psychiatric assessment. The defendant can also request an expert report. This is the pre-trial process. The jury can also order a psychiatric assessment at any time, even during the hearing.

For the expert report, the defendant is usually detained in the forensic hospital of Korydallos or in a general psychiatric hospital. Since in the psychiatric hospital of Korydallos, there are approximately 200 beds available, the detention of a suspected mentally ill offender in a common prison is not rare. Sometimes, when there is an urgent need for treatment that the forensic setting cannot provide, the detainee is transferred to either a psychiatric or a general hospital of the NHS (L. 2289/1995 article 10 §9). During detention at any of the above settings, the alleged offender can be under psychiatric treatment according to the instructions of a psychiatrist appointed at the setting. Thus the defendant can be on psychotropic medication, which often modifies the clinical picture, further complicating the assessment by the experts. During the examination process it is possible to grant psychological tests although the relevant legislation does not foresee this practice. Hence, the use of psychological tests is limited to certain tests, (e.g., MMPI, MMSE, WAIS). Other more specific tests are held by no means. We suggest that the main reasons for not using a wide range of psychological tests is that the juries are generally reluctant to take into account the results of the tests. And in any case, very few psychologists are trained to administer and evaluate tests more sophisticated than the ones mentioned above.

After the court's decision, the offender who has full criminal responsibility is incarcerated in one of the prisons in Greece. If there is a need for psychiatric treatment, this is provided by the psychiatrist at the prison. If there is a need for further treatment that cannot be provided in the prison, the prisoner is transported to a psychiatric hospital. In the event that the decision of the court is that of lack of criminal responsibility and the person is a danger to the public, the court orders his/hers guardianship in a public hospital. The guardianship is re-evaluated every three years (Art. 69, 70, p.c.). If the criminal responsibility of the offender is limited and he/she is dangerous to the public, the offender is detained in either a forensic hospital (namely the psychiatric hospital of Korydallos) or in a prison (Art. 38 §1, §2). This option is applicable, in practice, only to male offenders, since there is no forensic hospital for women.

Practice

The assessment is held by at least two psychiatrists who are appointed from a list of experts that is designated by the court of first instance of each region. This list is compiled every year after the application of interested experts and is ratified by the council magistrate's court. In order for an expert to be included on this list, it is enough to be a qualified psychiatrist without a criminal record. No other qualifications are required. With regard to the educational background, up until a few years ago psychiatrists in Greece did not receive any special training in forensic psychiatry during their specialisation. Within the last decade three months' practice in forensic psychiatry is foreseen for the trainees. Hence, there is a significant variation in both the content and the quality of the expert reports provided. Concerning the expert diagnoses, confusion often exists due to the terminology. For example, the term "psychotic syndrome" is often used indiscreetly for individuals suffering from schizophrenia, mood disorders, delusional disorders, etc. The use of the terminology and the criteria of either ICD-10, or DSM-IV is not mandatory and they are rarely used in the reports.
The report is always written and in most of the cases, the physical presence of the expert in the court during the hearing process is ordered. The court judges the expert report freely, and is not obliged to follow the conclusions of the experts. Since the authorities of the penal system (judges, public prosecutors, interrogators) lack essential training with regard to the subject of mental health, very often the danger of misinterpretations is exceptionally high.

In Greece there is only one forensic psychiatric hospital for male offenders, which is located near the Korydallos prison in Athens and has a capacity of roughly 200 beds. Some of the mentally disordered male offenders are treated in six of the public psychiatric hospitals in various areas of Greece (Madianos, 2002), but a significant number of mentally ill offenders remain in prisons without any special or adequate care. Nonetheless, neither the psychiatric nor the general hospital

of Korydallos fulfils the standards to meet the therapeutic needs of the incarcerated population. For example, the psychiatric hospital of Korydallos is not in a position to administer psychiatric treatments such as ECT. In such cases, the mentally ill offenders must be transferred to another hospital for a period of time.

Since there are no forensic psychiatric facilities for females, women suffering from mental illness are treated either in the female prison of Korydallos or in psychiatric hospitals of the NHS. As a result, those conditions lead to a high representation of mental illness in the correctional settings of Greece as opposed to rates in prisons in the other EU member states (Alevizopoulos et al., 1998). It is obvious that the degree of the relationship between the penal system and the NHS is occasional and rather the result of direct needs for treatment of mentally ill offenders in cases where the provision of treatment is impossible in the existing forensic settings. This vague relation poses a number of difficulties in the treatment of psychiatric populations within the penal system. For example, the treatments that are provided in the general psychiatric hospitals do not focus on delinquent behaviour. Also the therapists who provide services in the psychiatric settings of the NHS are reluctant to treat such populations, who do not constitute part of their professional choice but are occasional clients. Furthermore, they have not received any special training concerning the specific treatment of such patients. The relatively small number of health care providers at the psychiatric hospital of Korydallos, the lack of liaison with research centres, academic institutions and rehabilitation services limits the range of the treatment to merely psychotropic medications and the management of procedural issues.

Recently, there has been an important movement to incorporate the forensic settings in Greece, namely the general hospital and the psychiatric hospital of Korydallos, into the National Health System. Nevertheless, for the time being this remains a plan. The only improvement in this situation has been the establishment, in 2002, of a special care forensic unit for approximately 200 drug addicts, in the area of Eleon near Athens.

As it is clear from the precedents, the Greek legislation presents important advantages with regard to the guarantee of public safety. The placement of mentally ill offenders in the forensic settings of the penal system, as well as in the psychiatric hospitals of Greece serves this aim. On the other hand, however, the services provided do not focus on the particular needs of such a special population. There is no legislated pre-trial process, if, for example, an individual is incompetent to stand trial. There are no explicit guidelines with respect to the diagnoses of mental illnesses that are related to the charge, and there is no constant framework for the evaluation of mentally ill offenders. In practice, the time intervals between the arrest until the evaluation and the trial are often extremely long, sometimes lasting up to many months, time intervals that serve anything but the needs for placement and treatment of mentally ill offenders.

The absence of a developed subspecialty of forensic psychiatry in Greece, the limited training and the lack of explicit standards for the professionals in mental health in respect to forensic issues, as well as the limited resources do not allow the benefit of satisfactory provision of services for mentally ill offenders. At the same time, the interest in forensic psychiatry, psychology, social work, nursing, etc on the part of professionals in the field of mental health is limited in the correctional settings and absent in the psychiatric hospitals of the NHS. Thus in many cases, the phenomenon is observed that mentally disordered offenders can be inpatients for years in psychiatric structures without receiving any kind of treatment focused on the particular offensive behaviour. For example, there are no services or programs for sex offenders or other special offences. The only therapeutic programs available in the prisons in Greece are those for drug addicts. As a result, the evaluation of recidivism, the maintenance of factors that led to offensive behaviour, the assessment of the existence of other potential victims and so on is obscure, and the tendency is to detain mentally ill offenders for longer periods of time.

Beyond the above, the absence of a psychiatric network of community-oriented mental health services dramatically increases the danger of losing track of mentally ill offenders after discharge, particularly in cases where a supporting familial environment is absent. Overall, the system is far from being modern and rational.

Patients' Rights

The patients' rights during the entire procedure are guaranteed by both the penal code and the code of criminal procedure. Furthermore, the general legislation for prisoners covers certain issues with respect to the rights of any person in detention (L. 1851/1989, 2289/1995).
In practice, the problem is not the legislation, but the resources available. There is a characteristic shortage of adequate facilities in Greece. As has been reported previously, are no forensic psychiatric beds are available for women and there is a much greater need for forensic psychiatric beds among the mentally disordered male offenders than those that the psychiatric hospital of Korydallos can provide. The lack of adequate forensic care provision results in the inadequate placement and treatment of many mentally ill offenders.

Epidemiology

The epidemiological data are the weakest point in the entire system. Only a small part of the available information is collected and reported. The records of the National Service of Statistics contain only general information and the most recent update is the one of 1996. The data indicate a general decline in crime between the years 1990 to 1996, from 109,190 to 86,892 convicted persons, respectively. An interesting finding is that the number convicted male offenders sentenced to life imprisonment and detained in the psychiatric hospital of Korydallos increased from twelve in 1990 to 40 in 1996, respectively.
The relevant research is minimal, and to our knowledge there is only one study by Alevizopoulos et al. (in press) concerning the incidence of mental illness in Korydallos prison. According to our results, 15.96% suffered from a mental disorder: 2.63% of the population of the convicted prisoners suffered from schizophrenia, 4.44% from major depressive disorder, 1.01% from bipolar disorders and 1.41% had dual diagnosis; 29.26% were incarcerated for drug related crimes, 10.64% for homicide and only 0.8% for sexual offences.

Public Opinion and Mass Media

Unfortunately, in Greece there is still a great deal of stigmatisation of mentally ill offenders. The mass media play an important in manipulating the fear and the concern of the public. The legislation in Greece forbids the presence of media in court during the hearing in order to protect the defendant. Nevertheless, the trials of mentally disordered offenders are attractive subjects, particularly for television. Most of the relevant cases are covered without sensitivity, generating feelings of fear and insecurity, mainly with regard to the danger of recidivism among mentally ill offenders (Alevizopoulos, 2003). Finally, there are no NGOs for mentally disordered offenders other than the interest groups for prisoners and mentally ill persons. Public donations, the Greek Orthodox Church and the private sector support financially these groups.

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Fig. 26 Judicial and Placement Procedures for Mentally Ill Offenders in Greece

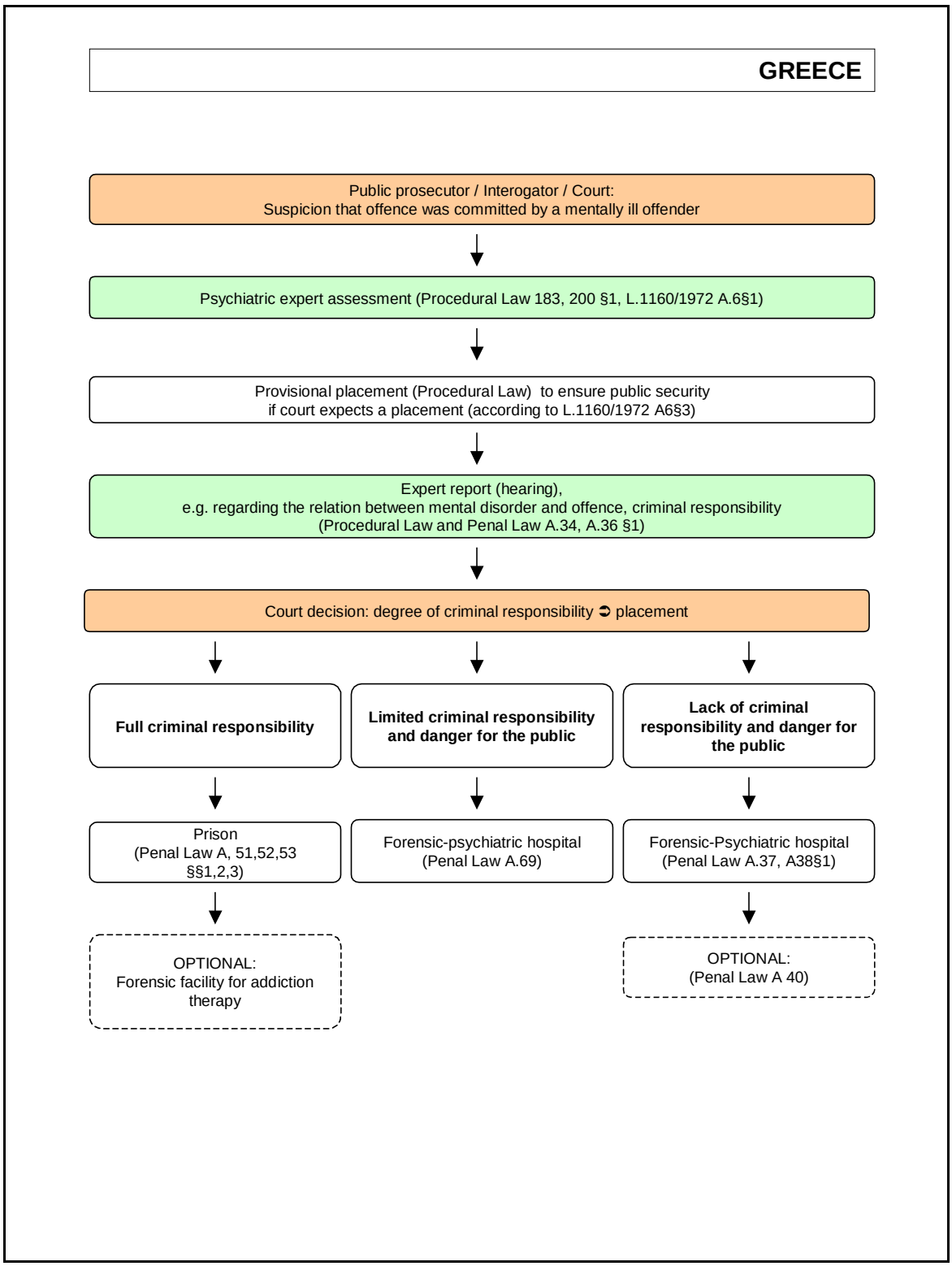
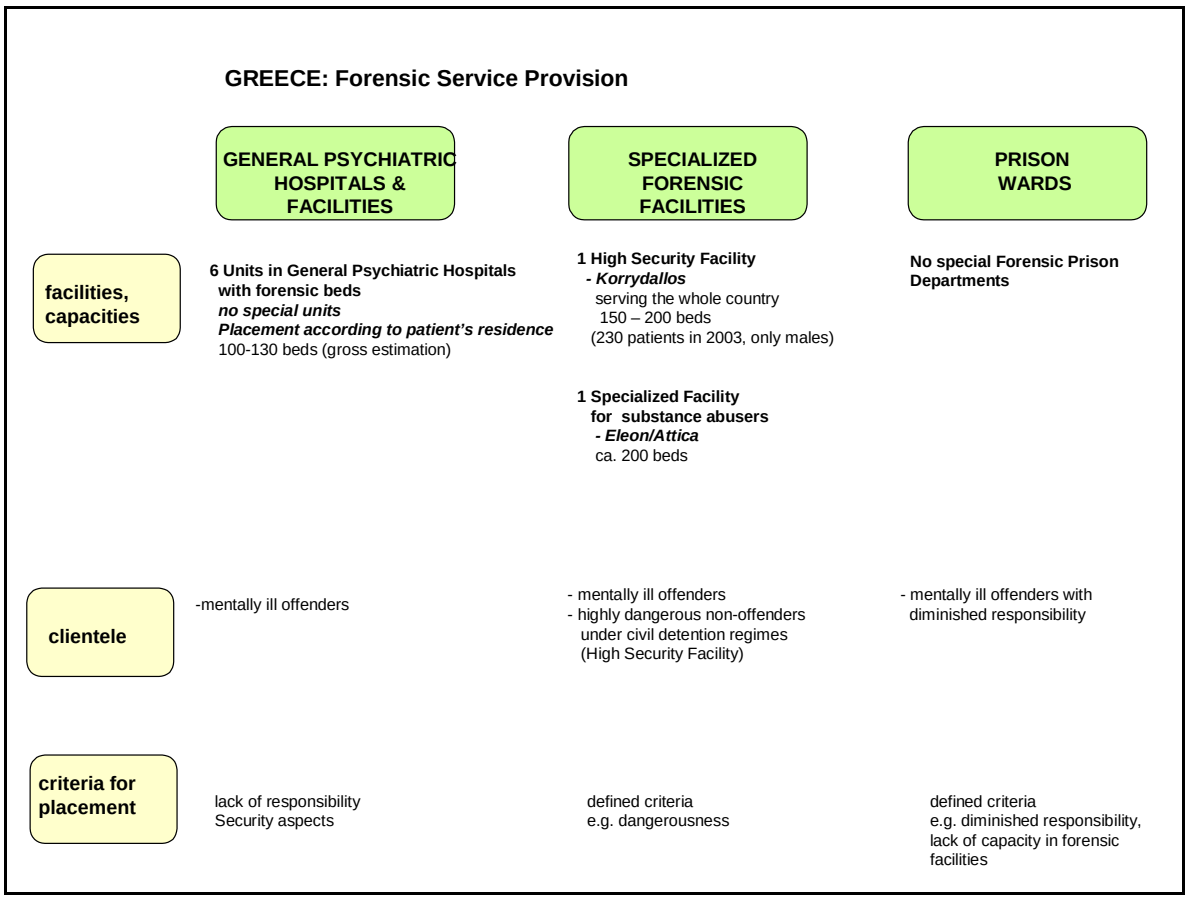


Fig. 27 Forensic Service Provision in Greece



Ireland

Dermot Walsh

The care of the criminally insane in Ireland was initially in the prison system and well established as such by the late 18th century. Prisons and bridewells were the recipients of many mentally ill persons, the majority of them guilty of minor offences such as thieving, vagrancy, etc. Since there were no public institutions for the mentally ill, whether criminally so or not the prison system became the usual repository for such persons and prisons were plentifully disposed around the major towns at that time. With the setting up of an Inspectorate-General of Prisons in 1773 some measure of surveillance of prison conditions and the acknowledgement of the civil rights of their occupants came into being.

With the passage of the Act of Union in 1800, Ireland became part of the United Kingdom of Great Britain and Ireland ceased to have an independent parliament until 1922. The country of Ireland was administered by a Lord Lieutenant and his administration on behalf of, and subject to, the Westminster Parliament in London. Accordingly, mental health legislation, although applying exclusively to Ireland, was very heavily influenced in philosophy and in practical application by the statutes elsewhere in the United Kingdom.

Legislation of 1812, 1821, 1846 and 1875 set out the provisions to be put in place for the care of pauper lunatics and the setting up and regulation of private madhouses. In these early years the compulsory admission and detention of lunatics in district lunatic asylums was a function of the local judicial authority. The quality of care provided in the institutions was subject to the regulatory and statutory role of the Inspectorate of Lunacy, an office established in 1846 as a breakaway from the Prison Inspectorate which in 1826 had been given statutory powers “to visit and inspect all madhouses and places where idiots or lunatics are confined, whether the same shall be any public establishment or kept for profit by any private individual, as well as all Gaols and Prisons throughout Ireland.”

In 1838 a statute to “make more effectual Provision for the Prevention of Offences by insane persons in Ireland” was enacted, which made it lawful for two Justices of the Peace to commit to gaol persons identified as dangerous lunatics or dangerous idiots. Significantly, in 1845, Parliament legislated for “The Establishment of a Central Asylum for Insane Persons charged with Offences in Ireland”, and on its erection, the transfer of all Criminal Lunatics held in detention in all gaols or district asylums. This asylum became known as the Central Mental Hospital in later years. In the 2nd half of the 20th century its administration became vested in the Eastern Health Board and subsequently the East Coast Area Health Board. It remains the only secure forensic psychiatric facility in the country.

The Lunacy Act of 1875 made further provision for the admission to and care of mentally ill persons in an extended network of asylums. With the foundation of a separate Irish Free State in 1921, British administration in the southern 26 counties of Ireland ceased, and the mental hospital system, as it had now become, was administered by the Irish Government from Dublin. Nonetheless, the provisions of the 1875 Act continued to operate until the putting in place of the Mental Treatment, 1945. This new legislation while still influenced by the 1875 Act, was innovative in a number of ways, not least in establishing a category of voluntary admission, which hitherto fore, had been exclusively compulsory. A Mental Health Act, 1981 was signed into law, but was found to be inoperable and never came into operation. In 2001 a Mental Health Act was signed into law by the Pre-

sident, but at the time of writing (August 2003) has not yet become operative. Accordingly, the provisions of the 1945 Act still operate.

Criminal Law Insanity Legislation

Since 1843 the test for insanity as a defence in a criminal prosecution stems from the Mc Naughten Rules which had applied throughout the United Kingdom where they were formulated. For a successful defence to be established on grounds of insanity they required that the accused person must have suffered, at the time of the act, from a defect of reason due to disease of the mind, such that he or she, did not know what he or she was doing, or did not know that what he or she was doing was wrong. These rules were accepted as the general test for insanity in Irish law despite doubts being expressed that they represented a comprehensive statement of Irish law on the subject. However, a decision by the Supreme Court in 1965 went beyond McNaughten in introducing a third factor, an irresistible impulse which the Court said "debarred the defendant from refraining from committing the act". The onus of proving insanity on the balance of probability is on the person alleging it. It should be borne in mind that the Irish legal system is an adversarial system with evidence and examinations and cross-examinations of witnesses being carried out in court by both sides, prosecution and defence, usually before a judge and jury. If the defence is successful the trial Judge must bring in the special verdict of "guilty but insane" as provided under the Trial of Lunatics Act 1883 and commit the person to detention in the Central Mental Hospital. In trials where insanity is raised as a defence this will be supported by expert witness testimony usually by a psychiatrist or occasionally by a psychologist and the State as prosecutor will do likewise if it feels that there are grounds for refuting the insanity defence. In such cases the prosecution will call psychiatrists from the national forensic service based at the Central Mental Hospital. When a person committed to the Central Mental Hospital as guilty but in sane is deemed recovered by the psychiatrist in charge there have been difficulties in determining who has power or responsibility for discharging the person, whether the courts or the executive. In cases where a prisoner is on remand facing charge and the matter of his or her "fitness to plead" arises on grounds of mental illness this will be tested in similar manner and be presented to the court. If the insanity plea is accepted then the Court will order the detention of the person in the Central Mental Hospital even though unconvicted, until such time as he or she becomes fit to plead and when expert evidence to this effect is given to the court.

If a prisoner requires treatment which cannot properly be given in a prison, the Minister for Justice may direct that he/she be transferred to the Central Mental Hospital for assessment and treatment. This is affected through the powers of what is known as a hospital order under 17(6) of the Criminal Justice Administration Act, 1914. If the treatment of such a prisoner/patient without his/her consent is an issue, steps may be taken to have the person certified. This is done under section 13 of the Lunatic Asylums (Ireland) Act 1875, as amended by the Criminal Justice Act, 1960. In this instance, a certificate in the appropriate form is completed by two doctors (usually general practitioners supplying medical services to the prisons) with or without the advice of a forensic psychiatrist to the prison. Following the medical certification the Minister for Justice may make an order that the prisoner be transferred to the Central Mental Hospital. This is referred to as a Ministerial Order. The decision as to whether a patient should be returned to the prison is treated as purely a medical matter, lying within the sole discretion of forensic psychiatrists at the Central Mental Hospital. There is no automatic review of such patients while detained in the Central Mental Hospital under existing legislation nor under the proposed Criminal Law (Insanity) Bill 2002. However representations have been made to the Department of Justice to include this group of persons in its remit.

Two sections of the Mental Treatment Act, 1945 and as amended, allow the transfer of patients from district mental hospitals and from private mental hospitals to the Central Mental Hospital. Section 207 provides that where a person detained in a mental hospital or unit is charged with an indictable offence before a Justice of the District Court sitting in such hospital and evidence is produced, which in the view of the Justice, constitutes prima facie evidence that a) the person committed the offence and b) that if placed on trial would be found unfit to plead, the Justice shall by order certify that such person is suitable for transfer to the Central Mental Hospital, subject to approval by the Minister acting on a report on the examination of the person by the Inspector of Mental Hospi-

tals. In practice, through doubts of the constitutionality of this section it has fallen out of use although there still remain some persons in the Central Mental Hospital transferred thereto under this provision many years ago. Section 208, which allows for the transfer of patients in psychiatric hospitals to other hospitals for the purpose of receiving therein treatment not available in their parent hospital has been used for the purpose of transferring persons to the Central mental Hospital contrary, one imagines, to the spirit of the section. The Supreme Court ruled in a test case in 1997 on the appeal of the parent of a person so transferred that for the purposes of this section the Central Mental Hospital was a hospital like any other – a thesis difficult to accept and leading to the employment of this section to make further transfers of this kind, mostly on the grounds of security in the absence of a national system of secure psychiatric units in the country apart from the Central Mental Hospital.

In the light of the generally unsatisfactory nature of statute provision for and management of the mentally ill offender an Interdepartmental Committee on Mentally Ill and Maladjusted Persons published an interim Report in 1978 which made a number of recommendations. As a result and for other reasons such as the European Convention on Human Rights Bill 2001 a new Criminal Law (Insanity) Bill was introduced to the Oireachtas (parliament) and as of August 2003 has had its first reading. Although this is still a bill rather than a law, it is likely that by the time this report is published it will be the functioning legislation and therefore will be the legislation on which this contribution is based and the questionnaire completed. In any case a very brief outline of the existing position has been presented.

Criminal Law Insanity Bill 2002

The area of the criminal law which is the subject matter of this Bill is concerned with the drawing up of appropriate rules to govern the criminal responsibility of mentally ill persons who may have committed offences. It has its origins mainly in the common and statue law of the 19th century with further significant developments in case-law throughout the 20th century. While the legal and medical definitions which apply are not co-extensive, the approach adopted in the Bill takes into account the overlap between the criminal justice elements, and the need to have regard to the treatment aspects of mental health legislation, particularly concerning matters which a court must take into account when considering the options available to it following a determination of “unfitness to be tried” or “not guilty by reason of insanity”, otherwise known under existing law – but due to be changed under the Bill – as “unfitness to plead” and “guilty but insane”.

The Purpose of the Criminal Law Insanity Bill 2002

With the development of modern psychiatry and greater understanding of the underlying causes of mental illness and its associated conditions, it has become apparent that this area of the criminal law needs clarification and development. The difficulty, however, in making any change is illustrated by the fact that no singular or uniform solution has been adopted in the various common law countries, including those with which we are closely connected. The purpose of the Bill is to clarify, modernise and reform the law on criminal insanity and fitness to be tried and on related issues; and, to bring it into line with the jurisprudence of the European Convention on Human Rights, which will soon be given further effect in domestic law in accordance with the provisions of the European Convention on Human Rights Bill, 2001. At present the Convention is law for Ireland on the international plane, but it is not part of the domestic law in Ireland. The Bill provides for extensive new provisions dealing with fitness to be tried, (which term will now apply rather than fitness to plead) as well as new rules in relation to appeals against such findings, a statutory definition and restatement of the test for criminal insanity based on the existing rules at common law as developed in Ireland, a new verdict of “not guilty by reason of insanity” to replace the existing “guilty but insane” verdict, and a new plea of “guilty but with diminished responsibility” in cases of murder. In doing so, the Bill implements certain recommendations made in the Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons (The Henchy Committee) published in 1978. In addition, and in the light of obligations under the Convention on Human Rights as already mentioned, the Bill will establish a new Review Body – the Mental Health Review Board – whose function

it will be to review at regular intervals or on application the cases of persons detained following verdicts of “not guilty by reason of insanity” or findings of “unfitness to plead”.

Provisions of the Bill

Psychiatric Centres and Prison Centres
Sections 1 and 2 of the Bill set out the nature of centres designated by the Minister for Health and Children (with the consent of the Minister for Justice, Equality and Law Reform in the case of the designation of a prison or any part there of) for the reception, detention and where appropriate, the care and treatment of persons committed there under the Bill. For the most part it is intended that most centres will be psychiatric centres that have in-patient specialised psychiatric facilities. The designation of a prison as a centre is to cater for the situation where it might be more appropriate, under the provisions of the Bill, to detain a person in prison rather than in a psychiatric centre.

Mental Disorder
The term “mental disorder” is defined for the purposes of establishing criminal liability and includes a person suffering from a mental illness or handicap, dementia or any disease of the mind, but excludes intoxication from alcohol or other substances. While the definition is not fully inclusive, the essential element for the court, for example when criminal insanity is pleaded, is had the accused the mens rea to commit the crime for which he or she is charged. The definition of mental disorder is intended as the test for the court in coming to a decision on that issue. It should be noted that the definition differs from that of the Mental Health Act 2001 which specifically excludes personality disorder and social deviancy from its definition of mental disorder – a matter not without some practical difficulties which will be referred to later.

Fitness to be Tried
Section 3 of the Bill introduces this concept in place of the term fitness to plead which is used in the relevant provisions of the Lunacy (Ireland) 1821, which will now be repealed. Where in the course of criminal proceedings against an accused person the question arises, at the instance of the defence, the prosecution or the court, as to whether the person is fit to be tried he or she will be deemed unfit if unable by reason of mental disorder to understand the nature of the proceedings so as to plead to the charge, instruct a legal representative, make a proper defence or understand the evidence. Where the Court determines that an accused person is unfit to be tried, that Court shall adjourn the proceedings until further order, and may, if it is satisfied, having considered the evidence of a consultant psychiatrist and any other evidence, that the accused is suffering from a mental disorder, as defined, and is in need of inpatient care or treatment in a designated centre, commit him or her to a specified designated centre. If the Court determines that the accused is fit to be tried the proceedings will continue. A Court determining fitness to be tried will be presided by a judge sitting alone without a jury. The period of committal to a designated centre shall be for a period of not more than 28 days. In effect this period of committal is for the purposes of assessment. And the Court will direct that the accused be examined by a consultant psychiatrist at that centre and within this 28 day period the psychiatrist of the centre shall report to the Court on whether the accused is in need of in-patient care or treatment in a designated centre. If the court is of the opinion that this is the case then the court shall make an order committing the accused to that centre. Notwithstanding this the defence may apply to the court to allow evidence to be adduced as to whether or not the accused committed the act alleged and if the court is satisfied that there is a reasonable doubt that the accused committed the act alleged, it shall order the accused to be released.

Not Guilty be Reason of Insanity
This new verdict is dealt with in section 4 of the Bill and replaces the existing special verdict of guilty but insane. The test to be applied relates to the state of mind at the time of the alleged offence and not at the time of trial. Where on trial the court or the jury finds that the accused person committed the act alleged against him or her, and, having heard evidence relating to the mental condition of the accused given by a consultant psychiatrist, finds that the accused person was suffering at the time from a mental disorder such that he or she should not be held responsible for the act alleged by reason that he or she did not know the nature and quality of the act or did not know that what they were doing was wrong or was unable to refrain from committing the act the court or jury

shall return a special verdict that the accused is not guilty by reason of insanity. Where the court considers that such a person not guilty by reason of insanity is in need of inpatient care or treatment in a designated centre the court may commit that person to a specified designated centre for a period of not more than 28 days and direct his or her examination by a consultant psychiatrist during that time. This period of time may on application to the court be for a period or the aggregate of the periods to a total not exceeding 6 months essentially for assessment purposes and during the period of committal the consultant psychiatrist of the centre shall report to the court whether the accused is suffering from mental disorder and is in need inpatient care or treatment in a designated centre.

Diminished Responsibility
Where a person is tried for murder and the jury or the Special Criminal Court finds that the person committed the act alleged, was at the time suffering from a mental disorder which was not such as to justify him or her being not guilty by reason of insanity, but was such as to diminish substantially his or her responsibility for the act, the jury or court shall find the person not guilty of murder but guilty of manslaughter on the ground of diminished responsibility. It shall be in such cases for the defence to establish, presumably on the evidence of expert testimony, to establish that the accused is not guilty of murder. While a verdict of murder carries with it a mandatory life sentence the verdict of manslaughter allows a the judge take into account the mental state of the convicted person when considering what sentence to impose. The availability of the verdict of diminished responsibility should reduce the danger that a jury will return an insanity verdict when faced with a person whom they regard as not completely sane, even if he or she does not meet the legal criteria for insanity.

Appeals
Under this Bill persons found unfit to be tried or not guilty by reason of insanity have the right of appeal to higher courts to have these decisions set aside on the grounds that he or she did not commit the act or was not suffering from mental disorder.

Health Review Board
The Bill provides for the establishment of a Mental Health Review Board which shall have regard to the welfare and safety of the persons whose detention it reviews and the public interest. The Board shall hold sittings for purposes of review and at the sittings may receive submissions and such evidence as it thinks fit, take account of the court record of the proceedings of the court to whose decisions the request for review relates and assign a legal representative to a patient the subject of the review unless he or she proposes to engage one. The establishment of the Board will comply with obligations under the European Convention on Human Rights. The main function of the Board will be to review the detention in designated centres of persons found not guilty by reason of insanity or unfit to be tried in designated centres by order of a court. The Board will determine when such a person should be released. The Board shall comprise a senior lawyer or judge, a consultant psychiatrist and such other number of members as the Ministers of Health and Justice may appoint.

Review of Detention
The Review Board shall ensure that the detention of a patient is reviewed at intervals of such length not being more than six months as it considers appropriate and the clinical director's hall comply with any request by the Review Board in connection with the review. Where the clinical director of a centre of a designated centre forms the opinion in relation to a detained patient that the patient is no longer unfit to be tried he or she shall forthwith notify the court that committed the patient to the designated centre of this opinion and the court shall order that the patient be brought before it as soon as may be to be dealt with as the court thinks proper. Where the clinical director forms the opinion that a detained patient, although still unfit to be tried, is no longer in need of inpatient treatment at a designated centre he or she shall forthwith notify the review Board of that opinion. On notification of this opinion the Review Board shall order that the patient be brought before it as soon as may be and having evidence given by the consultant responsible for the patient shall make an order for the patient's disposal, whether for further detention, care or treatment in a designated centre or for his or her discharge whether unconditionally or subject to conditions for out-patient treatment or supervision or both.

Temporary Release
The clinical director of a designated centre may, with the consent of the Minister of Justice, direct the temporary release of a patient on such conditions and for such period or periods as the clinical directors thinks appropriate.

Procedures

The legislation does not allow for pre-court assessment procedures such as when a person having committed an offence, is arrested by police, who suspecting or knowing that the person suffers from mental illness, can seek a psychiatric examination with a view to not proceeding with a formal charge and cannot, instead, seek care or treatment, thereby avoiding a charge and court appearance. Neither does the legislation prohibit such deviation procedures and it is the ambition of the forensic psychiatric services to move in this direction. As matters stand a person charged can be the subject of psychiatric assessment for the purposes of the court's deliberations at the instigation of the defence, the prosecution or the court itself. The point at issue is whether the accused is fit to be tried. If the court finds on the basis of psychiatric evidence that he or she is not then the court will order detention in a designated centre for further assessment up to a period of 28 days during which time a further report will be submitted to the court to determine, on the basis of the report of the consultant of the designated centre whether the accused is fit to be tried or not. If the court rules that he/she is unfit to be tried then the court will make an order committing the person to a designated centre where he/she must be the subject of review by the Review Board within six months or at any earlier time and as soon as may be if the consultant informs the Board that he/she is of the view that the accused has become fit to be tried. The board, then on hearing the consultant's evidence, will determine whether to send the accused back to the court or to continue care or treatment either in the centre or on an outpatient basis.

When a case proceeds to trial but a plea of not guilty, by reason of insanity at the time of the act the subject of charge, is raised by the defence, the court will hear expert evidence for the defence and perhaps refuting evidence by the prosecution. If a verdict of not guilty by reason of insanity is returned, the court will then consider the mental condition of the accused at the time of trial to determine whether he/she should be released or detained for inpatient care or treatment. If the latter is decided then the care and treatment will be provided in a designated centre. Thereafter this person shall be subject to the review procedures of the Review Board as set out for a person detained as unfit to be tried.

Where a court, on the basis of expert testimony, in the case of a person tried for murder, finds that the charge of murder is not sustained through diminished responsibility, it will bring in a verdict of manslaughter. No powers or responsibilities are given by the bill to the court in relation to care or treatment in such cases.

Practice

It is not possible to comment as the proposed legislation is still a bill which has not yet been enacted and therefore has not been tested in practice, however, a number of organisations have expressed some reservations about certain aspects of what is proposed.

There is much concern that the definition of mental disorder differs between the civil mental health legislation - the Mental Health Act (2001) – and the Criminal Law Insanity Bill, because the civil legislation specifically excludes personality disorder and the forensic does not. This may lead to substantial operational difficulties; for example where a court on the basis of personality disorder orders a person to be detained in a psychiatric unit which under the civic legislation by which it operates has no power to detain such a person. Additionally psychiatrists have generally not welcomed the responsibility of detaining persons in a milieu, a general hospital psychiatric unit, where as far as other patients are concerned, the emphasis is of care and treatment under the least restrictive alternative i.e. open doors etc.

Another point of contention, justifiable perhaps, is that courts can only refer persons, for assessment or treatment as detained in-patients instead of having the broader option in accordance with expert opinion of referring them for such interventions on a non residential basis, i.e., as out-patients, day hospital patients etc.

There is much criticism of the use of the concept of “irresistible impulse” as an ingredient in the not guilty by reason of insanity verdict, as being unsustainable on scientific and philosophical grounds.

The issue of whether the designated centre has powers to treat without consent is not dealt with and there is a sentiment that the forensic legislation should be brought into line with the civil psychiatric law which does deal with this giving powers of treatment without consent to detained patients under stipulated conditions.

There has been objection to the use of the word “insanity” in the Bill as being antiquated and pejorative. Likewise there is a fear that the verdict of not guilty by reason of insanity with the implication that the person has therefore not been guilty of any crime will hinder therapeutic intervention based on the self-perception of wrong-doing through lack of self-control.

Fig. 28 Judicial and Placement Procedures for Mentally Ill Offenders in Ireland

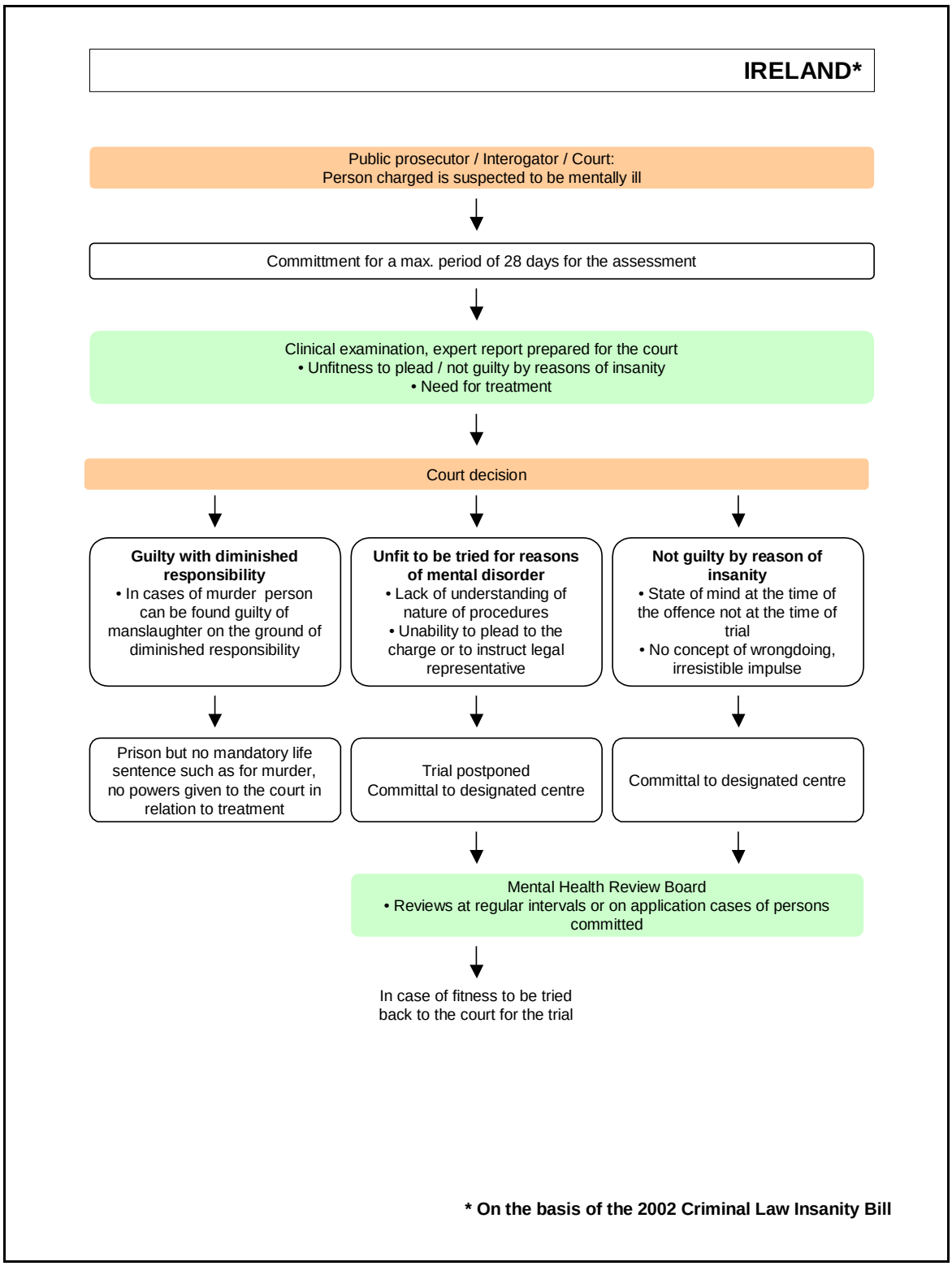
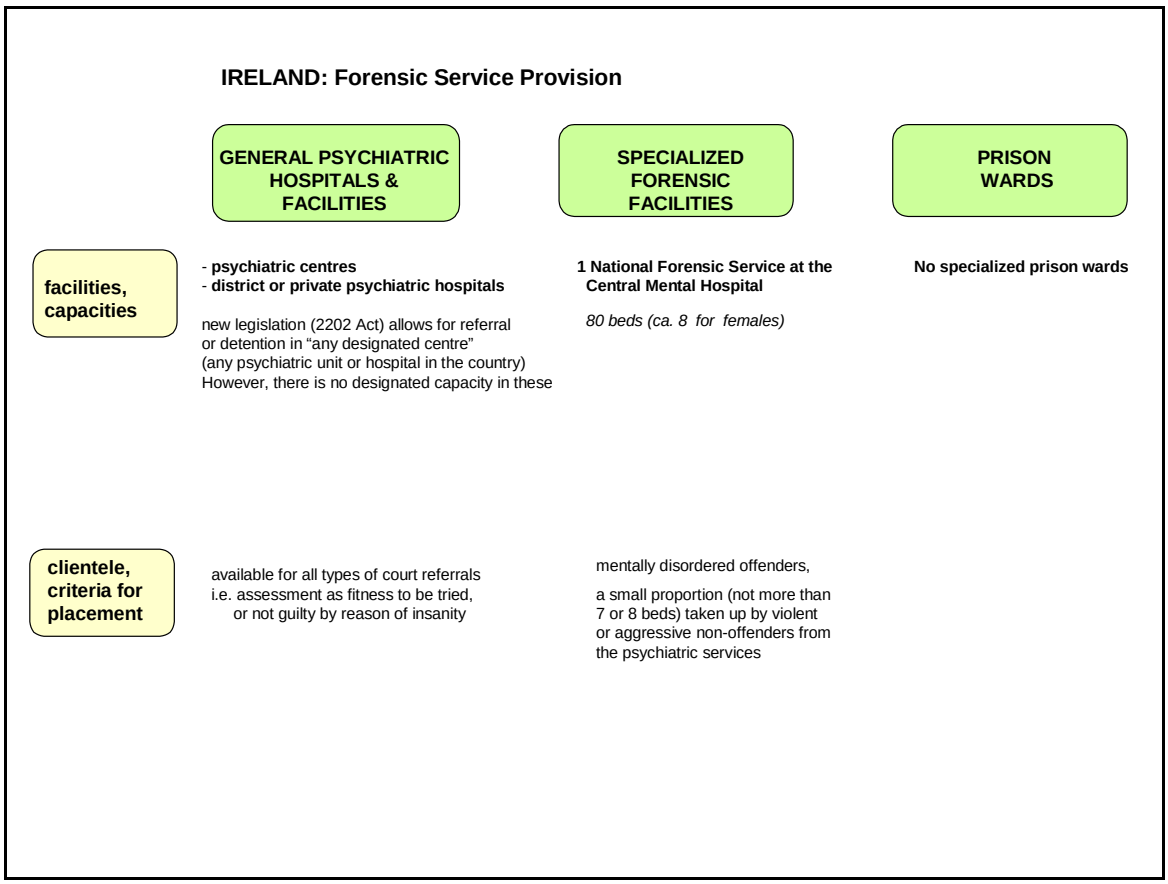


Fig. 29 Forensic Service Provision in Ireland



Italy

Angelo Fioritti

Legislation

The Italian legal framework, like many other systems in Europe, is based on Roman Law. Four codes [Criminal (CP), Criminal Procedural (cpp), Civil (CC), Civil Procedural (CPC)] strictly define rules and procedures, and the role of interpretation by magistrates is quite limited. The Criminal Code was approved in 1930 and since the '60s several boards appointed by the Italian Parliament have been working on a new CC revision, which is not expected to reach its final version until the elapse of another five to six years. In 1988, a new Criminal Procedural Code was approved, whose main purpose is to balance the power of attorney and defence during the pre-trial and trial phases. In general, the system is much more prescriptive and less flexible than those following the Anglo-Saxon system of Common Law.

Both criminal and civil tribunals are national institutions, while regional legislation regards purely administrative issues, such as health legislation, which is shared between the national level (general principles, objectives and criteria) and the regional one (their actual implementation and use of resources). This explains why the changes in health legislation are much more rapid than those in criminal law. In 1978, Italy passed a major reform in psychiatry, establishing a radical community-based system and the closure of all mental hospitals. This law has promoted a dramatic change in the philosophy behind and the practice of all mental health services, but has not affected the procedures and practices regarding mentally ill offenders, which have basically remained regulated by the Criminal Code of 1930.

All magistrates and attorneys (civil and criminal) involved both in pre-trial and trial procedures belong to the same professional body (*Magistratura*), though many political parties are claiming for a separation of their functions and careers. The general philosophy of Italian criminal law follows Cesare Beccaria's principles of equity and balance between punishment and treatment, assuming that the main scope of a sentence is to bring back citizens to society. The declared philosophy of Italian prisons aims at integrating preventive and treatment approaches by means of offering opportunities for the social rehabilitation of the criminal offender.

Due to the above-mentioned split between administrative and criminal legislation, current provisions regarding mentally ill offenders and their placement reflect the philosophy and practice of the 1930's, while ordinary psychiatric services are designed along the lines of a post-de-institutionalisation community-based system of care. Public opinion, most political representatives, and psychiatric professional associations all agree that a harmonisation of these two aspects is mandatory, but the long times required to produce changes in criminal law are likely to prevent such an update in the short run.

Procedures

Current procedures for the management of mentally ill persons who have committed a criminal offence comprise four phases: Inquiry, Pre-trial, Trial and Placement.

Inquiry

During this phase the General Attorney (*Procuratore della Repubblica - PR*) must acquire all elements in order to decide whether the act committed is a crime. In this phase he is entitled by §359

cpp to appoint a psychiatric expert in order to obtain elements which can enable him to decide whether to start a prosecution by the preliminary judge (*Giudice per le Indagini Preliminari - GIP*). In the case of trivial offences committed by a person deemed ill by the expert, it is not unusual for the PR to refer the offender to ordinary community services rather than to prosecute him/her.

Pre-trial

The structure of the pre-trial phase is quite similar to that of a small trial, with one judge (GIP) who has to take a decision about investing a court of the trial and about all measures to be taken before the trial, including the placement of the offender in this phase. The PR and the defence play a substantially equal role in this phase. They can present elements and proofs, including the results of assessments carried out by their experts. The GIP can appoint his/her own expert (according to §392 CPP) in order to obtain a psychiatric assessment, including recommendations about provisional placement. The parties have the right to appoint their own experts, who can participate in all sessions that the GIP expert is having with the suspected offender. The GIP expert must refer orally and present a written report. The PR's and defendant's experts can present their own reports. The GIP holds a hearing at which all experts are present and can debate among themselves.

During this phase the GIP can order provisional placement in a prison, in a forensic psychiatric hospital (*Ospedale Psichiatrico Giudiziario - OPG*) (§312 CPP) or in an ordinary psychiatric facility (§73, §286 CPP), when there is a need for care or a problem of public safety.

At the end of this phase the GIP must decide whether or not to convict the offender by the Court. In the case of trivial offences committed by a person deemed mentally ill, the GIP usually ceases prosecution and commits him/her to ordinary psychiatric care. In the case of serious crimes or of persons deemed dangerous, a trial is common practice.

Trial

Court composition varies according to the severity of the crime committed. Crimes punishable by four years or less of detention are judged by the Low Courts (*Giudice Monocratico*), composed of only one judge. More serious crimes are judged by a High Court (*Corte d'Assise*); when there is a conviction for homicide, the Court also comprises lay members who work together with three judges whose task is to compile a written report on the reasons for the sentence.

The court usually holds a hearing of the expert(s) who have been working during the preliminary phase. Where these have not been appointed or when the Court warrants an independent assessment, the Court appoints its own expert (§508 CPP). All parties can appoint an expert and they have the right to participate in all sessions.

All experts are heard both independently and together. Sometimes all experts from the pre-trial and the trial phases are heard together and they can be cross-examined by the Court and by the parties: Sometimes courts allow for a real debate among the experts.

The court takes the final decision according to the criteria of criminal responsibility and dangerousness (§§88-89 CP; §70 CPP). Criminal responsibility refers to the time of offence, dangerousness to the time of trial. In the event of full criminal responsibility, the offender receives his/her sentence without any special treatment. In the event of a complete lack of criminal responsibility (§215 CP and following) there are two options:

a) If the offender is deemed dangerous to public safety, he/she is acquitted and sent to a psychiatric forensic hospital (OPG) for a period which varies according to the crime (two, five or ten years).
b) If he/she is deemed not dangerous, the offender is acquitted and set free and enters ordinary psychiatric care.

In case of a partial lack of criminal responsibility and of dangerousness (a verdict often passed for offenders with learning disabilities or severe personality disorders), there are again two possibilities:

a) The sentence is mitigated by approximately one third.
b) The offender is sent to a psychiatric forensic hospital (OPG) for half of the period provided for complete lack of responsibility and then to prison for the second half.

Practice

The system of practice resulting from these provisions is well established and reasonably consistent, as it has been in effect since the 30's. Although some psychiatric concepts are defined only legally (e.g., criminal responsibility criteria reflect the legal categories of insanity and mental flaw, not clinical ones) tradition and professional work over the decades have produced a certain degree of homogeneity in GIPs and decisions by the courts. Following many decades of harsh debates and conflicts medical professionals themselves (psychiatrists, forensic medicine experts and criminologists) now share a more common scientific and professional ground, though the case for different conclusions by Court, PR and defence experts in the trial arena is still frequent.

This system is nonetheless far from being considered satisfactory by many stakeholders involved in it. The main perceived limitation regards:

1. the selection, certification and appointment of experts,
2. the actual complete split between the ordinary psychiatric system and that of forensic psychiatry,
3. the actual organisation of the forensic psychiatric sector and the quality of care it provides.

The Experts in the Court

Currently PRs, GIPs, defence and the courts can appoint any registered medical doctor, without any need for certification of specific training and experience in the forensic field. Although for all tribunals there is a register of experts by specialty, this is rarely used and appointments follow the general rule of personal knowledge. Furthermore, criminologists and coroners (with usually little experience in clinical psychiatry) are appointed most frequently, while clinical psychiatrists play a minor role in forensic practice. This paradox is also enhanced by the scarcity of educational and training opportunities in forensic psychiatry at the medical faculties of Italian universities. Forensic Psychiatry is neither a field of post-graduate specialisation nor a subspecialty of psychiatry in Italy. A more formal system of certification and appointment is currently demanded by most psychiatric scientific societies.

The Split between Psychiatry and the Forensic System

Italy has been operating a National Health Service (NHS) since 1978 and about 5% of the NHS resources are allocated to child and adult psychiatry, excluding services for drug abuse and learning disabilities. The NHS is organised into 235 Local Health Trusts *(Aziende Unità Sanitarie Locali – AUSL)*, each of which cares for a geographically-defined population of 200-500,000 inhabitants and each of which comprises one Mental Health Department (*Dipartimento di Salute Mentale – DSM*) that provides comprehensive psychiatric care to the population and manages on a unitary basis the full set of services established as necessary by national policy documents: community mental health centres, day-hospital/day-care rehabilitation centres, psychiatric wards by the general hospital, non hospital residential medium- and long-term facilities.

This system (Fioritti et al., 2003) is the conclusion of a process that began with law 180 of 1978, which basically decided five issues: 1) All mental hospitals were to be gradually phased out, with a halt to all new admissions; 2) general hospital psychiatric wards each having a maximum of 15 beds were established; 3) severe limitations in procedures for compulsory admissions and in their length (maximum period: seven days, renewable weekly) were set; 4) community mental health

centres were established to provide psychiatric care to geographically defined areas; and 5) all new and old public psychiatric services were integrated into the NHS.

The only area left untouched by the reform is Forensic Psychiatry, which still comprises only six Forensic Psychiatric Hospitals. These institutions host those acquitted on grounds of mental infirmity and judged to be socially dangerous for a term commensurate with the crime committed and extensible without any upper time limit. They are run by the Ministry of Justice and have virtually no contact with the ordinary psychiatric sector. The law allows for placement of mentally ill offenders in an ordinary psychiatric setting only during the pre-trial phase, but does not allow for treatment or rehabilitation reasons once they are acquitted. One recent sentence bys the Supreme Court seems to enables post-trial placement in alternative NHS ordinary psychiatric settings, but it is unclear to what extent this option will be used.

This situation is perceived as a real discrimination and as a breach of equality in the right of citizens to health. An important consequence of this paradoxical split is that once the offender leaves the judicial system, there is no specific legal tool to allow an assertive follow-up by DSM services. This lack of flexibility is perceived as highly negative by mental health professionals and caregivers associations.

Quality of Care within the Forensic System

One additional problem is the situation of forensic institutions themselves: Five of them (Reggio Emilia, Montelupo Fiorentino, Napoli, Aversa and Barcellona Pozzo di Gotto) are old-fashioned and obsolete 19th century institutions, with a severe shortage of medical and nursing resources, run by the Ministry of Justice mainly by means of custodial staff. Only one (Castiglione delle Stiviere) is run by the NHS Trust of Mantua, under an allowance scheme by the Ministry of Justice, and employs only health staff under the supervision of Prison Magistrates who decide on prolongations, discharges and transfers. Apart from Castiglione delle Stiviere, living conditions and the quality of care are widely perceived as very poor and most users associations, psychiatric scientific societies, associations of psychiatrists working in OPGs and also the political parties are demanding a radical reform of this sector and its integration within the NHS.

Other problems on the agenda include:

1. a revision of provisions about the criminal responsibility and placement of alcohol and drug abuse offenders, who now constitute 40% of the prison population and show increasing rates of psychiatric co-morbidity, and
2. the absolute lack of provisions for the treatment and rehabilitation of sex offenders (who are now dealt with completely within the prison system, with no specific psychological or psychiatric monitoring or approach).

Unfortunately, all of these problems imply a revision of the penal code, which is not a realistic objective in the short run, given the procedural aspects connected with the Roman Law system.

Epidemiology

One remarkable aspect of the Italian situation is the shortage of institutional data on the commission of crimes by the mentally ill and on their management. Although the Ministry of Internal Affairs and the Ministry of Justice publish periodical reports monitoring criminality rates and the prison population, periodical reports from the psychiatric forensic institutions are not released and only a few ad hoc studies by the Ministry of Justice are available (Andreoli, 2002). Moreover, there is not a national register linking the forensic psychiatric sector with the judicial authorities and no connection between the NHS and any institution from the judicial sector.

Most available data indirectly support the view that there has not been an increase of severe crimes committed by the mentally ill during the deinstitutionalization process. The actual number of people placed in OPGs has not increased since 1978. In 1980, the population of OPGs comprised

1,424 people and then a gradual trend of decrease took place until 1998, when it reached its lowest number (977). Since 1999, an opposite trend has appeared and the last census available counted 1,282 people on March 12th, 2001. The prison population increased dramatically at the beginning of the '90s, due mainly to a change in provisions about drug crimes. In 1990, at a census day there were 25,573 people in Italian prisons. In 1994, their number reached 50,723, which remained stable throughout the '90s. Since 1999, a new increasing trend appeared, bringing this figure to 56,403 in March 2003. However, the degree to which the mentally ill are represented within the prison population remains absolutely unknown.

Despite the relevance of the above-mentioned problems, the epidemiological literature on the problem in Italy is confined to a handful of articles (Fioritti & Melega, 2000). One five-year retrospective follow-up has been conducted on 96 patients discharged from the OPG at Barcellona Pozzo di Gotto, showing a poor liaison with ordinary psychiatric services and a 23% rate of criminal recidivism, with serious crimes (homicide, attempted homicide) committed in 7% of cases (Russo, 1994). The same group has recently carried out a retrospective comparison of clinical and criminological features of a sample of patients from Barcellona Pozzo di Gotto OPG and a sample of patients admitted to a public NHS nonforensic hospital (Russo et al., 2003).

In a study aimed at describing clinical, criminological and psychosocial features of the population of forensic hospitals (Fioritti et al., 1998; Fioritti et al., 2001a), 118 patients admitted to three OPGs and 118 matched controls from community non-forensic services were assessed and followed-up for three years. Seventy-two percent of the subjects had a diagnosis of non-affective psychosis, and 75.2% had committed serious crimes against persons. Fifty-four percent of the crimes were homicide or attempted homicide. 60% of the subjects were being treated by a community service at the time they committed the index crime, and 68.9% had been compulsorily admitted previously. OPG inmates had a more frequent history of substance abuse, had committed more crimes, and had lower social disability than controls. This study showed that the population of Italian OPGs is quite homogeneous, comprising mainly patients with severe Axis I disorders who committed serious crimes or repeated trivial crimes. Data about follow-up from the same project showed that the mean length of stay within the OPG is about three years and that discharge criteria are based mainly on the seriousness of the crime while a diagnosis of schizophrenia plays an independent role. The most common destination after discharge is a sheltered psychiatric environment, generally in a supported housing facility (Fioritti et al., 2001b). Preliminary data from the three-year follow-up of the same cohort of patients show that criminal recidivism by discharged patients is very rare, much lower than the commission of crimes by their matched controls who were followed by community psychiatric services (Fioritti et al., 2002).

Mental health care in prisons presents the same kind of problems as those caused by the split between NHS and Forensic Health Systems provided by the Ministry of Justice. According to penitentiary codes (§11 L.354/1975), all prisons must have a health facility and at least one psychiatrist, only occasionally belonging to NHS community mental health services. In 1998, a national law (D. L.g.vo 22/6/1999, n.230) allowed for a pilot project to gradually transfer health services to local trusts in six regions. In May 2000, the National Health Prison Framework was published, in which mental disorders are among the priorities emphasised. Nevertheless, psychiatric care is mostly provided by private psychiatrists under an allowance scheme with the Justice Department.

Only one cross-sectional study has tried to define the prevalence of mental disorder within an Italian prison (Carrà et al., in press) among consecutive male prisoners referred, over a twenty-month period, for a clinical psychiatric assessment, among the population (n=990 with 22% foreigners) of prison "Torre del Gallo", Pavia. One hundred and ninety-one men of 990 consecutively admitted male prisoners (19.3%) had one or more DSM-IV Axis I current mental disorders (excluding substance misuse), including 13 cases of (1.3%) psychosis; 53 cases of (5.4%) mood disorder; 24 cases of (2.4%) anxiety disorder; and 26 cases of (2.6%) adjustment disorder. The prevalence of mental disorder in this population seems to be higher than the US and EU averages, and might even be underestimated for particular diagnostic subgroups.

Public Opinion and Mass Media

The 2000s have seen a resurgence of fears and emotional attitudes in Italian public opinion towards crimes committed by mentally ill people. A few famous cases involving mentally ill people or just impulsive crimes of highly emotional content (murder of a child by his mother) have been widely publicized by the media and debated in very popular TV talk shows. This has enhanced a climate of suspicion and irrational fear. It is possible that the rise both in the prison population and in the OPG population may be attributed indirectly to this new mass media attitude.
This new trend has had political consequences too. Some interest groups (especially some associations of caregivers) have demanded a more restrictive psychiatric legislation, revising the reform of 1978. Associations of psychiatrists and some political parties have proposed to link any administrative reform to a radical reform of the criminal justice system, bringing into practice the integration of forensic institutions into the NHS.

Currently there are four psychiatric reform bills under examination by the Parliament and one commission working for the revision of the part of the penal code regarding the assessment, responsibility and placement of the mentally ill offender. No major change in either the laws or practice can be expected before the passage of another couple of years.

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Fig. 30 Judicial and Placement Procedures for Mentally Ill Offenders in Italy

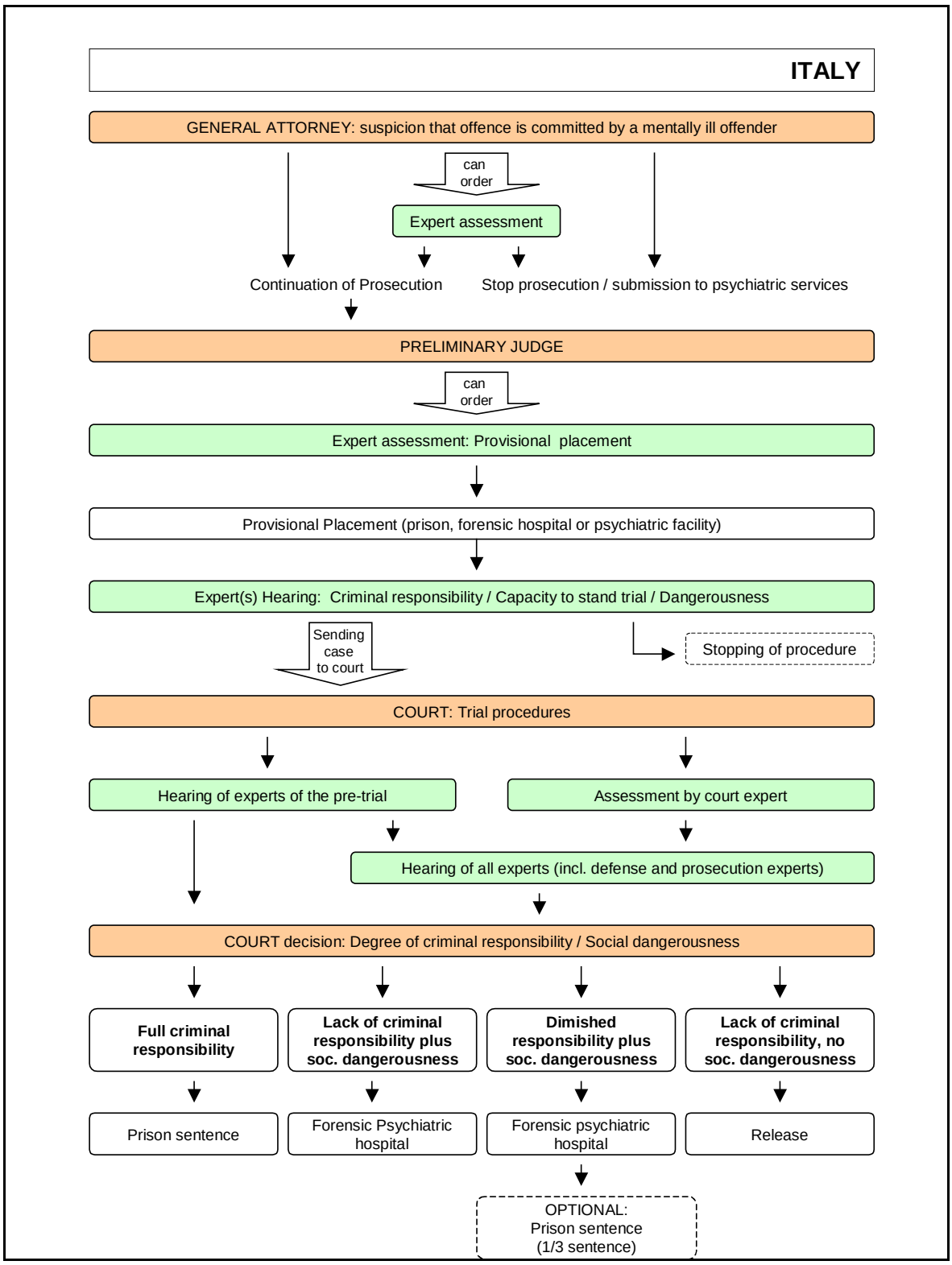

Fig. 31 Forensic Service Provision in Italy

ITALY: Forensic Services Provision

	GENERAL PSYCHIATRIC HOSPITALS & FACILITIES	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	All general psychiatric hospitals closed by 1997 only psychiatric wards by general hopsitals, small scale private clinics and university clinics available for civil inpatient treatment; they can admit under judicial order during the pre-trial phase	**6 Forensic Hospitals** (5 run by Ministry of Justice, 1by NHS on allowance) no integration with civil psychiatric services. Reggio Emilia 232 beds Montelupo Fiorentino 243 beds Napoli 197 beds Aversa 188 beds Barcellona Pizzo di Gotto 213 beds Castiglione delle Stiviere 209 beds	**unknown capacities**
clientele	*Forensic patients are defined according to legal status (sse below)* *In practice all forensic hospitals host the same clinical mix:* *Schizophrenia and Non-affective psychosis 61.2%* *Personality disorders 14.8%* *Mental retardation 8.3%* *Affective and anxiety disorders 4.9%* *Substance-related disorders 1.6%* *Other or pending diagnoses 9.1%*		Criminal responsible mentally ill offenders
criteria for placement	Just legal criteria applicable to all forensic hospitals. 1- Pre-trial phase: patients suspected to be mentally ill and dangerous 2- Post-trial: patients deemed to be unresponsible and dangerous. 3- From prison: if detainee becomes mentally ill after judgement and cannot be treated in prison.		

Luxembourg

Jean-Marc Cloos, Romain Thillman, Philippe Penning & Jean-Marie Spautz

Structure of the Legal System

Compulsory admission and involuntary treatment of mentally ill persons in Luxembourg is governed by a special mental health act (Loi du 26 mai 1988) that abrogated regime of the old law on the insane (Loi du 7 juillet 1880). The Youth Protection Law regulates the procedures concerning minors (Loi du 10 août 1992). In some cases, adolescents over the age of 16 may be held fully accountable.

In order to regulate the judicial procedures of the placement and treatment of mentally ill offenders, a new law was issued on August 8th, 2000 (Projet de loi n 4457, Loi du 8 août 2000) that amended Chapter VIII of Book I of the Penal Code (article 71) (Ministère de la Justice: Code pénal du Grand-Duché de Luxembourg), Art. 3 of the Criminal Investigation Code (Ministère de la Justice: Code d'Instruction Criminelle du Grand-Duché de Luxembourg), the Law of the Penitentiary Administration (Loi du 27 juillet 1997), as well as the 1988 Mental Health Law, which now includes a special section on mentally ill offenders. The respective legal texts are available online at http://www.legilux.lu (in French).

a) Legislation prior to the Law of August 8th, 2000 *(Hoffmann, 1993)*
The text of Article 71 of the Penal Code: "There is no infraction if the accused or the prisoner was in a state of dementia while committing the act." ("Il n'y a pas d'infraction lorsque l'accusé ou le prévenu était en état de démence au moment du fait. ") dates back to 1810. It was introduced in the national legislation at the same time as the Penal Code by the law of June 16th 1879 and for a long time was identical to Article 64 of the French Penal Code and Article 71 of the Belgian Penal Code.

The major difficulty of Article 71 was the absence of a legal definition of dementia. The jurisprudence has since suggested several formulations, for instance: "The notion of dementia applies to all pathological mental states capable of influencing determination in a way that the person pursued no longer has control over his free will […]." This Article therefore emphasizes the situation of the accused, who, during the moment of committing the objectively reprehensible act, suffered from a severe psychological disorder which alienated his discernment and control faculties and abolished his will to not commit the infraction (Court – Adjudication 180/99 of June 29th, 1999).

Article 71 also did not include intermediate cases in which mental faculties were seriously diminished without being completely impaired. In tangible cases, however, the psychiatric assessment on which the judge relied mentioned either a complete lack of discernment or a diminished responsibility, which the judge could consider while pronouncing the sentence.

Finally, there was a clear separation between Article 71 of the Penal Code and the procedures of the Mental Health Law of May 26th, 1988. According to Article 2 of the latter, a person can be involuntarily placed should he/she present a severe mental disorder and should he/she pose a danger to himself/herself or to other persons, but this decision is mainly a medical one and the legal authorities did not have any ability to decide upon a placement or the maintaining of a mentally ill offender (e.g., a murderer) in a closed psychiatric ward. In practice, a mentally ill offender could

therefore be acquitted according to Article 71 of the Penal Code without, however, being automatically placed in a closed psychiatric ward.

b) The Law of August 8th, 2000

In France, the law of July 22nd, 1992 abolished the old Penal Code Article 64 and replaced it by the two new Articles 122-1 and 122-2 (see chapter on France). With the law of August 8th, 2000, Luxembourg also modified its corresponding Article 71, including the two new Articles 71-1 and 71-2, with texts similar to those of the French Articles 122-1 and 122-2.

The title of Chapter VII of Book I of the Penal Code (that contains Article 71) has also been changed into: "On the causes of justification, irresponsibility and excuse". The new Article 71 now includes a cause of penal irresponsibility for persons suffering from mental disorders having abolished their discernment and control of actions. It reads as follows:

Art. 71: "Is not considered responsible according to the penal law, the person who, at the time of the act, suffered from mental disorder suppressing discernement or control of her or his actions." ("N'est pas pénalement responsable la personne qui était atteinte au moment des faits, de troubles mentaux ayant aboli son discernement ou le contrôle de ses actes.")

The mental disorder is considered to have influence not over the acts themselves but over the perpetrator of the acts. For this reason, in order to describe the cause of non-imputability, the legislator has introduced the concept of penal irresponsibility. Please note that Article 71 refers to "mental disorder" to qualify the state of dementia rather than to "psychic or neuropsychic disorder" (as in Article 122-2 of the French penal code) in order to maintain conformity with the international psychiatric classifications. The concept thereby covers all the medical definitions of mental disorders without, however, listing them explicitly.

The new Article 71-1 covers diminished criminal responsibility in the case of impairment of mental faculties, thereby providing current practice with a legal foundation:

Art. 71-1: "The person who, while committing the acts, suffered from a mental disorder impairing his/her discernment or the control of his/her actions remains punishable; however, jurisdictions take into account this circumstance to determine the sentence." ("La personne qui était atteinte, au moment des faits, de troubles mentaux ayant altéré son discernement ou entravé le contrôle de ses actes demeure punissable; toutefois la juridiction tient compte de cette circonstance lorsqu'elle détermine la peine.").

In the case of an offence committed while under the influence of alcohol or drugs, the judge, however, remains the one to decide whether or not the suspect is fully responsible.

Finally, the new Article 71-2 covers the lack of criminal responsibility in certain other cases, e.g., a crime of passion:

Art. 71-2: "Is not considered responsible according to the penal law, the person who acted under the influence of an irresistible power or restraint." ("N'est pas pénalement responsable la personne qui a agi sous l'empire d'une force ou d'une contrainte à laquelle elle n'a pas pu résister.")

Another major change in Article 71 is the fact, that if the article is applied and if the person continues to represent a danger to himself or to others, the judge then has to order the placement of the offender in a certified psychiatric institution or ward, thereby introducing the concept of "judicial placement" in addition to the regular placement of the mentally ill.

Procedures

While sentence and/or placement after trial is regulated by the Penal Code, more specifically by Article 71, 71-1 and 71-2, pre-trial placement (for treatment or reasons of security), psychiatric as-

sessment, placement, and treatment, as well as discharge and aftercare are regulated by the amended 1988 Mental Health Law, which now includes a chapter on "judicially placed persons" (Chapter 4).

In the new law, as opposed to regular placement and the previous legal situation, decisions concerning the maintenance of the "judicial placement" are no longer taken by a physician but by a special commission (Art. 21) that includes two magistrates and two persons suggested by the Ministry of Health (one of whom should be a psychiatrist).

Two months after admission, a report on the mental state of the person placed and addressed to the special commission has to be written by the psychiatrist in charge. If placement is continued, an annual re-examination is scheduled.

If the psychiatrist in charge considers that the mental status of the placed offender has improved in such a way that placement is no longer necessary, he informs the special commission, which will decide or rule upon the case within a one month period.

The special commission may also decide upon several forms of leave during placement (alone, daily or weekly). The expansion of the placement conditions may be requested at any time by the person placed or a relative. However, in the case of refusal, the person place or the relative must wait a full year before filing a new application.

Should the mentally ill offender be discharged on probation, he/she will be placed under medico - psycho-social guardianship. The special commission decides upon the modalities and duration of the guardianship. If the guardianship conditions are not respected or the person again becomes dangerous, the person wll be re-admitted.

Practice (Spautz, Graas & Hentgen, 2000)

Mentally ill offenders can be placed only in a specially designated institution, currently the Neuropsychiatric Hospital Centre (Centre Hospitalier Neuropsychiatrique, CHNP) in Ettelbruck, formerly known as the State Neuropsychiatric Hospital. There no institution other than the prison and the CHNP that is able to deal with mentally ill offenders. A major problem continues to be the absence of adequate structures for aggressive minors, who therefore are often placed in the CHNP as well.

Concerning prison, in 1996, Professor Bernheim from Geneva was asked to study the general medical and psychiatric treatment of prisoners (Bernheim & Restellini,1996). The resultant study recommended that the psychiatric treatments of prisoners should be offered mainly within the prison walls, while the CHNP should contribute to the functioning and direction of a psychiatric annex of the prison medical ward. This psychiatric ward was inaugurated in July 2002.

Even though a project of a specialised ward for mentally ill offenders is under discussion, the current psychiatric infrastructure may show insufficiencies and may [not??] have the necessary means of security needed for the treatment of this population in the future.

Since the introduction of the new law in 2000, there has been no "judicial placement" up to now (January 2004). No epidemiological data are available.

Patients' Rights

In case of an expertise, the Criminal Investigation Code allows the suspect to choose an expert to assist him at all stages of the assessment. He may address all possible requests to the experts appointed by the court and state his observations at the end or in a separate report.

Article 71 of the Penal Code allows the filing of an appeal against the placement decision. In this case, however, the placement procedures will be pursued.

The 1988 Mental Health Law evokes the respect of human rights and freedom. Concerned persons such as family members or tutors are informed in the event of an involuntary placement. The law stipulates that the patient has the right to be treated according to his/her condition. A personal treatment plan has to be established and applied by qualified medical and paramedical staff. The treatment aims to reintegrate the patient into society and is given with respect to the patient's freedom of thought, as well as to his/her religious and philosophical convictions. Family and social contacts should be encouraged whenever possible.

Public Opinion and Mass Media

In Luxembourg there is still a strong stigma attached to mental disorders. Public opinion and that of the mass media opinion are ambivalent and vary from "lock them up for life" to "abolish the asylum", making necessary objective discussions about the subject difficult. The level of political interest in mental health can be qualified as low and the future will show if the legal presence in the field will increase with the new regulations.

The best-known recent case of a mentally ill offender in Luxembourg is the one in 2000 covered by the media worldwide in which a man took several children hostage. At trial the offender was not given a diminished sentence but was sentenced to 22 years of imprisonment, despite the fact that the psychiatric assessment had concluded that the offender was suffering from paranoia.

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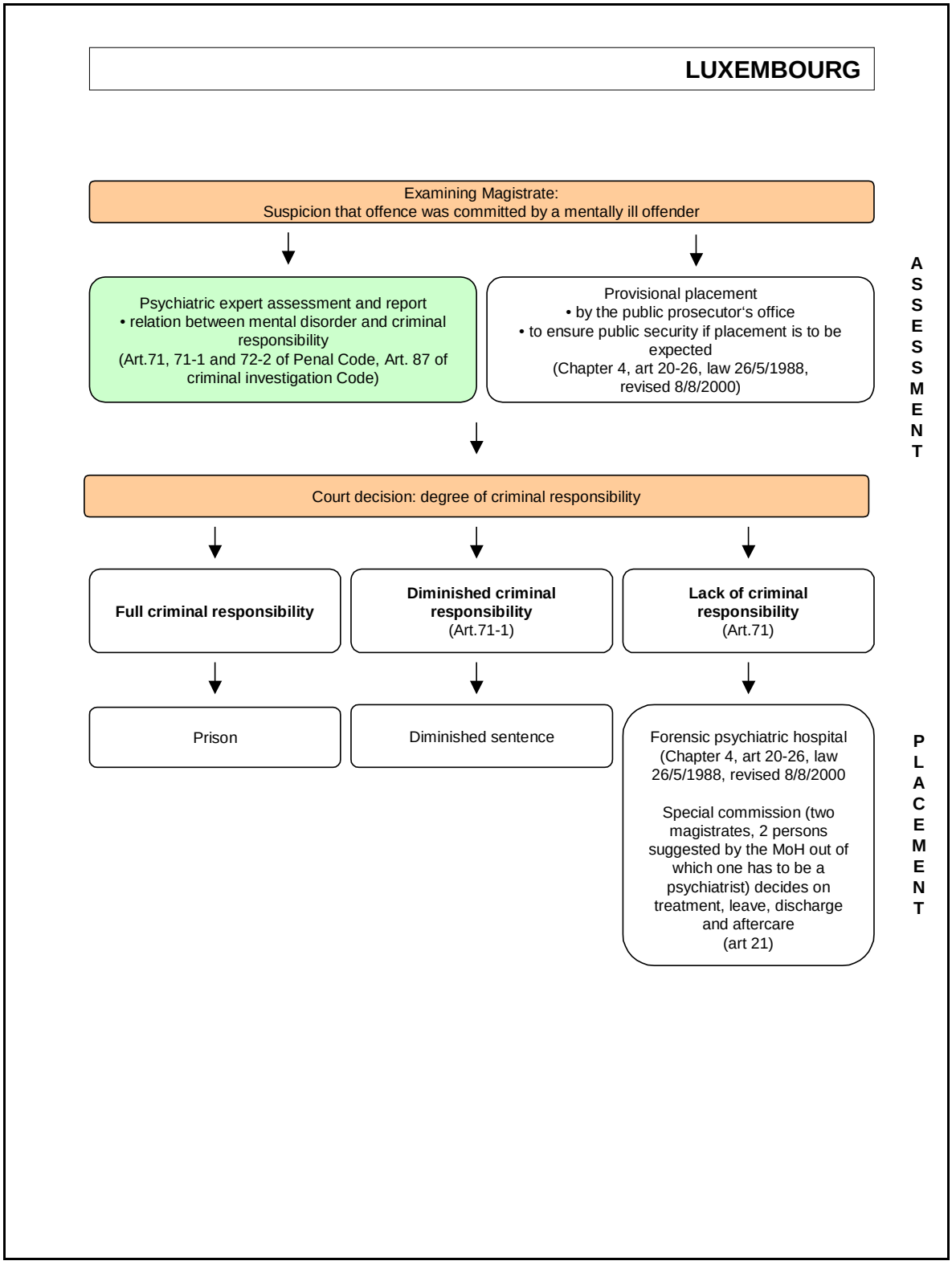
Fig. 32 Judicial and Placement Procedures for Mentally Ill Offenders in Luxembourg



The Netherlands

Catharina H. de Kogel

Main Legislation

The Netherlands Criminal Code (CC) applies nationwide and contains several different pathways that can lead to the hospitalisation and treatment of mentally disordered offenders. Two main non-punitive measures exist for adult mentally disordered offenders: the entrustment order of 'Terbeschikkingstelling' (TBS-order, article 37a CC) and the hospital order (article 37 CC). Detainees who are considered unfit for penitentiary institutions due to a mental disorder or developmental deficiencies can be admitted to a psychiatric hospital for the duration of their pre-trial custody and/or prison sentence (article 15 PBW). For juveniles, the measure of 'Placement in an institution for juveniles' exists (article 77s CC) which can (also) be applied to mentally disordered juvenile offenders. The hospital order, 'commitment to a psychiatric hospital' (article 37 CC) can be imposed upon offenders who are mentally disordered and are considered by the court not to have been responsible for their acts. The function of article 37 is to 'branch off' mentally disordered offenders from the justice system to the mental health system, where they are then subject to mental health law (Cleiren & Nijboer, 2002).
The TBS-order can be imposed upon mentally disordered offenders who are considered not responsible or to bear only a diminished responsibility for their offence(s). The measure of TBS is reserved for offenders who have committed serious, almost always violent offences. Most TBS-patients are found in maximum security hospitals within the justice system (e.g., Van der Heiden & Eggen, 2003). In the case of partial criminal responsibility, an additional prison sentence or other penalty is optional. A condition for both the TBS-order and the hospital order is that the offender is considered to be dangerous to others or to the general safety of persons or goods. The hospital order can also be imposed if the person concerned is 'only' a danger to him or herself. In all cases, the dangerousness must have a causal relationship to a mental disorder or developmental deficiencies.

The court can impose TBS or a hospital order only after it has sought the advice of at least two experts. There are two versions of TBS: TBS with mandatory hospital care (article 37b CC) and TBS with conditions attached. The first can be imposed almost only for violent (sexual) offences. The latter version can be imposed for offences which do not directly concern the physical safety of other persons, in which cases the risk of criminal recidivism is considered to be such that mandatory hospitalisation is not necessary.

TBS has to be imposed for two years. Thereafter the court can extend TBS for one or two years each time. TBS with mandatory hospitalisation is in principle unlimited in duration, however, as soon as the risk of criminal recidivism has diminished to a level considered to be acceptable, the TBS measure must be terminated. TBS with conditions attached can be extended only once and thus has a maximum duration of three or four years. The application of extension of the TBS measure by the prosecutor has to be accompanied by a report and the advice of the institution treating the patient. The district court decides whether or not the TBS measure is to be extended. Appeal against this decision is possible to a special section of one of the courts of appeal. Every six years an independent expert report (not by the hospital treating the patient) has to accompany the application of the prosecutor.

TBS ends when the prosecutor does not apply for continuation or upon the court's rejection of the requisition to prolong TBS. A further elaboration of the legal position of TBS-patients, such as rules for care and treatment, is laid down in the Principles Act TBS (Beginselenwet Verpleging Terbeschikkinggestelden, BVT) and the TBS regulations (Reglement Verpleging Terbeschikkinggestelden, RVT). This chapter will focus on the TBS-order, the main measure for dealing with mentally disordered offenders within the justice system in the Netherlands.

General Philosophy of TBS Legislation

In 1928 the entrustment order of TBR (Terbeschikkingstelling van de regering) was introduced to create the possibility to sanction individuals who were considered not to be or only particlely criminally responsible. TBR was criticised among other things for its lack of regulation of the legal position of TBR-patients (Hofstee, 2003): TBR could be imposed for any offence, there was no maximum to the duration of TBR, nor was appeal against the verdict of TBR possible. Only the institution of treatment could decide about prolongation of TBR. The government decided that the legal position should be regulated by law and in 1988, a temporary regulation of the legal position of TBR-detainees (TRT) went into effect. In 1997, the present TBS-legislation took effect. The main function of the TBS measure, especially TBS with mandatory hospitalisation, is to protect society from the risk of criminal recidivism with serious consequences. The second function of the TBS-measure is to care for the TBS-patient and provide treatment in order to prevent criminal recidivism in the longer term.
Much has been invested in the treatment, education and rehabilitation, and thus in the interests, of the TBS patient. In TBS-hospitals a socio-therapeutic climate has been created to support patients' learning and their rehabilitation. On the other hand, in individual cases the measure can have, due to its unlimited (and usually long) duration and preventive character, a greater impact on individual autonomy than a prison sentence. Although judicially not a punishment, TBS-patients in practice experience TBS as a severe punishment, due to the uncertain duration of the measure and the stigmatisation of being a 'mad criminal' (e.g., Noorlander, 1999). The duration of unlimited TBS is often substantial. Calculated on the basis of patients whose TBS ended, the mean duration is about seven years. If calculated on the basis of cohorts entering TBS, the current mean duration is about nine years. This is due to the fact that a substantial number of TBS-patients cannot be discharged since treatment was not successful. In the past five years, two so-called long-stay units for TBS-patients have opened. Here, patients are no longer treated with the objective to re-socialise them but care is provided in order to stabilize their condition and optimise their quality of life.

The duration of TBS can exceed the maximum prison sentence for the offence in question. Research in the early 90s showed that the longer the duration of the TBS-measure, the more the court tended to terminate it, contrary to the advice of the hospital, especially if the duration exceeded the maximum prison sentence for the offence in question (Drost, 1991). The same study shows, however, that patients whose TBS was terminated contrary to the advice of the hospital subsequently more often committed serious offences than patients whose TBS was terminated upon the advice of the hospital.

The Future of TBS

The suggestion to abolish the TBS-measure is a recurrent topic of discussion in Parliament and in the media. There are several points of criticism with regard to the TBS-measure. On the other hand, the obstacles to replacing TBS are also substantial. Objections against the TBS-measure come from different angles: economical, crime prevention and legal protection of the TBS-patient. An intrinsic argument against the TBS-measure is the long duration of TBS-treatment, and for a substantial number of TBS-patients, the lack of treatment success. The sector therefore struggles with overwhelming capacity problems and a substantial rate of criminal recidivism, in particleicular among sex offenders (e.g., Leuw, 1999; De Vogel et al., 2003). However, recidivism rates of former TBS-patients are substantially lower than recidivism rates of offenders released from prison

(Wartna et al., 2005). Furthermore, the same study shows that recidivism rates of former TBS-patients appear to be dropping in recent cohorts.

Economical arguments criticise the high daily costs of a TBS-bed compared to the costs of a bed in prison or a long-term bed in a psychiatric hospital: circa 468 vs. 155 and 143 Euro, respectively, in 2000 (Commissie Kosto, 2001). A judicial argument is the proportionality of the duration of detention. The unlimited duration of TBS has been and continues to be a topic of serious discussion in judicial circles. The mean duration of TBS-treatment is circa seven years. In addition, TBS can be combined with a (long) prison sentence. The main objection to it is the loss of proportionality between the offence and the duration of the sanction (e.g., Van der Landen, 1993; Cleiren & Nijboer, 2002) which is a forteriori the case for the so-called long stay-patients (De Hullu, 2003). A related topic of discussion is the sequence of execution of the TBS-measure and a prison sentence in the case where both have been imposed. The function of TBS is less credible when a person who needs treatment urgently is first sent to prison. The usual sequence is to execute the prison sentence first, which has a retaliatory function. Some advocate the simultaneous execution of both sanctions, integrating TBS completely within the prison sentence (De Hullu, 2003).

Another aspect is that it may be more or less coincidental whether TBS is imposed (De Hullu, 2003). The possibility to impose TBS is strictly connected to the mental state of the person in question while he or she committed the offence and to the seriousness of the offence. For instance, the question of whether a (serious enough) offence has been committed can determine the choice between TBS or a hospital order (article 37 CC), more so than the type of treatment and security needed. Furthermore, in the Netherlands as well as in other countries, prisons host a substantial number of mentally disordered offenders (e.g., Bulten et al., 1999; Schoemaker & Van Zessen, 1997; Agency of Penal Institutions, 2001).
One suggestion is to (in term) integrate the TBS-measure within the prison sentence (Van der Landen, 1993; De Hullu, 2003). The TBS-measure would then no longer serve the function of protecting society because it would be temporally maximised. In that case, there should be a sufficient number of adequate treatment facilities within the prison system, and long-stay facilities to protect society from incurable dangerous offenders should be provided by the mental health system. However, this would not be a short-term solution because at present, the prison system is not equipped to take over the treatment of TBS-patients. Nor does the mental health system seem sufficiently capable at the moment of dealing with patients who have committed serious violent (sexual) offences and have a high risk of criminal recidivism.

Legal Procedures

A global description of procedural steps regarding mentally disordered offenders in the pre-trial and trial phases of the criminal process follows below (see also flow charticle at the end of this chapter). If in the pre-trial phase it is suspected that the offence was committed by a mentally disordered offender, an expert assessment is usually performed. If the court considers imposing TBS (article 37ab, 38 CC) or a hospital order (article 37 CC), such an assessment is mandatory. An expert assessment can be initiated by the prosecutor, the judge of inquiry, the defence or the court, depending on the phase of the criminal process. The assessment of mental state and mental disorders has to be performed by two experts, for whom it is mandatory that one be a psychiatrist.

Subsequently the court decides about the degree of criminal responsibility and the sanction. In the case of full criminal responsibility, depending on the offence a prison sentence or another penalty can be imposed. If the offender is considered not to be responsible for his acts, then no penalty will be imposed. In such a case, depending on the offence and the risk to society, the court can impose TBS or a hospital order (article 37 CC). An offender can also be considered particlely criminally responsible. In such a case, TBS can also be imposed, depending on the seriousness of the offence and the risk to society. Offenders judged to bear diminished criminal responsibility often receive an additional prison sentence.

Practice

About 80% of the TBS-patients are diagnosed with a personality disorder, 25% with a psychotic disorder, and about 40% with substance abuse (Van Emmerik, 2001). Co-morbidity is high, about 60% of the TBS-patients are diagnosed with disorders on both axis I and axis II of the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 2000). Problems of validity and reliability exist with respect to the concept and classification of personality disorders as well as discussions on treatability (McMurran, 2001). In TBS-hospitals the approach is increasingly one of risk assessment of criminal recidivism, risk management and treatment directed at 'criminogenic factors'.
In the nineties of the last century the TBS-sector had to deal with a dramatic increase in the number of TBS-patients (see table 51). This was due to a growing number of TBS-orders imposed by the courts and an increase in the mean duration of TBS-measures (Van der Heide & Eggen, 2003). A general increase in violent criminality, and a decrease in the non-judicial alternatives for dangerous and mentally disordered persons are identified by Leuw (1998) as the most likely explanations for the increase in the TBS-population. A consequence of the rising numbers of TBS-patients was capacity problems. Capacity problems have been a dominant policy-theme regarding TBS since the nineties.

Tab. 51: Numbers of TBS-patients and influx and efflux in the Netherlands 1965-2002

	Imposition of TBS by court	Ending of TBS with mandatory hospitalisation	Persons with a TBS measure (ultimo)	TBS patients waiting in prison* (ultimo	Formal capacity TBS-hospitals (ultimo)
1965	142	243	1493	65	
1970	131	250	985	21	
1975	99	143	461		
1980	85	105	391	10	
1985	106	81	452	19	421
1990	95	63	522	18	405
1991	117	91	550	32	506
1992	117	64	597	42	541
1993	134	49	685	71	570
1994	199	59	772	109	607
1995	180	73	855	158	630
1996	196	57	840	170	728
1997	156	73	1110	167	866
1998	150	69	1200	171	970
1999	171	84	1224	148	1175
2000	151	79	1328	138	1183
2001	177	88	1409	136	1222
2002	203	80	1509	153	1304

Table adjusted from Van der Heide & Eggen 2003. Data taken from Agency of Penal Institutions (Dutch Ministry of Justice)
** This concerns persons whose TBS-treatment should starticle but who have to wait in prison for a place in a TBS-hospital due to lack of capacity*

One of the aspects is the so-called 'Passantenproblematiek'. 'Passanten' are TBS-patients without a prison sentence or whose prison sentence has been executed, who have to wait in prison for a place in a TBS-hospital. Their numbers are increasing (table 51). In 2001, for instance, 151 patients waited in prison for a mean period of 259 days. According to legislation (Principles Act TBS) a patient whose TBS is in execution must be placed in a TBS hospital within six months. Twelve months after the start of the TBS-measure, a patient whose placement has not been effectuated is entitled to a compensation of 600 Euro a month. Every three months the compensation is increased by 125 Euro. This compensation, although judicially correct, is considered to be unacceptable by many in view of the serious offences committed by the persons concerned.

Serious offences by (ex) TBS patients have a great impact on society. The most recent study of criminal recidivism in former TBS-patients indicates that recidivism rates are dropping. After 10 years, about 60% of patients whose TBS ended in 1974–1988 had recidivated with a serious offence[1] while in patients whose TBS ended in 1994–1998 this was about 30% (Wartna et al., 2005). The recidivism for grave offences[2] is more constant at about 30% after 10 years in older cohorts and about 20% in patients whose TBS ended in 1994–1998. There are also studies on recidivsm of specific subgroups of TBS-patients. Hildebrand and co-workers (2003) found 55% of a group of sex offenders were sentenced for another violent (sexual) offence (mean follow-up period: 11.8 years after TBS, range: 1.8-23.5 years). Sex-offenders who were also psychopathic (in the sense of the Psychopathy Checklist, e.g., Hare et al., 2000) had the highest rate of recidivism after TBS: 76% were sentenced for a violent (sexual) offence.
Several strategies have been initiated to deal with the capacity problems, long duration of TBS treatment and criminal recidivism of (ex-) TBS patients. The capacity of TBS-hospitals was increased mainly by the building of three new TBS-hospitals in the late nineties. Investments were made to reduce the duration and increase the effectiveness of treatment. A financial differentiation was made according to treatment duration. TBS hospitals are reimbursed at a lower rate for patients with a treatment duration in excess of six years. At the same time research ('What works for whom?') and the implementation and development of new treatment methods were stimulated. Since the mid-nineties, research and the practice of risk assessment and management of violent behaviour (following the Canadian model) has experienced a strong growth in the TBS-field. To enhance the efflux of patients from TBS hospitals, 'forensic circuits' are stimulated in different regions. Several judicial and mental health institutions work together within these circuits to offer a complete range of care and security to forensic psychiatric patients. More forensic facilities are being created within the mental health sector. In addition, facilities for aftercare have been strengthened. Every TBS hospital has a forensic out-patient clinic and more sheltered living facilities for ex-TBS patients have been created. In order to reserve treatment opportunities for patients who may profit from them, long-stay facilities have been developed for forensic patients who are no longer considered to have a realistic treatment perspective but who are still considered to pose a danger to society. As of 2003 there are a total of 60 long-stay-beds in the TBS-sector. However, the need for long-stay facilities appears to be much greater (De Kogel et al., 2005), and the Ministry is planning additional facilities. In conclusion, the TBS-sector undeniably has to cope with serious difficulties. Nevertheless, several promising developments have been initiated to deal with these problems.

Patients Rights

The Principles Act TBS regulates the legal position of TBS-patients. Three values are fundamental to the measure of TBS: protection of society, treatment to reduce the risk of recidivism, and protection of the legal position of the TBS-patient. The aspect of protection of society mainly has consequences for decisions about leave and termination of the TBS-measure. Security is a high priority: the head of the institution in nearly all cases may deny privileges if that is considered necessary for order and security. Appeal against such measures is then possible after a certain period of time.
The first evaluation of the Principles Act TBS (Leuw & Mertens, 2001) concluded that although in general, the Act and the way it is practiced protect the legal position of TBS patients adequately, there has been relatively little development of the legal position with respect to treatment. The TBS-patients have few enforceable rights with regard to the nature, course and evaluation of their treatment. Yet the course and evaluation of treatment are of great importance to the patient because these usually are a prerequisite for terminating the TBS.

1 Including e.g. particular violent offences, particular sex offences, theft, burglary, and trafficking of illict drugs.
2 Including e.g. murder, manslaugther, violent offences with grave physical damage, theft and burglary while using violence, sex offences like rape or sex with children under 16, arson.

Epidemiology

Several judicial and mental health agencies maintain databases to support work processes and facilitate management, which (in particle) contain information about mentally disordered offenders. For instance, the foundation GGz Nederland (Mental Health Care Netherlands) keeps a national database called Zorgis that includes information about treatment, patient trajectories and costs. The police, the Prosecution Service and the Forensic Psychiatric Service keep databases with case registrations. However, these databases were not developed primarily for research purposes. One of the consequences encountered in practice, for instance, is that variables of interest to research are not always coded in a reliable manner. Criminal records are registered in the national Judicial Documentation System (JDS) of the Ministry of Justice. The Judicial Documentation Database for Research and Policy (OBJD) contains a processed selection of the data. This database is the main source of information about criminal recidivism. The Monitor Information TBS-patients (MITS) is a national database managed by the Agency of Penal Institutions of the Ministry of Justice. MITS was developed as a management information and research database and contains, for instance, information about judicial history, demographic information, and information about the execution of the current TBS-measure (see also the epidemiological trends described in tab.1).

Public Opinion and Mass Media

When scanning newspaper articles about TBS, topics that most often catch the eye are case stories and figures about violent (sex) offences by (ex-) TBS-patients, and the question of how this could have happened and how society can be better protected from criminal recidivism by such mentally disordered offenders. Offences against children particularly shock the public. Cases of escape and re-offending by TBS-patients have given rise to questions in Parliament n a regular basis. In an effort to enhance the protection of the public, there have been several discussions about the TBS-measure, focusing, for instance, on the necessity of stricter criteria for leave and release, calls to abandon unescorted leave for TBS-patients all together and for more intensive monitoring of sex-offenders after their release. This recently led to a bill to change the maximum period of conditional release for TBS-patients from three to six years. Furthermore, Medio 2004, a new protocol for leaves, including mandatory use of a risk assessment instrument has come into effect. On the other hand, ethical and economical questions about the placement and treatment of mentally disordered, difficult patients and offenders are also covered in the media. For instance, the position of mentally retarded and mentally disordered (juvenile) offenders in prison, often with few opportunities for adequate treatment, is a regular topic of discussion.

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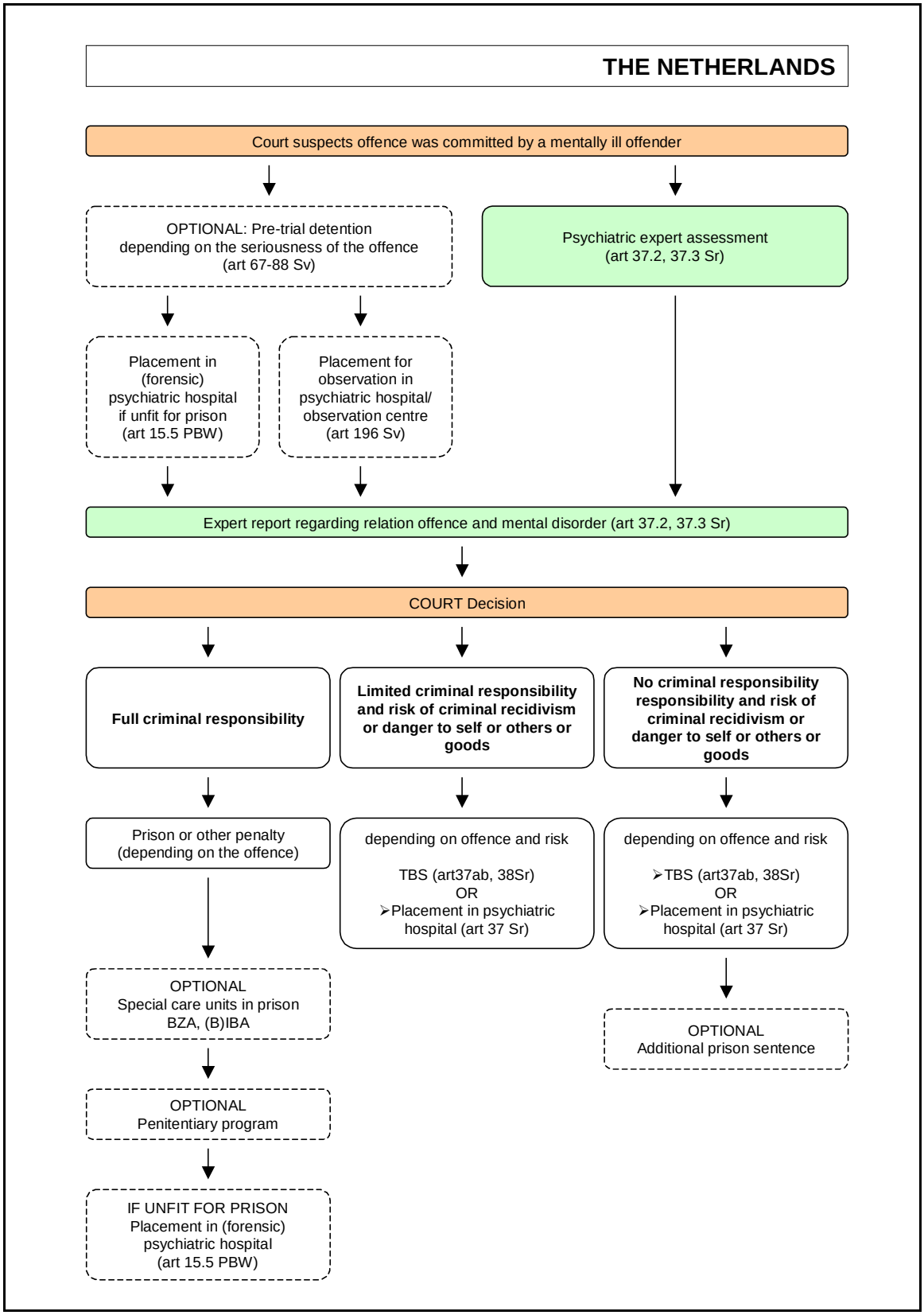
Fig. 33 Forensic Service Provision in the Netherlands

The NETHERLANDS: Forensic Service Provision

	GENERAL PSYCHIATRIC HOSPITALS & FACILITIES	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	**9 Forensic Psychiatric Units (Forensisch Psychiatrische Afdelingen, FPA's)** at General Psychiatric Hospitals (unspecified/ unknown capacities) - FPA Roosenburg, Altrecht, Den Dolder - FPA Warnsveld, GGNet, Warnsveld - FPA Heiloo, GGZ Noord Holland noord, Heiloo - FPA De Mare, GGZ Westelijk Noord Brabant, Halsteren - FPA Parnassia, Parnassia, Den Haag - FPA Het Kompas, De Gelderse Roos, Wolfheze - FPA Zuidlaren, GGZ Groningen, Zuidlaren - FPA Franeker, GGZ Friesland, Franeker - FPA Venray, GGZgroep Noord en Midden Limburg, Venray	**9 Terbeschikkingstelling-Hospitals (TBS)** (provider: Ministry of Justice) - Dr. Van Mesdag Kliniek (Groningen) - FPC Veldzicht (Balkbrug) - FPC Oldenkotte (Rekken) - Flevo Future Amsterdam (Amsterdam) - Flevo Future Utrecht (Utrecht) - Dr.van der Hoeven Stichting (Utrecht) - FPI De Kijvelanden (Poortugaal) - Prof. W.P.J. Pompestichting (Nijmegen) - FPI De Rooyse Wissel (Venray) All with external resocialisation units, 2 with longstay units: Veldzicht (20 places), Pompestichting (40 places), most TBS with services for oupatient forensic treatment **3 Forensic Psychiatric Hospitals (FPK's)** (provider: Ministry of Health) - FPK De Meren (Amsterdam) - FPK GGZ Drenthe (Assen) - FPK GGZ Eindhoven (Eindhoven)	**Forensic Prison Wards/Units** Total capacity in 2000: ca. 733 beds - Units for special care (BZA) pre-trial (509 beds) - Units for special care (BZA) post-trial (39 beds) - Units for individual care (IBA) pre-trial (123 beds) - Units for individual care (IBA) post-trial (62 beds) - Units for high security indiv. (BIBA) (44 beds) - Units for crisis intervention (FOBA) (66 beds)
clientele	clientele: psychiatric hospitals: mixed - suspects with mental disorders (pre-trial detention) - civilly detained mentally ill patients (art 2 Wet BOPZ) - mentally ill patients with penal sentence (e.g. art 37Sr, art 15 lid 5PBW, art 14e SR) FPAs:mixed forensic patients with relatively good prognosis and no immediate offence risk (e.g. TBS-patients in later phases of treatment, other forensic patients, civilly detained patients)	clientele: TBS-hospitals: TBS-patients FPK's: mixed -TBS-patients, mainly with psychiatric disorders, -other forensic patients with psychiatric disorders, -civilly detained high risk patients	clientele: mixed - mentally disordered inmates - criminally responsible mentally ill offenders - criminally non-responsible mentally ill offenders (due to lacking capacity in specialized forensic services)

Fig. 34 Judicial and Placement Procedures for Mentally Ill Offenders in the Netherlands



Portugal

Miguel Xavier & Bernardo Barahona Corrêa

Legislation - General Philosophy

The Portuguese legislation on crimes committed by mentally ill offenders is essentially to be found in the 1982 Penal Code (CP). The 1995 revision of the Code, which was undertaken following a number of general recommendations by the European Union, paid particular attention to the social reintegration of offenders, the replacement of prison terms by alternative forms of punishment (e.g., fines, community work), and improvements in the preconditions for applying "security measures" (it established maximum periods for the latter that cannot normally be exceeded).

A ruling that the Supreme Court of Justice (STJ) handed down on October 28th 1998 offers a good example of the general philosophy underlying the manner in which the law is applied in relation to crimes committed by mentally ill offenders in Portugal: "*The purpose of interning a dangerous person who may not be held responsible for his acts is on the one hand to relieve the community of the presence of a citizen who endangers it by not behaving in accordance with its ethical, moral and social values; but on the other – and more importantly – to cause the state of social dangerousness that has led to the internment to cease to exist in the offender and thus return a citizen who is capable of respecting the community's rights to life in the community*".

One of the most important guiding principles laid down in the CP is the crucial difference between *punishments* (applicable to persons who may be held responsible for their acts) and *security measures* (applicable to those who may not). Although both seek to protect legal rights and reintegrate the offender into society, security measures are fundamentally undertaken with a view to treating him/her in such a way as to stop him/her from being dangerous. In other words, in cases in which an offender cannot be held responsible or be considered "guilty", it does not make sense to punish his/her behaviour and he/she is therefore sentenced to a security measure and not a punishment. In cases in which both a punishment and a security measure are appropriate, the CP requires that the latter occur first because it is more directly aimed at the treatment and elimination of the cause of danger. Internment is not the only security measure that can be applied to persons who cannot be held responsible. On the contrary, it is considered to be the alternative of last resort and once applied, the courts are under a general duty to suspend it (subject to the minimum three-year period determined by law) when it is plausible to expect that doing so will contribute to the fundamental objectives described above – i.e., the protection of legal rights and the offender's reintegration into society.

In addition to the general provisions of the law, persons aged less than 16 years are exempt from criminal responsibility (CP Art. 19) and there is specific legislation for those aged between 16 and 21 years (CP Art. 9). This specific legislation is based on the observation that juvenile delinquency can be a transitory phenomenon and is intended to avoid stigmatising young people early on in their lives. Under this principle the law resorts as little as possible to prison terms and instead imposes fines, community work or internment in establishments designed for young people.

Given that Portugal is not a federal state, this set of laws is applied in the same manner throughout the country (on the mainland and in Madeira and the Azores) and there is no legislation of a regional nature in this area.

Legal Instruments and Law

Besides the general provisions laid down in the Constitution of the Portuguese Republic, the legislation on penal matters is basically contained in the 1982 Penal Code, as revised in 1995 (conceptual aspects of the law), and the 1987 Code of Criminal Procedure (CPP) (procedural issues). The legislation governing crimes committed by mentally ill offenders is incorporated into the general penal law, unlike that on the compulsory admission of mentally ill non-offenders, which is the object of a specific law (the Mental Health Act – Law 36/98). However, this separation is not complete and there is a certain degree of overlap between the two. For instance, under the Mental Health Act (Art. 29) a mentally ill offender whom a court has considered not responsible, but who has not been placed in a Forensic Unit, may nevertheless be subjected to compulsory placement on a general psychiatric ward if his/her clinical condition requires it.

The Legal View of Mental Disorders

The legal view of mental illness: Within the overall range of mental disorders, the CP purposely fails to describe or list any nosological categories that can cause a reduction in criminal responsibility. This is partly due to the observation by the judicial and legislative communities of the uncertainties that underlie the definition of mental illness, the successive changes in the nosological classification systems in the psychiatric field and the difficulty of determining the relative effect that each nosological entity has on a person's intellectual capacity and volition. As a result, the law employs the concept of "psychological anomaly", which is not narrowly defined but includes all kind of mental disorders. Legal instruments also apply for persons, who, while not suffering from a mental disorder, have committed an offence while being intoxicated with substances: In fact, intoxication should be assessed and valued for the purpose of attenuation or increasing the sentence, according to the circumstances of each particular situation.

Criminal Responsibility

From a theoretical point of view the legal concept of not being responsible for one's acts is really quite a complex one, inasmuch as despite the fact that the concept is not of a biological nature, its application in a legal context is always subject to prior psychiatric evaluation of a person's mental state. A look at the historical evolution of the notion of "lack of criminal responsibility" shows that the balance between its bio-psychological (medical) and normative (legal) components inevitably leads to the development of one of two different paradigms for the assessment of criminal responsibility, in which, when it comes to taking the final decision as to whether or not a person is responsible, the weight given to expert psychiatric evidence is completely different.

Under the restricted model a lack of responsibility results from the existence of a mental illness that reduces the sufferer's intellectual and affective capacity and volition; the assessment of both the diagnosis of the illness and the latter's impact on the offender's behaviour lies with a psychiatrist and cannot be questioned by a judge. Under the broad model there must still be a mental anomaly, but not necessarily a categorical nosological entity, and this more flexible concept includes any disturbance that affects individual behaviour; in this situation the declaration of non-responsibility lies more in the hands of the judge and the psychiatric evidence is relatively less important and is not binding.

Although no formal statement is made to this effect, the Portuguese Penal Code leans more towards the restricted model of lack of responsibility, under which judges cannot issue rulings that go against the expert evidence and can only ask the experts for additional clarifications or order a new examination (CP Art. 158). The concept of criminal responsibility is therefore a key concept of the penal legislation that states the next four categories: full responsibility, diminished responsibility, slightly diminished responsibility and lack of responsibility. Under the Portuguese legal system "*A person is not responsible for their actions when, due to a mental anomaly, at the moment when he acts he is incapable of assessing the illicit nature of his action or acting in accordance with that assessment*" (CP Art. 20-1). Thus, the legal pre-requisites for lack of criminal responsibility are:

presence of a psychological anomaly; diminished/absent capacity to evaluate the illicit nature of an act, due to this psychological anomaly; diminished/absent capacity to act according to this evaluation, as a consequence of the psychological anomaly.

If the ability to assess an action's illicit nature is not totally lacking, but is significantly diminished due to a psychological anomaly, in certain circumstances an offender can still be held non-responsible (CP Art. 20-2). If the inability to assess what is or is not illicit is merely transitory and results from a voluntary act in which the offender engaged with a view to committing the crime, he/she is considered responsible (CP Art. 20-4). The most paradigmatic cases in this respect are those involving alcohol or drug-induced intoxication, in which the mental anomaly was self-induced with the intention of reducing criminal liability.

Pre-trial Procedures

Pre-trial placement is regulated by the general laws mentioned earlier, not by a specific law concerning only the mentally ill offenders. The Court is entitled to place a person suspected of being mentally ill in a specialised forensic facility (never in a prison), even in the absence of a preliminary expert full evaluation. Whenever doubts are raised as to the extent of an offender's criminal responsibility, the Court must order an expert psychiatric assessment (CPP Arts. 159, 160, 351), which is a mandatory prerequisite for a trial. This assessment, which can also be requested by the Public Prosecutor, looks at the following aspects of the offender: socio-demographic and economic circumstances, presence of *psychological anomaly*, ability to control his/her actions, level of insight, dangerousness and recidivism.

The experts (always psychiatrists), who are appointed by the National Institute of Forensic Medicine, are expected to give a report stating their opinion as to whether the crime was a direct consequence of a psychological anomaly. If the offender refuses to be assessed, they should mention this in their report. The CPP states that judges are not free to evaluate the judgement that is inherent in expert evidence – in reality, a judge can disagree with an expert's opinion, but in this case must justify the reasons for this disagreement with technical/scientific arguments of the same nature as those presented by the expert (Art. 163-2). A judge can always require experts to give additional clarifications and can also order a new expert assessment by the same or different psychiatrists (assisted by psychologists, where necessary) and this does provide a greater degree of balance between expert testimony and a judge's freedom of decision (CPP Art. 158). However, a judge cannot rule *against* the results of an expert assessment.

Trial

This kind of case is heard on the same basis as any other trial, in the same courts (see *Annex 1* for a description of the types of court in Portugal), with the same number of judges and, in the majority of cases, without a jury (although the defence is entitled to ask for one). The suspected mentally offender has to attend all the Court sessions. Besides the right to appoint a particular trial lawyer, the offender has the right to claim for an assigned counsel, fully paid by the Ministry of Justice; on the other hand, the offender can be assigned a counsel against his/her will, namely when he/she refuses to have any legal representative (e.g., due to paranoid delusions), in order to guarantee the constitutional right to defence at trial.

Both the defence and the Public Prosecutor have the right to ask for an additional independent expert report, namely in the following situations: 1. Disagreement with the diagnosis or other conclusions, 2. Failure to demonstrate a causality link between the mental condition and the offence, 3. Discrepancy with previously existing psychiatric reports. The court may rule that an offender is either responsible or not responsible for his/her acts; in the former case, responsibility may be full, diminished or slightly diminished. If an offender is not considered to be criminally responsible for his/her acts (CP Art. 20), the court will hand down a "security measure" and can place him/her in a Forensic Unit whenever the seriousness of the mental anomaly and the crime mean there is a fear that he/she may otherwise commit more offences of the same kind (CP Art. 91-1).

In cases in which the crime in question is punishable by a prison term of more than five years (for offenders who are not mentally disturbed), this internment must last for at least three years (CP Art. 91-2).

If it is proven that the accused did not commit the crime or did so but there is no reason to intern him/her in a Secure Unit, he/she can still be forcibly interned in a general psychiatric service, but under the terms of the Mental Health Act (Law 36/98). The difference is that in these circumstances, the purpose of the internment is only to ensure the patient's treatment in a strictly medical/psychiatric context, and not to punish him/her criminally.
In cases in which an offender is held responsible for his/her acts, but it is shown that a psychological anomaly which existed prior to the crime means that there is a risk that he/she may be prejudiced by the normal prison regime, the court must place him/her in an institution intended for persons who are not responsible (CP Art. 104-1), because this will be more beneficial to his/her reintegration into society.

If the mental anomaly has arisen since the crime and the condition renders him/her dangerous, the court will also intern the offender in a Forensic Unit (CP Art. 105-1); if not, the court will suspend the criminal sentence until such time as the mental anomaly has passed. Offenders not suffering from any form of mental disorder but whose crime has been considered to have been committed under the influence of extreme affective conditions (e.g., *crime of passion*), may be convicted and given a shorter sentence due to their diminished responsibility. Internment ends when a court determines that a patient's dangerous state has ended (CP Art. 92-1). However, in cases in which the normal sentence is greater than eight years of imprisonment and the danger continues to exist, the internment may be extended for successive two-year periods (CP Art. 92-3).

In the particular case of a person who has committed a crime while drunk and has a prior history of alcoholism, the punishment is deemed "indeterminate" and is equal to 2/3 of that normally applied for the same crime (CP Art. 86); the same occurs in situations involving drug abuse (CP Art. 88). In both cases, the sentence is geared towards treating the addiction (CP Art. 87) and the prison authorities are required to actively work to help offenders of this kind recover (CP Art. 89).

If both psychiatric treatment and a prison sentence are imposed on a mentally ill offender, the most frequent sequence is treatment before prison, although both may occur at the same time; in both situations, the duration of the psychiatric treatment is always part of the total duration of the prison sentence. A practical example of the way in which these provisions are applied is to be found in the Drug-Free Units (ULD), which are independent from standard prison areas and house drug-addict inmates who want to be treated. The treatment programme in these residential units, which aims to achieve abstinence from drug taking, lasts for an average of 18 months and includes educational, occupational and therapeutic activities with a strong group element. Apart from placement, a court can issue other types of sentence, such as compulsory treatment, prohibition of further consumption and/or prohibition from entering places where alcoholic beverages are sold.

Placement /Treatment

The convicted mentally ill offenders lacking criminal responsibility have to be placed in special Forensic Units. There are just five units in the entire country (ten million inhabitants), three of which belong to psychiatric hospitals. The mentally ill offenders are not placed in prisons, except for those cases where, despite the mental anomaly, there is a full criminal responsibility. Unlike the concept of 'unlimited placement for treatment purposes', the concept of 'limited placement for treatment purposes' is incorporated into the law. The criteria for a limited placement include the type of psychiatric diagnosis, the current clinical situation and the degree of severity of the offence.
Concerning leave, there are several forms allowed during the placement of mentally ill offenders, ranging from attended leave on the premises of the forensic unit up to unattended over-night stay off the premises of the forensic unit, all possibilities and combinations are permitted by law. The only thing that changes is the institutional status of the person charge with deciding whether or not the request for leave will be granted: the therapist's authorization is enough to grant unattended

leave off the premises of the forensic unit, but not to grant an over-night leave; the latter at all times demands an authorization by the Unit's Director (leave < 48 h) or even by the Court (leave > 48h).

The law stipulates periodical re-assessments, which may occur at any time during the placement period (e.g., when required by the offender, the Public Prosecutor, etc.), with a maximum re-assessment interval of two years. The re-assessments (and the reports for the Court) have to be made by the psychiatrist(s) of the Forensic Unit, covering several aspects such as the offender's mental state, general behaviour, socio-familiar conditions (in terms of predictable support), risk of recidivism and danger to the public. Despite the absence of legally defined criteria to portray it, the effectiveness of the forensic treatment has to be reported by the psychiatrist to the Court at least every two years and also before any scheduled discharge. If forensic treatment is certified as effective by the Court prior to the end of an additional prison sentence, the sentence does not have to be completed, and the offender can be discharged.

Regarding the therapeutic procedures, there is no difference between mentally ill offenders and non-offenders – in both cases, therapeutic programs seek to integrate biological and psychotherapeutic care with social skills training and professional education, thus following the general principles of the Mental Health Act. The greatest obstacle to integrating care in this manner continues to be the shortage of forensic services, inasmuch as in Portugal there are no specialised facilities reserved exclusively for offenders with mental disorders; at the same time, those Forensic Units that do exist do not have specialised outpatient facilities, so in parole situations psychiatric supervision can only be conducted at the general psychiatric service of the offender's area of residence. Recently the Directorate-General of Prison Services (DGSP) has been doing some very interesting work in the field of offenders suffering from drug addiction, which includes the Drug-Free Units (in prisons), treatment motivation programmes, methadone replacement programmes and programmes involving the use of opiate antagonists. There is also a halfway-house for female inmates who have successfully completed the drug-addiction treatment programme and whose judicial situation allows them to be housed under an open regime. The objective of this facility is to consolidate the gains they have made during treatment by inserting them into society and work, thanks to a number of community resources that offer them jobs.
According to the law, specific kinds of treatment, such as ECT and psychosurgery, can only be applied after informed consent from the offender plus an authorization by the National Council for Mental Health, based on an assessment conducted by two independent psychiatrists.

Rights

As soon as a suspect is charged, he/she immediately acquires a set of rights that apply in every phase of the judicial process (CPP Art. 61): to be informed, to be present at court sessions, to be heard by the court, to choose his/her own defence counsel and to ask the court to appoint a public defender, not to answer any question unless he/she wishes to do so, to intervene in the investigation process by submitting evidence and to appeal against unfavourable rulings.

Similarly, the accused may appoint a technical consultant of his/her choice to assist with (and object to) any expert assessment to which he/she is obliged to submit by the court (CPP Art. 155-1). One important right is enshrined in the principle of the proportionality of the law: a security measure (e.g., internment) cannot be imposed in judicially insignificant cases, must be related to the seriousness of the offence and the extent to which it constitutes a danger to society, and can be imposed only when there is a danger that the offence may be repeated in the future. Similarly, the more serious security measures can only be imposed when there is no other way of ensuring the protection of legal rights, and even then the period of internment cannot exceed the maximum term of imprisonment that could be imposed for the same type of crime, had it been committed by a non-mentally ill person (CP Art. 92-2).

Review of an offender's situation is obligatory every two years after a period of internment has begun or has been extended (CP Art. 93-2). Before the latest revision of the law, when an offence was considered serious or very serious, the CP required the imposition of a security measure of a

minimum of three years' internment, which had to be completed, even if the offender had ceased to be dangerous or had become capable of returning to the community sooner. Knowing that in a large number of cases an offender could be released after less than three years of internment without running any significant risk, psychiatrists strongly disapproved of this provision and argued against a mandatory three-year security measure when the objective was to *treat* the offender. The 1995 revision retained the three-year minimum, but added the following text to the Article in question: "…*unless release should prove compatible with the defence of lawful order and a peaceful society*" (CP Art. 93-1). In cases where there is a reason that would justify ending the interment measure because there is no longer any danger, the court can and must immediately reassess it and is not bound by any mandatory period of internment.

Epidemiology - General Trends

Between 1992 and 2001, crime increased in Portugal and this increase progressively led to a corresponding rise in the number of court cases and the number of people sentenced. The proportion of the population who were found guilty in court rose from 836/100,000 (1998) to 1,003/100,000 (2001), mainly due to cases involving male offenders (see table 52).

Tab. 52: Suspects and Convictions in Portugal 1992-2001

	1992	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Suspects	**82,973**	**74,274**	**95,107**	**89,678**	**90,360**	**90,858**	**119,530**	**115,958**	**106,795**	**103,623**
• Male	69,934	64,302	82,898	76,757	76,843	77,282	100,787	101,823	94,369	91,768
• Female	13,039	9,972	12,209	12,921	13,517	13,549	18,703	14,095	12,324	11,735
Convictions	**30,352**	**37,442**	**34,484**	**36,372**	**36,771**	**37,735**	**40,622**	**44,509**	**53,682**	**60,553**
• Male	26,990	33,860	31,434	32,824	33,305	34,195	37,326	41,384	49,575	55,657
• Female	3,362	3,582	3,050	3,548	3,466	3,525	3,281	3,114	4,063	4,823
% Conviction	37	50	36	41	41	42	34	38	50	58
Suspects/ 100,000	836	751	960	904	910	912	1,196	1,160	1,043	1,003
Convictions/ 100,000	306	379	348	367	370	379	407	445	524	586

Source: Ministério da Justiça (http://www.gplp.mj.pt/estjust/serviços_prisionais.htm)

There was a general trend towards an increase in the number of people accused of and sentenced for crimes involving acts (including those of a sexual nature) committed against other persons, together with a fall in those accused of and sentenced for crimes against property (approximately 20% of all convictions in 2001).

The growth in both the number of crimes and persons found guilty in court was responsible for a rise in both the absolute and the relative (from 96/100,000 to 131/100,000 population) numbers of prison inmates throughout the 1990's. One particularly significant element in this trend throughout the decade was the number of people who were held preventively before being formally accused and brought to trial, which, although it did not increase, represented a very high proportion of the total number of people held (see table53).

Tab. 53: Inmates in Portugal 1992-2001

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total	9,451	11,000	10,035	12,029	13,874	14,361	14,598	12,808	12,675	13,025
Inmates/100,000	96	111	101	121	140	145	146	128	124	131
Pre-trial	3,465	3,850	3,632	4,629	4,977	4,328	4,250	4,052	3,854	3,690
Convictions	5,986	7,150	6,403	7,400	8,897	10,033	10,348	8,756	8,821	9,335

Source: Ministério da Justiça (http://www.gplp.mj.pt/estjust/serviços_prisionais.htm)

Epidemiology of Mentally Ill Offenders

There is no substantial data available on this particular topic, except for the number of mentally ill offenders placed in forensic facilities, which shows a continuous decrease during the last five years - 277 (1998), 283 (1999), 261 (2000), 235 (2001) and 220 (2002) (source: Ministry of Justice web-site).

Annex 1: Courts in Portugal

The judicial sector in Portugal includes a set of different Courts:

- Tribunal Constitucional
- Tribunais Judiciais
- Tribunais Administrativos e Tributários
- Tribunal de Contas
- Tribunais Militares
- Tribunais Comunitários.

Tribunal Constitucional (The Constitutional Court) – assesses the constitutionality of laws, oversees referenda, hears appeals in cases in which a Member of Parliament is deprived of his/her seat for disciplinary or other reasons, receives declarations of assets and hears cases involving the regime governing the compatibility or otherwise of persons holding political office.

Tribunais Judiciais (Courts of Law) – (in ascending hierarchical order) the Courts of 1st Instance, the Courts of Appeal and the Supreme Court of Justice: hear both criminal and civil cases, appeals against rulings in lower courts, petitions for *habeas corpus*, criminal cases with an international scope and cases in which the accused holds senior political office.

Tribunais Administrativos e Tributários (Administrative and Tax Courts) – includes the Circuit Administrative Courts, the Tax Courts and the Supreme Administrative Court (STA). The Circuit Administrative Courts (courts of 1st instance) hear appeals against acts taken by the central public administration, petitions for the recognition of rights that are protected by law and cases involving contracts with the public administration or the state's contractual or civil responsibility. The Tax Courts (1st instance) hear appeals in fiscal cases, including those against levies or other measures imposed by the customs authorities. The Supreme Administrative Court hears appeals in cases that have already been judged by the lower administrative or tax courts.

Tribunal de Contas (The Court of Accounts) – are responsible for inspecting public income and expenditure and assessing the financial management of the state purse.

Tribunais militares (Military Tribunals) – judge crimes of a strictly military nature, but only during a state of war (the Constitution precludes them from sitting in peacetime).

Tribunais comunitários (Community Courts) – the Court of Justice of the European Communities is responsible for interpreting and applying Community Law.

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Fig. 35 Judicial and Placement Procedures for Mentally Ill Offenders in Portugal

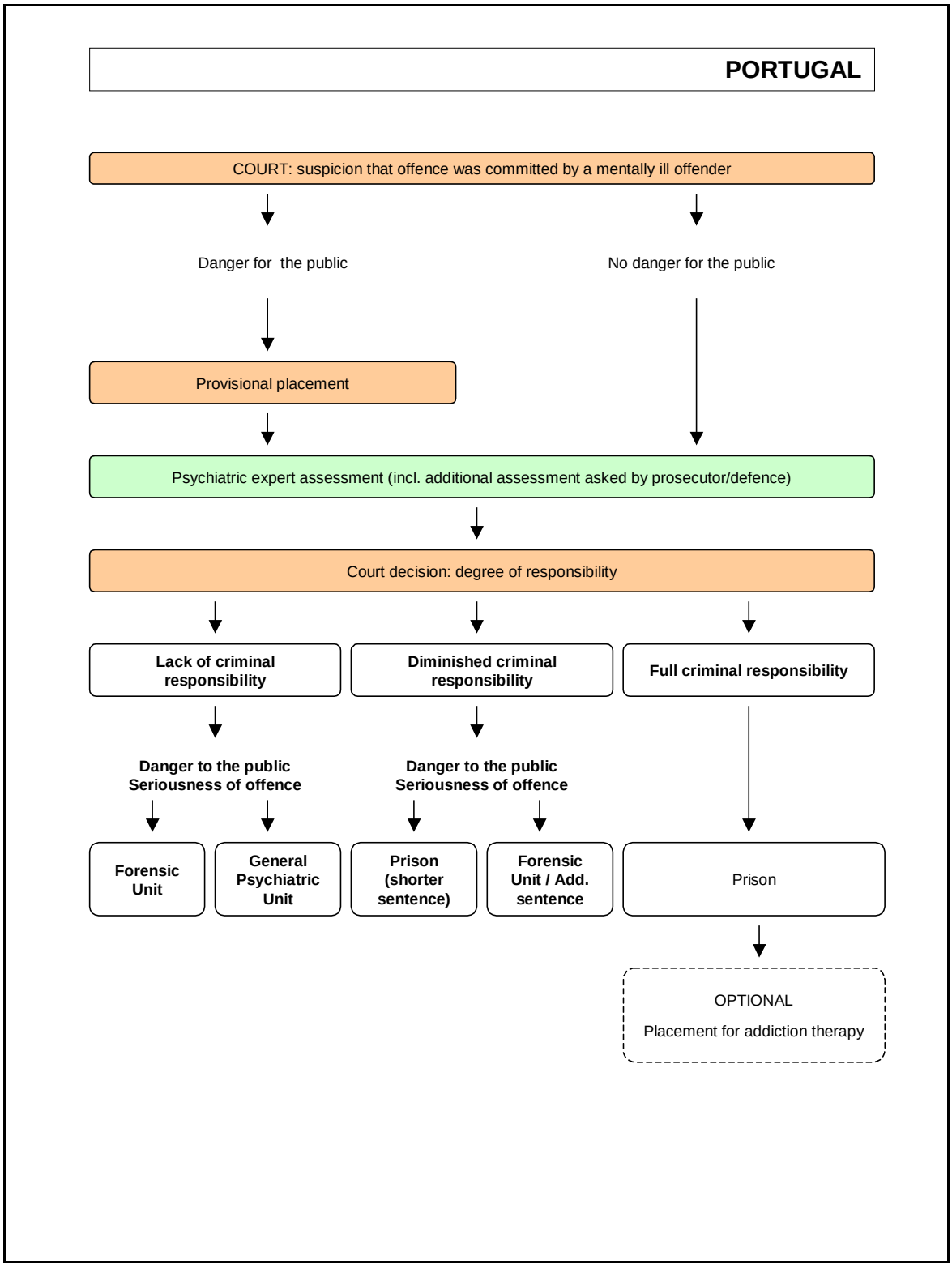
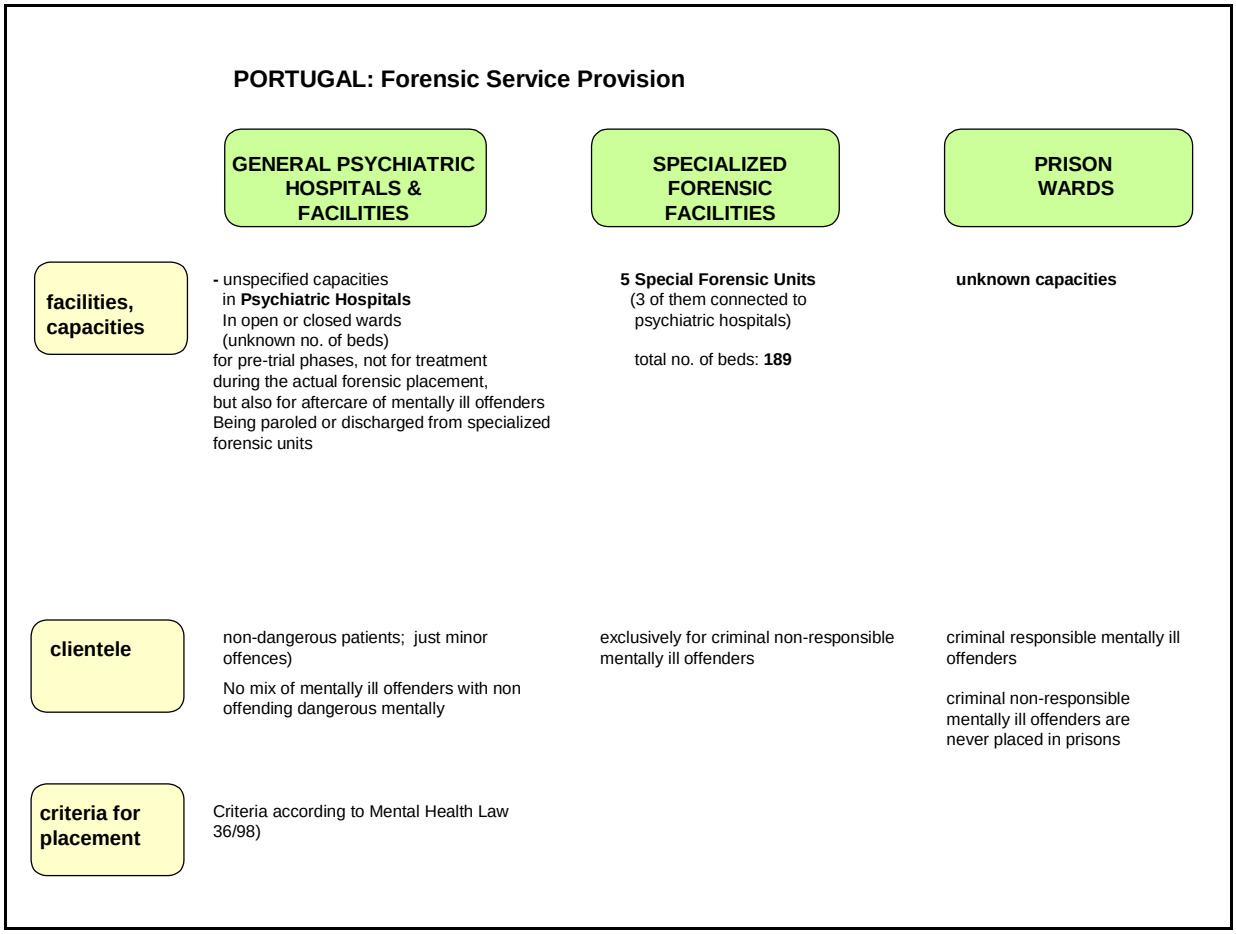


Fig. 36 Forensic Service Provision in Portugal



Spain

Francisco Torres-González & Luis Fernando Barrios

Legislation

The concept of lacking criminal responsibility of “lunatics and people suffering from dementia” was already considered in the first Spanish penal codes of 1822 and 1848. It is still codified in today’s Penal Code, approved by Organic Law 10/1995 of November, 23 (CP 1995).

The CP (*Código Penal* or Penal Code) of 1848 stipulated that those exempted from responsibility for mental reasons should be hospitalised *"in one of the hospitals designated for the ill persons of that class"*. During the 19th century it was common that “criminal lunatics” were imprisoned as often as they were sent to asylums. Finally, the Royal Ordinance of September 1st, 1897 provides that mentally ill criminals should be separated from healthy prisoners, so that it became necessary to build specialised penitentiaries for mentally ill. However, the lack of sufficient financial means has always been a constraint to the provision of appropriate facilities.
At present, three forensic facilities are provided for Spain, located in Alicante, Seville and Barcelona. The selection of patients follows the criteria of proximity to their homes.

The Penal Law of 1995 introduced improved and modernised security measures for imprisoned mentally ill patients (including the mentally retarded and patients suffering from alcoholism or drug addiction) such as

a) a maximum time-frame of the measure, which had not been regulated before,
b) the continuing judicial control over the execution of the measure, and
c) the powers assigned to the judicial authority regarding the termination, substitution or suspension of the measure.

Fundamental changes also took place on the general penitentiary level, mainly by the Organic General Penitentiary Law 1/1979 (LOGP) from September 26th, 1979, which was promulgated after the approval of the Spanish Constitution of December 28th, 1978. *This meant a radical change in penitentiary norms and standards within the Spanish panorama.* The LOGP was developed further by means of *Regulation of 1981 (RP 1981).* Following this, the current Penitentiary Regulation was approved by Royal Ordinance 190/1996 (RP 1996), which introduced for the first time important regulations of forensic detention.
It determines the implementation of "Psychiatric Units" in penitentiary centres to complement Psychiatric Penitentiary Hospitals. It further regulates the implementation of so-called "Multidisciplinary Teams", which are the key-groups responsible for the treatment, supervision and reporting on the execution of forensic detention.

On a procedural level, the Law of Criminal Prosecution from 1882 (LECrim) has not been modified in this respect. For that reason, the expert testimony prior to and during court trials is governed by obsolete and insufficient norms.
Modifying this basic procedural law, the Organic Law 5/1995 from 1995 on the Tribunal of the Jury (LTJ) constitutes a jury as the deciding authority in many trials against mentally ill offenders.
The rights of offenders suffering from a mentally illness have been regulated only very recently.
A first step has been made in 1986 with the General Law of Health (LGS). In 2002, the Law of Autonomy of the Patient 41/2002 (LDP) entered into force. It is mandatory to apply these laws in all public and private health facilities. Therefore these laws are also applicable to the facilities within the penitentiary system.

Procedures

The Phase prior to the Judgement

A person suspected to suffer from a mental illness and of having committed a crime is usually sent to a penitentiary facility, either to a general prison department or a medical ward, according to his or her state. Health care or medical treatment of these persons corresponds to the health care standards of the Penitentiary Administration or, in their case, to the appropriate service of the Health Administration (207 RP 1996). It is possible to admit patients to hospital treatment due to mental disorders (209.2.2 RP 1996), but in practice they are cared for by liaison psychiatrists or the regular physician of the respective penitentiary centre (288.2ª RP 1981, effective).

During the investigation, the responsible examining judge can name one or two experts for psychiatric assessment. This depends on whether a regular or shortened procedure is exercised. A shortened procedure can only apply for offences punishable by a maximum of nine years of deprivation of freedom (785.7ª 459 LECrim). It is also at the discretion of the examining judge to order the admission of the suspect to a psychiatric penitentiary hospital or a psychiatric penitentiary, which happens rather frequently. This is allowed for the purpose of observation and issuing an expert report (184.to RP 1996). All involved parties, the suspect or his defence, the plaintiff or the prosecution can name an expert at their own expense (471 LECrim).
The expert might be a psychiatrist, psychologist or forensic doctor, since the procedural laws do not provide any specification on the expert's professional background. In practice, the assessing expert is most often a psychiatrist or a forensic doctor. The latter can be specialised in psychiatry but does not necessarily have to be so.

Court Trial and Expert Assessment

The Spanish legal system knows three types of trial procedures with consequences for the expert assessment and testimony.
First, a shortened procedure applies to crimes punishable by imprisonment for a period of up to nine years (779 LECrim). Here, one single expert is required to issue a written expert's report (793.5 LECrim).
Second, the regular trial procedure, applicable to crimes punishable by imprisonment of nine or more years, includes an additional oral examination by the experts during the trial (724 LECrim).
Third, a Jury Tribunal (usually mandatory in cases of homicide, threats or forest fires and comprising a total of nine randomly selected citizens) is entitled to submit written questions to the experts (1.2 LTJ). The *Fiscal*[1] as well as the defence or the plaintiff are allowed to forward questions to the experts (46.1 5 LTJ).
An expert report is never binding, but any verdict or sentence is supposed to be appropriate (120.3 CE), should be based on proven facts (248.3 LOPJ, 142.2ª LECrim and 52.1.to LTJ) and reflect conditions or circumstances that might modify or diminish the criminal responsibility of the person concerned (142.4ª. Third LECrim and 52.1.B LTJ).

Generally, during the time of the trial the defendant assumed to be mentally ill remains in the penitentiary centre closest to the town where the trial takes place.
The verdict can consider the lack of criminal responsibility or extenuating circumstances. It also may occur that only after a sentence had been imposed, is a serious mental disorder of a defendant detected. This is usually termed "happened insanity".

To exempt an individual from criminal responsibility requires the presence of at least one of three major causes:

- an anomaly or alteration of mind that prevents the individual from understanding the illicitness of an action or from acting according to this understanding. This includes transitory mental states unless it was caused purposely for the commission of a crime or the subject should have been able to foresee the criminal action (20.1º PC);
- the syndrome of abstinence preventing the individual from understanding the illicitness of an action or from acting according to this understanding; or full intoxication due to the

[1] Within the Spanish legal system, the Fiscal or "Public Ministry" acts as the public and official advocate before the judge and, eventually, before the Court if his/her assessment does not agree with the judge. It is more or less equivalent to Public prosecutor (England), Government attorney (USA) or "Staatsanwalt" (Germany).

intake of alcohol, toxic drugs, narcotics, psychotropic substances or the like, in case it had not been taken with the purpose of offending (20.2º PC);
- alterations in perception from birth or childhood that gravely alter the person's awareness of reality (20.3º PC).

A diminished criminal responsibility due to these causes can be decided (20.1º. 2º 3º PC) when not all requirements are met to exempt one fully from responsibility (21.1ª PC). This is also possible in cases in which the person concerned suffers from severe addiction and acted under the influence of substances mentioned in code 20.3º PC (21.2ª PC).

When a delinquent who had been assessed as fully criminally responsible and been sentenced under that assumption is diagnosed with a mental disorder during imprisonment, he will be cared for by either the health care services of the respective penitentiary or, in cases in which the condition is considered transitory, by the general health care services.

Whenever the disorder seems to be serious and probably enduring, the prisoner will be subjected to observation, and the director of the Penitentiary Centre will include a physician for examination (991 LECrim). If a mental illness is confirmed, the nature and severity of the disorder will be reported to the tribunal that has issued the verdict (992 LECrim).
After a hearing including the *Fiscal,* the prosecutor, and the defence of the prison inmate, an official investigation on the facts will be opened (993 LECrim) which usually is closed by a judgement (994 LECrim).
In the case of a judicially confirmed severe and enduring mental disorder, the execution of the sentence will be suspended and medical care will be guaranteed (60.1 PC), which means the order of secure placement in a Penitentiary Centre or in a Psychiatric Penitentiary Unit (184.C PC). After recovery, the remaining sentence has to be served, unless the judge or tribunal order a reduction or a remission (60.2 PC).

Measure of Psychiatric Penitentiary Placement
Mentally ill offenders whose criminal responsibility has been declared lacking can be placed under security arrangements, which could differ according to the cause:

- Persons whose criminal responsibility was declared fully lacking according to code 20.1º PC can be detained in "a facility adapted to the confirmed type of anomaly or psychological disorder". This placement can not exceed the period an imprisonment would have lasted, when the person concerned would have been declared responsible for the act (101.1 PC).
- Persons whose criminal responsibility was declared fully lacking according to code 20.2º PC can be detained in a "public specialised centre for drug-addiction treatment, or in a private centre, if it is properly accredited" (102.1 PC).
- Persons whose criminal responsibility was declared fully lacking according to code 20.3º PC can be detained in a "special educational centre" (103.1 PC).

In all cases, any termination of the placement, discharge, transfer or leave of the facility is subject to authorisation by the responsible judge or tribunal (101.2, 102.2 103.2 PC). Since the "Psychiatric Penitentiary Units" have not yet been implemented, the only available facilities are the Psychiatric Penitentiary Hospitals of Alicante and Seville and a new one recently opened in Catalonia, which is privately managed, but contracted for and supervised by the Catalan government.

For mentally ill offenders whose criminal responsibility has been declared as being diminished according to article 21.1ª or 2ª PC, the judge or tribunal could impose in addition to a deprivation of freedom a (forensic) placement according to arts. 101 to 102 PC. In that case, the duration of the placement could not exceed the period of prison punishment (104 PC) and the length of placement counts towards the imprisonment (99 PC). In the case of a good outcome of a finalised forensic placement, remaining imprisonment might be suspended (99 PC).

The Spanish penitentiary system has not developed its own specific educational or treatment centres for drug-addicts referred to in the arts. 102.1 103.1 PC. Only Psychiatric Penitentiary Hospitals are available.

As soon as a subject is admitted to a Psychiatric Penitentiary Hospital under a measure of security, the physician in charge later decides on the basis of his own preliminary evaluation and available reports, whether the person concerned has to be treated and classified further (186.1 RP 1996). A Multidisciplinary Team (EM) of psychiatrists, psychologists, general physicians, nurses and social workers will be assigned (185.1 RP 1996), forwarding to the judicial authority an initial report on the diagnosis, developmental process, prognosis and rehabilitation programs. The report will also assess the necessity of prolonging, terminating or substituting the measure of forensic placement, and will propose a transfer to other facilities or additional specialised measures, in case they are pertinent (186.2 RP 1996).

The EMs review the personal situation of each patient and write a report on the mental state and development of the person concerned at least every six months. The reports are forwarded to the Tribunal of Penitentiary Supervision and to the *Fiscal* (187 RP 1996).
On the basis of the reports from the treating professionals or from other appropriate sources, this Tribunal or the Judge of Penitentiary Supervision is eligible to propose a modification of the placement measure to the judge or tribunal that issued the sentence or ordered the measure (98 PC). In view of this proposal, the judge or tribunal that set up the sentence is able to (97 PC):

a) order the termination of the measure due to no longer enduring threat by the patient;
b) order a more appropriate measure. This includes measures without deprivation of freedom, which can not be imposed for periods longer than five years, as
    - outpatient treatment in medical or psychosocial centres,
    - restriction of residence to a certain place,
    - prohibition of taking residence in designated places or territories,
    - prohibition of visiting certain places, licensed bars or other establishments serving or selling alcoholic drinks,
    - family custody or participation in formative or educational programs;
c) suspend the execution of the security measure for the remainder of the sentence. This suspension remains conditional pending any re-offending during the fixed term or a prognosis of new crimes (95.1 PC).

Annually, the Judge of Supervision proposes the maintenance, termination, substitution or suspension of the security measure of deprivation of freedom.

Aftercare
For persons discharged from forensic placement, general health care resources are available which are provided by the 17 Autonomous Regions in Spain. Usually psychiatric departments at general hospitals will offer treatment when readmission to psychiatric inpatient care is necessary (20.2 LGS).

Practice

Some psychiatric associations are questioning the current institutional model for mentally ill offenders, suggesting instead the suppression of the specialised penitentiary centres and integration of the patients into the general health care system.
It has been criticised that the closure of psychiatric hospitals with half- and long-stay units has been at the expense of transferring many patients into psychiatric penitentiary centres. The lack of specialised centres for addiction disorders and mental retardation poses additional disadvantages. Patients suffering from these disorders are placed in the general prison system (when a prison sentence has been ordered) or in psychiatric penitentiary centres (when a placement measure has been ordered and an additional mental illness has been confirmed). Psychiatric penitentiary centres are completely lacking in specific treatment programs for sex offenders. Such programs are available only at general prisons.

The three psychiatric penitentiary facilities which are currently implemented differ considerably. The service in Alicante (340 beds) provides several modules, an acute unit and an infirmary. It has large sport facilities available and offers cultural and outdoor activities. The Seville psychiatric penitentiary (150 beds) developed from an infirmary ward within a high-security prison which

eventually was transformed into a psychiatric hospital still located inside the high-security centre. It lacks appropriate conditions for inmates.

One of the greatest problems concerns the continuation of care following finalisation of the originally ordered placement measure. General hospital services are often reluctant to admit persons whose state requires ongoing hospital treatment.
Leaves during placement measures are hardly regulated, thus making room for sometimes arbitrary decisions by the jurisdictional organs.
With some modifications (e.g., the provision of multidisciplinary teams), psychiatric penitentiary facilities are more or less organised along the lines of the general prison centres. However, it is astonishing that no direction of the Spanish psychiatric penitentiary centres includes psychiatrists.

Patient's Rights

The general statutes applicable to any ill person in Spain are also in force for patients admitted to psychiatric penitentiary facilities. This includes especially law 41/2002 from November 14, 2002 (basic regulation of autonomy of the patient and of rights and obligations as regards information and clinical documentation) and law 14/1986 from April 25, 1986 (General Sanity). Informed consent is guaranteed in consequence (8.1 LDP and 210.1 RP 1996), excluding those cases bearing a public health risk (9.2.to LDP and 210.2 RP 1996) or immediate severe danger for the physical or mental integrity of the person concerned (9.2.B LDP and 210.1 RP 1996). In both cases, the judicial authority will be informed (210.1 2 RP 1996). Similarly, the confidentiality of clinical information and data is guaranteed (10.3 LGS and 215.1 RP 1996). The same health care as that provided to the general population is also guaranteed (208 RP 1996). During a placement measure the penitentiary legislation recognizes the following rights in particular:

- The personality of confined persons will be respected and their rights and legitimate interests will not be affected by the placement measure (3 LOGP and 10.1 LGS).
- The patients may make use of their civil, political, social, economic and cultural rights, unless these are incompatible with security measures (3.1 LOGP). Restrictions may only be executed when necessary for the state of health or the success of treatment (188.2 RP 1996).
- The penitentiary administration is supposed to look after the life, integrity and health of the confined (3.4 LOGP).
- Coercive means are to be applied only as a measure of last resort and only when medically indicated and for a minimum indispensable length of time. The dignity of the person has to be respected in any event. The judicial authority has to approve the application (188.3 RP 1996).
- General disciplinary regimes of penitentiaries are not to be applied (188.4 RP 1996).
- The patients have the right to forward complaints or petitions to the Judge of Penitentiary Supervision (72.2.G LOGP), who regularly visits the respective facilities (76.2.H LOGP). In practice, these visits take place weekly.

Public Opinion and Mass Media

Public opinion in Spain exhibits an ambivalent feeling towards offences committed by mentally ill persons. Immediately after spectacular crimes, usually positions of a not always well-founded rejection or for stiffer punishments are expressed. More compassionate feelings may arise later on, increasing with the passage of time.

As in most countries, the Spanish media pay great attention to serious offences committed by mentally ill persons (especially cases of homicide and arson). Usually, their attention lasts from the time the criminal acts were committed until the judgement. Once they have been judged, only punctual references might be made to particular cases.
Periodically broadcasted reports on crimes by mentally ill persons (e.g., on Spanish serial killers) usually generate a special impact, although the biographical reconstruction of the respective mentally ill offender's personality might be highly selective. Media access to penitentiary centres for these purposes is generally restricted.

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Fig. 37 Judicial and Placement Procedures for Mentally Ill Offenders in Spain

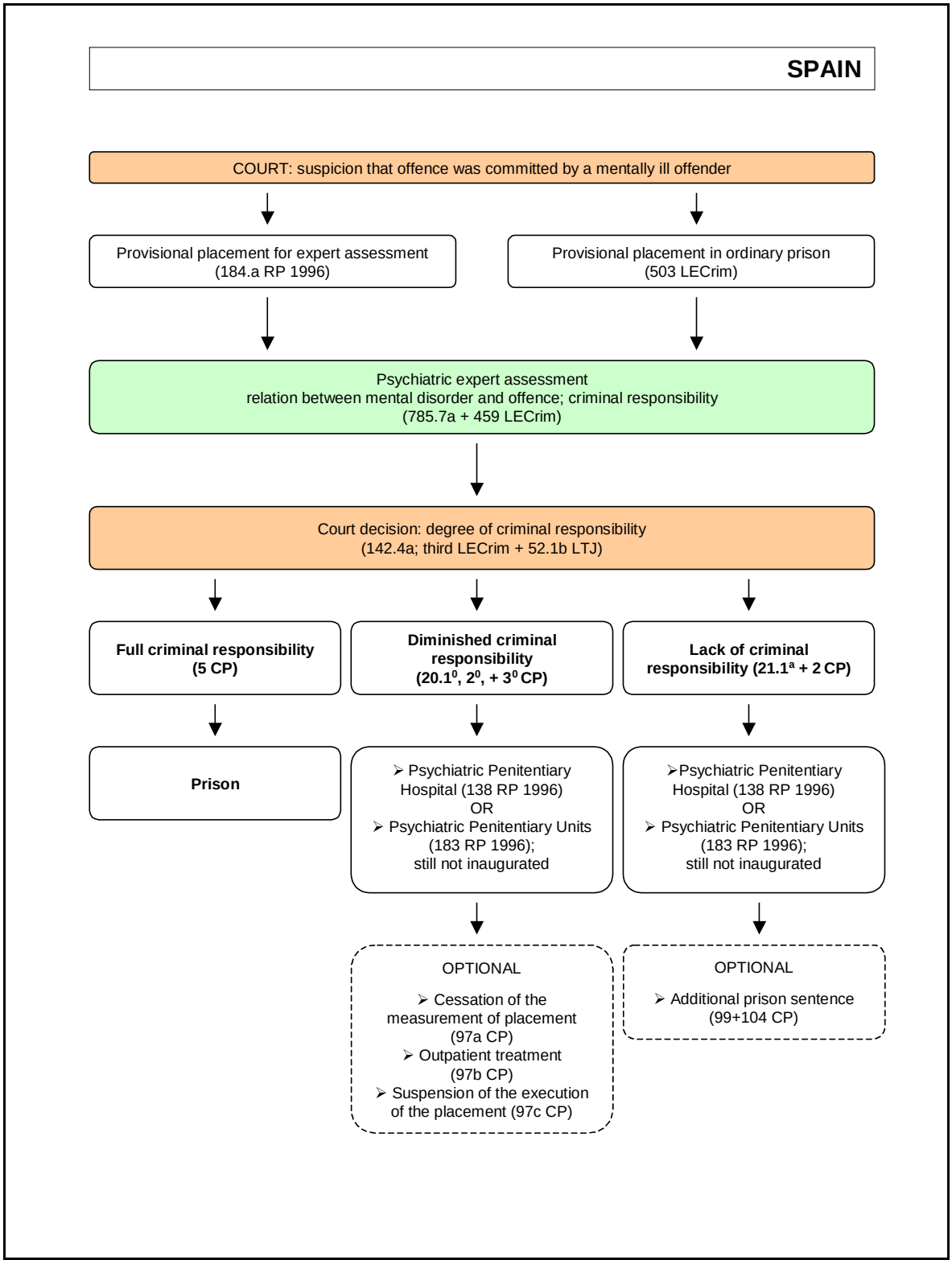
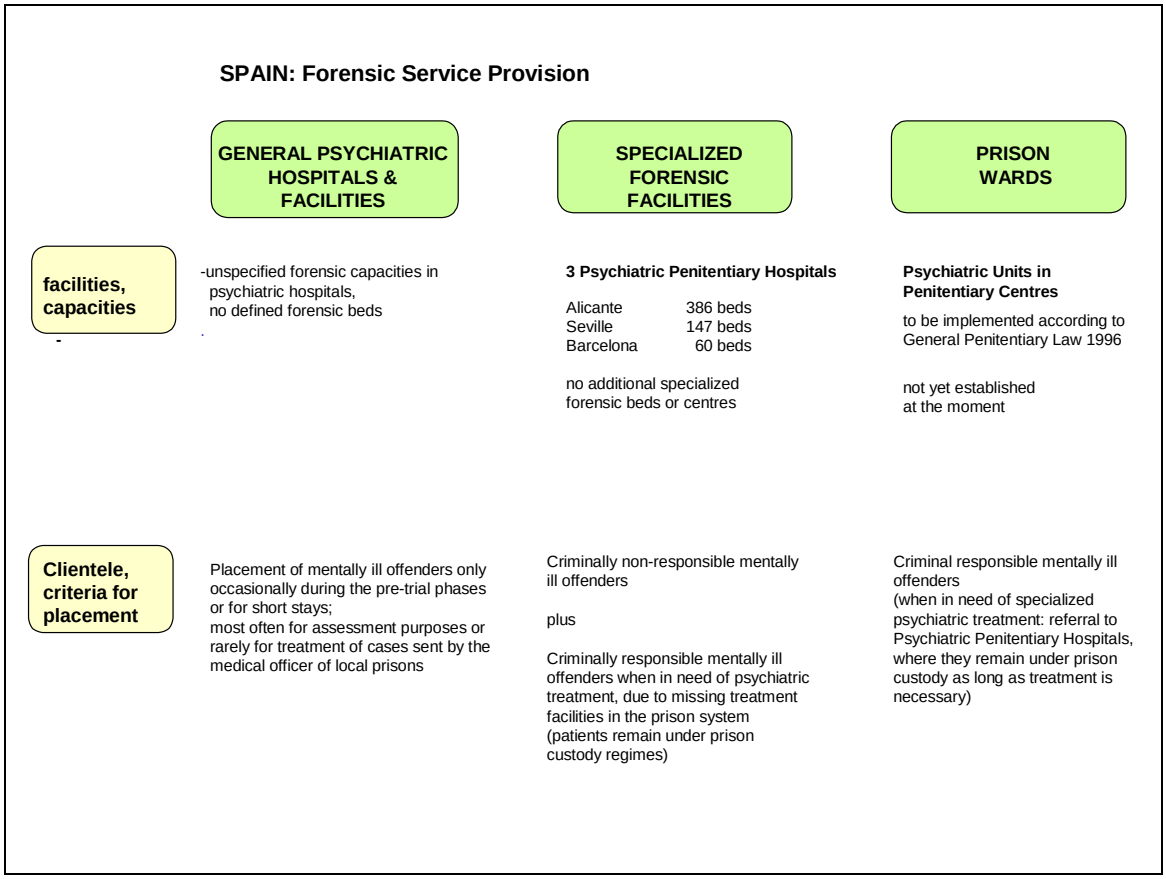


Fig. 38 Forensic Service Provision in Spain



Sweden

Helena Silfverhielm

Introduction

Sweden is a kingdom governed by a social democratic government. Nine million inhabitants populate a surface of 450,000 square kilometres. Given its surface, it is sparsely populated with 20 inhabitants per square kilometre. The distance between the northernmost and the southernmost point in Sweden is 1,600 kilometres.

The opening paragraph of the Swedish Health Care Act states that the community should provide high quality care on equal terms in co-operation with the patients and their families. This is in line with one of the major goals for the welfare state: to build a good society for all, and for the care of the exposed groups. A basic social standard (sufficient daily food, clothing and housing) is considered a fundamental right, ensured by the social welfare authorities.
A major goal of Swedish mental health care policy is to meet the needs of the mentally ill in a de-institutionalised community setting, where they can be integrated and obtain a larger degree of autonomy and a higher quality of life. In Sweden, forensic psychiatry is a speciality of its own.

Each of the 21 county councils is responsible for providing the total psychiatric care, including forensic psychiatry. Six regional forensic hospitals are responsible for the treatment of the most dangerous of those sentenced to forensic psychiatric care, which correspond to about one third of all forensic patients. Another third is treated in hospitals at the county level (several sectors go together) and the remaining one third in general hospitals.

Structure of the Legal System

In the Penal Code of 1965, the concept of accountability was abandoned and the concept of mental illness and thus comparable mental abnormality introduced. The mentally ill became responsible for their acts and psychiatric care became a sanction as opposed to the mentally ill not being accountable and thus free from sanction.

After more than 20 years of debate about the treatment and care of mentally ill offenders, the previously unitary coercive legislation on psychiatric care in 1992 was divided into two Acts that are separate from the Penal Code and from the general Health Care Act. The Acts are: the Compulsory Psychiatric Act and the Forensic Psychiatric Act.
The distinction implied notable changes with regard to mentally disturbed offenders. The legal concept of “mental illness and thereby comparable mental abnormality” was changed to “severe mental disorder”. The purpose of the new legislation was to

- strengthen the legal safeguards for the patients,
- to restrict the use of compulsory care and coercive measures, and
- to improve safeguards for next-of-kin and the community.

Another aim was to expand opportunities for detainees, persons remanded in custody, or for prison inmates to obtain psychiatric care on a voluntary basis in medical institutions.
The forensic Psychiatric Care Act applies to the following categories of patients:

- those committed to forensic psychiatric care by a court of law,
- those who need forensic psychiatric care while detained or remanded in custody,

- those who come from the prison and probation sector and are in need of forensic psychiatric care, and
- those who are remanded in custody and undergo forensic psychiatric examination by court order.

The laws were continuously evaluated during the 1990s. The length of the period for leave was not reduced as expected so that in 2001, some minor changes were made to the Act and the regulations concerning leaves for forensic patients were tightened.

Offenders with Severe Mental Disorders

According to the Penal Code, (Chap. 30, Section 6) nobody should be sent to prison if he due to a severe mental disorder has committed a crime. “Severe mental disorder” is a legal concept and is defined in the general recommendations to the Psychiatric and Forensic Acts that are issued by the National Board of Health and Welfare. “Severe mental disorder” according to the Section 4 of the Forensic Care Act should include mainly psychosis, but also severe personality disorders with psychotic outbreaks, as well as depression with a risk to commit suicide. In certain cases pyromania, kleptomania and sexual perversions can be included in the concept.

Pre-charge Medical Assessments

A person who has committed a crime under the influence of a severe mental disorder can not be sent to prison. If the person who shall be sentenced is in need of psychiatric care, instead of sending the person to prison, the court can sentence him to forensic care. Before such a decision is taken, the court is obliged to have the person medically assessed. This can be done either by means of a major or by means of a minor forensic investigation.

The court then sends the documents of the case to the unit in charge of the assessment. In a minor investigation, the physician looks through the documents and makes his assessment after examination of and an interview with the suspected person. The assessment is presented to the court in a so-called § 7-certificate.

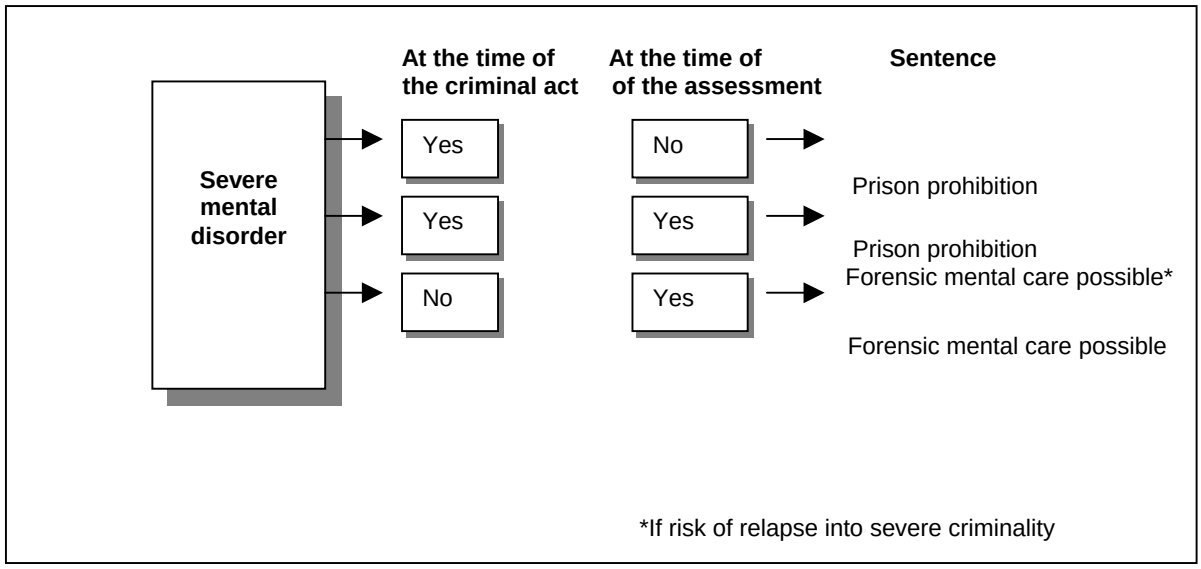
In a major forensic investigation, a team consisting of a forensic psychiatrist, a psychologist, a social worker and nursing staff participates in the assessment. The physician is responsible for the final document. The assessment must be terminated within four weeks. If the suspected individual is not under arrest, the time limit can be up to six weeks and the suspected person may in that case be in his home or in another hospital or nursing home and come to the team for examination and tests. The National Board of Forensic Medicine is responsible for the forensic investigations.

Sanctions

According to Chap 30, Section 6 of the Penal Code, a person who has committed a crime under the influence of a severe mental disorder may not be sentenced to prison.

According to Chap. 31, Section 3, a person who has committed a crime under the influence of a severe mental disorder may be sentenced to forensic mental care with an order for special assessment for discharge if there is any risk, on account of the mental disorder which occasioned the order for special assessment for discharge, of a patient’s relapsing into criminal behaviour of a serious nature. A patient can only be released or have permission after a trial in a county administrative court
If there is no such risk, a patient may be sentenced to forensic care without special assessment for discharge. Since 1991 approx. 80% of the patients cared for require a special assessment.

Fig. 39 **Conditions for Sentencing to "Forensic Mental Care with an Order for Special Assessment for Discharge" in Sweden** (Kullgren, 1996**)**



Care

Medical institutions authorised by the government to provide forensic psychiatric care for detainees, persons remanded in custody and prisoners can be engaged for the care of patients who wish to receive voluntary psychiatric care but who for security reasons cannot be treated in general psychiatric practice. Six regional clinics ("maximum security") throughout the country provide care to one third of the forensic patients. The remainder are cared for in general psychiatric clinics.

The decision to sentence a person to care or to prison is taken by the court. If a care sentence is handed down, a message is sent to the senior consultant in the area where the offender is registered and he then decides in what kind of institution the offender shall receive his care and the degree of security needed. The offender is therefore admitted to a psychiatric or forensic facility depending on the degree of illness and dangerousness. The senior consultant can decide about leaves and release without being obliged to consult the court if the sentence is to forensic care without special assessment for discharge. If the sentence is to forensic care with an order for special assessment for discharge, the county administrative court has to decide on both leaves and releases. The opinion of the prosecutor should also be obtained before the leave or release can be put into effect.

When the court commits a patient to forensic care with a special pre-discharge assessment, the prosecutor is entitled to make a representation when either a leave or release is planned. The treatment of sex offenders consists of psychotherapy and anti-hormonal therapy. The treatment of drug abuse is dependent of the nature of the abuse. The court supervises the use of forensic care by means of a system of fixed-term committal so that at least every six months an assessment has to be made as to whether or not the care shall continue. The care is also supervised by the National Board of Health and Welfare.

Problems with the Current System - Care Issues

There is an ethical conflict built into the care system. This is mainly due to the difficulties in satisfying the need to provide effective care for the mentally ill offender. Many of the patients have

a dual diagnosis problem which is difficult to treat, especially if it is combined with a personality disorder.
With the system of special review of remission, the patient can be retained in custodial care despite the fact that such care is not needed for medical reasons. This is another source of ethical conflict. There is a risk that continued forensic care will evolve into a form of hospitalisation for purposes other than treatment.
Some of the persons in forensic psychiatric care have been sentenced for minor criminality. Some of them have been cared for over very long periods and at great expense. It can be questioned whether this level of care is appropriate for the purpose.

In penal institutions there are inmates with mental health problems. However, the capacity of the prison and probation service to provide care is limited. It is also difficult to satisfy their need for care within the public health care service.
The aftercare, regardless of whether the person has been cared for in a penal or in a medical institution, is almost nonexistent, partly due to a lack of motivation by the patient and partly to relapse into drug abuse. There are great difficulties to attract and to maintain competence for the care.

Criminal Law Issues

If someone has committed a crime under the influence of a severe mental disorder, the sanction of imprisonment may not be imposed as mentioned above. But, if at the time of the judgement there is no longer any severe mental disorder present, the sanction can not be determined to be forensic psychiatric care. In this situation it can be difficult to find a suitable and sufficiently intervening sanction, especially if a severe crime has been committed. If, for example, a murder has been committed, it is unsatisfactory that the only sanction that may come into question is a conditional sentence or probation.

With the current prohibition of imprisonment, a mentally disordered person is excluded from certain sanctions or forms of enforcement, i.e., conditional sentences or probation in combination with community service, probation with so-called contract care or submission to monitoring with electronic controls. Thus the current system can result in a more severe penalty being dealt to a mentally ill offender than to other offenders, because a mentally ill offender is excluded from some of the less intervening forms of enforcement.

Public Protection Issues

If an offender has been found guilty by the court and the sanction determined is forensic psychiatric care, this can be combined with a special review of remission to satisfy the need for public protection.

A person who has committed a severe crime and has been sentenced to forensic psychiatric care, may, after a short period of inpatient care, be declared healthy and discharged out into society. From the point of view of public protection, this can be unsatisfactory. Several evaluations have shown that that the lengths of stay for care for offences of a less serious nature are longer than the lengths of stay in prison for the corresponding offence. Instead, the lengths of stay for more serious crimes are longer in case of imprisonment.

Patients' Rights

Patients' rights are guaranteed by the laws, independent of the step of the process the individual is currently in. Some of the most important rights are:

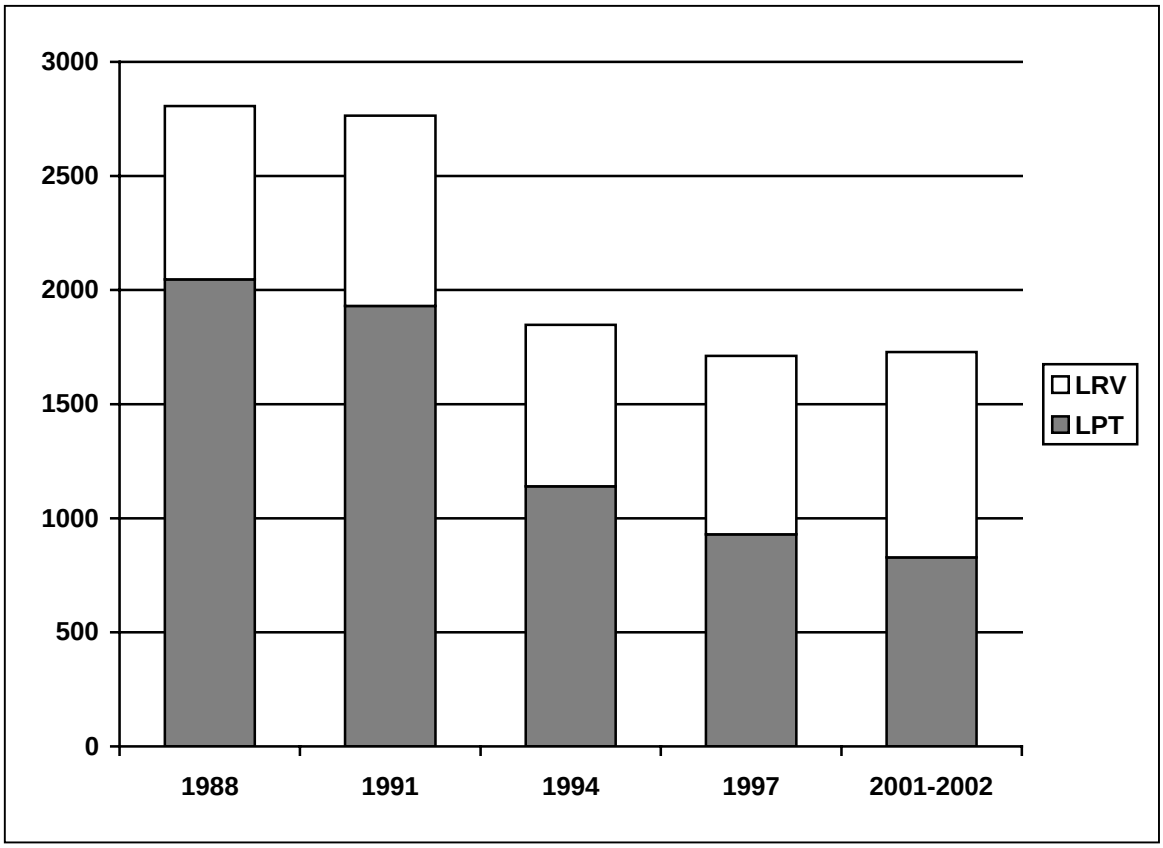
- the right to information concerning compulsory care and its implications, particularly regarding the measures of restraint, medication and other measures taken against the consent of the patient,
- the right to communicate with the exterior, which cannot be restricted for medical reasons,
- the right to take an active part in the treatment plan,
- the right to a supportive person whose duty it is to assist the patient in court sessions or otherwise help him with matters concerning compulsory care, and
- the right to appeal against orders concerning the care.

The patient has no right to refuse treatment, but his opinion shall be considered.

Ethics

In Sweden a person can be sentenced to forensic care even if in some special cases there is no effective medical treatment to offer. For a judicial community this is unsatisfactory. If a person is sentenced to care there are no means for him to refuse treatment. It is considered unethical to offer care without offering treatment.
A person sentenced to forensic care with an order for special assessment for discharge can not be released until there is no longer any risk, on account of the mental disorder which occasioned the order for special assessment for discharge, of a relapse into criminal behaviour of a serious nature. The patient can only be released or have permission after a trial in a county administrative court. This means that a person has to stay in compulsory care even if his treatment has been successful in the sense that he no longer has a severe mental disorder.

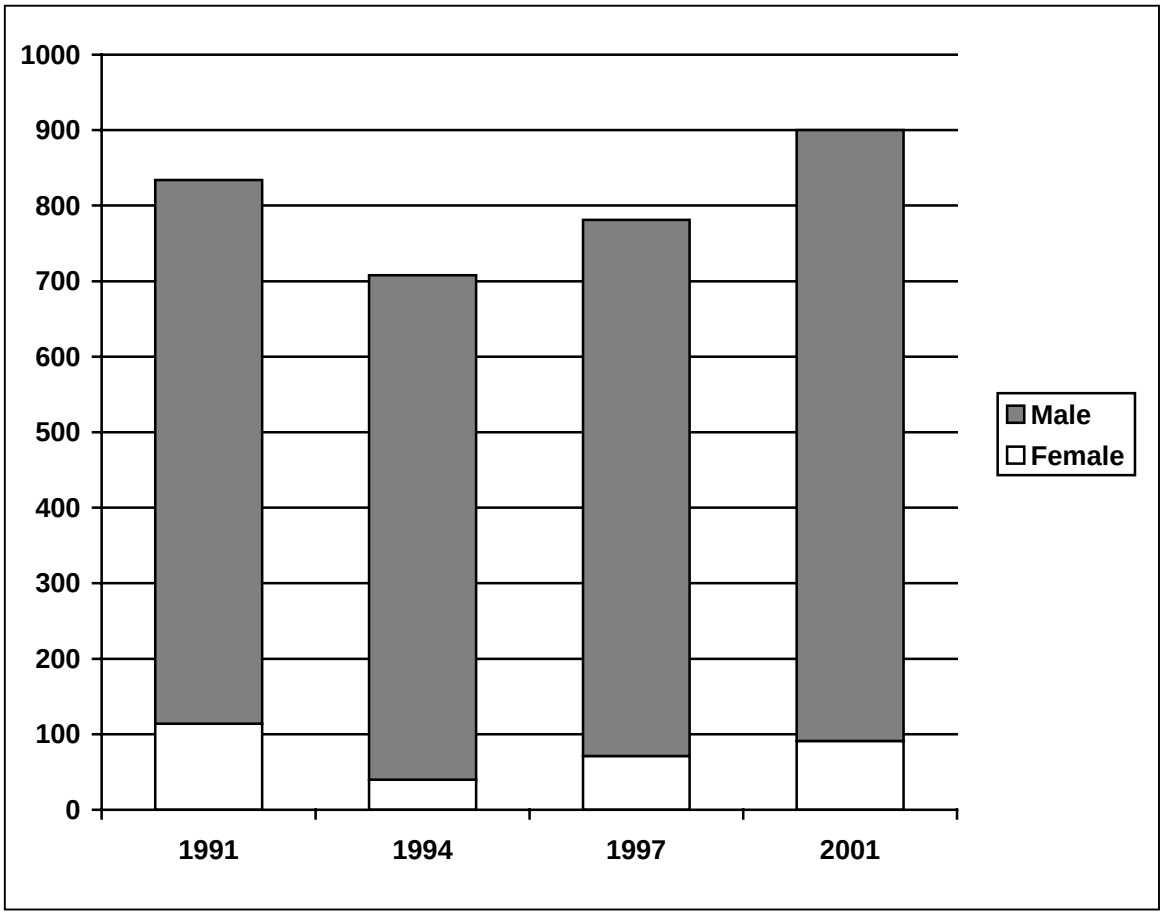
Fig. 40 **Number of Patients in Psychiatric Compulsory Care (LPT) and Forensic Psychiatric Care (LVR) on Census Day 1988-2002 in Sweden** (Source: National Board of Health and Welfare). The total number of inpatients in 2002 was 5,600 (census-day)



Epidemiology

Regional data on forensic care and coercive measures are collected by the National Board of Health and Welfare every three months and national data are collected annually. Data on the extent of compulsory care and on compulsory measures are prioritised. There are also regular follow-ups and evaluations of forensic care. Most of them are in connection with new reforms or other major changes in the legislation. Selected results from national surveys are shown below.

Fig.41 **Gender of Patients in Forensic Psychiatric Care in Sweden 1991-2001** (Source: National Board of Health and Welfare)



In 2001, there was an evaluation on the changes in the Forensic Care Act. One hundred and twenty patients who were discharged during a six-month period were studied. Of these 120 patients, seven had committed suicide and one had died from natural causes after discharge.
The patients sentenced to forensic care generally have a long length of stay. Forty-seven percent of the patients with a special assessment before release had spent more than three years in forensic care.

Tab. 54 Length of Stay for Forensic Patients Discharged in Sweden in 2001

Length of stay	Number of patients
< 8 days	2
1 - 3 months	5
3 - 12 months	27
1 - 3 years	42
3 - 5 years	14
5 - 10 years	16
> 10 years	6
Total	**112**

The trend is towards a longer length of stay, the effect of which is that instead of 1,000 persons under care on one day census 2001 there are 1,200.

Tab. 55 Age and Gender of Patients in Forensic Care in Sweden in 2001

Age	Women	Men	Number
18 - 24 years	1	4	5
25 - 34 years	7	16	23
35 - 44 years	4	45	49
45 -54 years	2	30	32
55 - 64 years	1	8	9
> 65 years		2	2
Total	**15**	**105**	**120**

As table 55 shows, men are in the majority across all age groups and most of the patients are middle-aged. The comparatively high age is probably due to the fact that the patients stay rather long and experience several episodes during their illness.

Tab. 56 Country of Origin of Patients in Forensic Care in Sweden in 2001

	%
Sweden	56
Other Nordic country	4
Other European country	11
Outside Europe	30

Tab. 57 Most Severe Crimes of sentenced Forensic Patients in Sweden

Crime	%
Murder, manslaughter etc.	12
Rape	5
Other violent crime	42
Arson	8
Sexual crime against children	3
Other crime	31

Tab. 58 Diagnoses of Patients in Forensic Care in Sweden in 2001

Disorders	number
Organic disorder	5
Alcohol- and drug-related disorder	13
Schizophrenia and other psychosis	51
Mood disorder	12
Adaptive disorder	5
Personality disorder	30
Other	4
Total	**120**

National research is extensive, producing many scientific papers, publications and theses. Data are available only for research, evaluation and other "follow-up" activities. The quality of the data depends on what the clinics report. We have no idea of the extent of what should have been - but has not been – reported. There is no specific network for the exchange of data.

Public Opinion and Mass Media

There are daily discussions in the mass media concerning aspects of mental illness. The focus is generally on the negative aspects of the care or living conditions. As soon as a serious and violent crime has been committed, the mass-media proclaim that "it must be a mentally ill person" or "the care has collapsed". When after investigation it then turns out that the offender was not mentally ill, the media stay silent.
One of the problems this gives rise to is a stigmatisation of the group of mentally ill as such. It is difficult to explain to the media that most of the mentally ill are not violent. The media do a lot to create negative "myths" regarding the care of the mentally ill. In Sweden the care of the long-term mentally ill underwent a legal reform in 1995. To date the media have mostly reported on the "failure" of the reform, not taking into account all its positive effects. Examples of some of the myths created include:

- "It is better for patients to stay in mental hospitals than to be out in the society."
- "The number of suicides has increased due to the reform."
- "There is more deadly violence due to the reform."
- "More people are homeless due to the reform."

This became very evident following the murder of the Swedish Foreign Minister Anna Lindh in 2003. The mental health care system was heavily blamed for not having been able to prevent a crime of this dimension. The court has not found the offender to have a severe mental disorder and has thus sentenced him to prison.

Need for a New Reform

As mentioned above, the current system has several shortcomings. A new reform is planned whose aim it is to establish a system whereby legal offenders with severe mental disorders who are criminally legally liable can be sentenced to a sanction that satisfies both their need for care and the public need for a safeguard. In other words, the time spent in the mental health care system should not be any longer than what is justifiable to provide the care needed.

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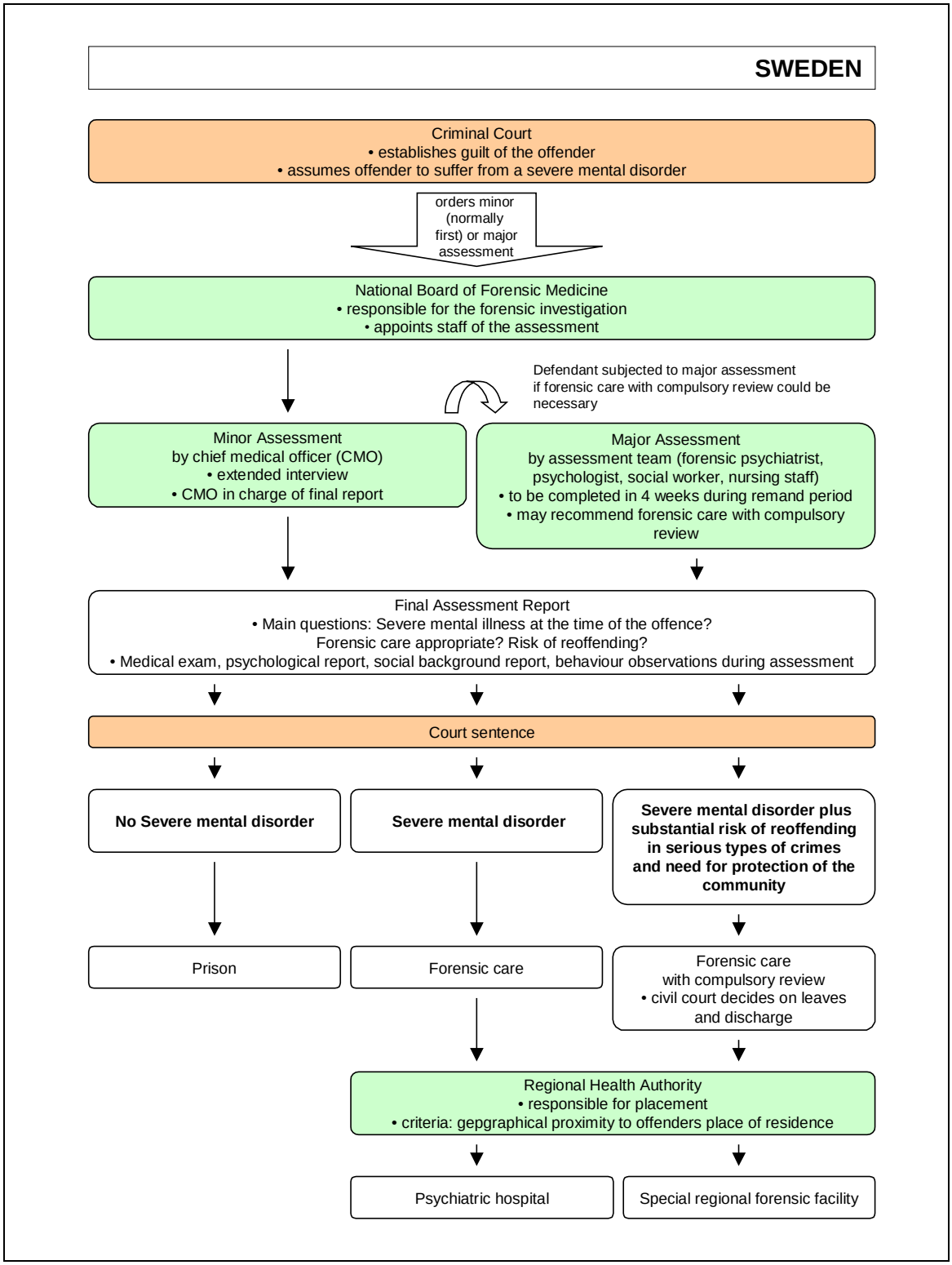
Fig. 42 Forensic Service Provision in Sweden

SWEDEN: Forensic Service Provision

	GENERAL PSYCHIATRIC HOSPITALS & FACILITIES	SPECIALIZED FORENSIC FACILITIES	PRISON WARDS
facilities, capacities	unspecified capacities in **psychiatric hospitals** on county level in **psychiatric departments** at general hospitals partly with forensic wards, partly integrated care together with civilly detained patients approx. 400 forensic beds in total	**6 Regional Forensic Hospitals** (maximum security hospitals) - Umeå 11 beds - Sundsvall 50 beds - Säter 42 beds - Katrineholm 96 beds - Vadstena 40 beds - Växjö 74 beds	**Forensic Prison Wards** (unknown no.) 142 beds in total for mentally disordered prisoners
	provider: Ministry of Health purpose: for pre-trial placement and post-trial treatment	provider: Ministry of Health	provider: Ministry of Justice
clientele	clientele: generally mixed regardless of security level (criminal responsibility as a concept is not applicable for Sweden, so security level or dangerousness is the criteria to classify mentally ill offenders)	clientele: most dangerous forensic patients	clientele: prisoners with mental disorders, transferral to psychiatric hospitals or psychiatric departments if necessary

Fig. 43 Judicial and Placement Procedures for Mentally Ill Offenders in Sweden



5 Summary and Conclusions

There are no generally agreed criteria for evaluating the judicial procedures, placement or health care of mentally disordered offenders, owing to the complexities and complications involved in these controversial issues.

This chapter summarises, in a descriptive manner, the major findings of this report, as detailed in the results section. The main focus of the report and of this summary is on the availability of basic information or data, and on identifying common patterns and approaches in legal frameworks, general policies and routine practice across the Member States. Such patterns, as well as major shortcomings or advantages of national policies, are described wherever the information gathered for this study allows it. Thus, this chapter may be used as an executive summary.

Overall, the shortage of evidence in this much debated field is surprising, given the high level of public awareness and the wide mass-media coverage of the issue. The shortage of evidence may be compounded by methodological obstacles in analysing the complicated structures and varied systems for regulating forensic cases in the diverse legal and health care systems of the European Union Member States. The judicial, health and crime reporting systems of the Member States have currently not sufficiently incorporated forensic indicators into their routine practice. Standardised European indicators are completely absent. Nevertheless, cross-national research in this field would seem to merit encouragement and stimulation.

The issue seems to suffer from its position at the interface of criminology, jurisprudence and psychiatry, all of which are closely interconnected fields. However, these disciplines have not yet developed common methods of assessing and analysing the various aspects of, and problems in the field, in a multidimensional approach.

So this study breaks new ground by including fifteen countries in structured overviews of legal and care procedures for mentally disordered offenders. This has not been attempted before in a comprehensive manner. Despite the considerable methodological and definitional problems, this study has succeeded in providing many standardised comparisons and follow-up data that have never before been published.

Legal Frameworks & Key Concepts

Forensic legislation in the Member States is not incorporated into a single, specific code, but is contained in a variety of codes, laws or acts regulating the multifold aspects of forensic cases. Forensic legal provisions may be spread among penal codes or in health or mental health laws. The distribution follows no clear pattern, thus not allowing conclusions to be drawn as to whether Member States place more stress on medical or punitive considerations in the judicial handling of forensic cases.
In most Member States, these laws are relatively new or were revised during the last decade. Forensic regulations are subject to constant change, a process which is additionally influenced by continuing developments and advances in forensic psychiatric treatment. On the one hand, such change contributes to the complexity of the problem, but on the other it offers opportunities for the revision, improvement or harmonisation of legal frameworks.

Mental disorders

The basic terminologies for addressing the mental state of mentally disordered offenders vary widely in the laws of the Member States. Most terms as used in codes or acts are non-specific, descriptive in nature and to a large extend outdated. The legal terms have little relation to medical concepts or to modern international classification systems for mental disorders (e.g., DSM-IV or ICD-10).

This vague terminology makes it hard to draw conclusions as to which mental states are specifically covered by or excluded from forensic legislation. It embraces all kinds of mental disorder and is open to broad interpretation. It does not further the equal treatment of those concerned within or across the Member States.

However, routine practices in the majority of the Member States show a common pattern, at least in including within the scope of the relevant legislation the major mental disorders such as schizophrenia (most often termed "psychotic state"), affective disorders and organic mental disorders, although arrangements for trial procedures and post-trial placements may differ.

However, there is extreme variation as regards the inclusion or exclusion of addiction disorders, personality disorders or paraphilias. For instance, forensic legislation in the Netherlands makes it possible to impose TBS-detention orders on offenders who are partly criminally responsible. This results in a particular focus on offenders with personality disorders, whereas England & Wales considers them as eligible for forensic treatment only in cases where the condition is judged to be treatable. The laws in most of the remaining Member States do not clarify to what extent personality disorders are included or not.

Even more variable is the handling of alcohol-related disorders. The wide range of mental states connected to these syndromes – from simple intoxicated states to severe addiction or even psychotic states – prevents the elucidation of common approaches or typical judicial procedures for offences committed under the influence of alcohol. With the absence of legally-defined guidelines, the consideration of individual circumstances may influence legal outcome in alcohol-related cases,. This may result in rather varied court rulings, even where the mental states or offences committed may be similar.

Only a small minority of Member States (e.g., Germany, Austria) provide specific codes for alcohol-related cases. The shortage of specific services for addicted offenders in most Member States may be a consequence of this. Differing cultural attitudes towards alcohol consumption may complicate the case further.

In short, vague definitions or terminologies mean that the basic forensic laws of the Member States do not qualify as guidelines for decision making in routine practice (e.g., assessment procedures during pre-trial or trial stages).

The variable or non-specific inclusion of alcohol-related, addiction or personality disorders marks a clear shortcoming in the forensic legislation of the Member States and prevents the harmonisation of legal frameworks or routine practices within or across the Member States.

Criminal responsibility

The forensic legislation of a Member State may be categorised according to the legal tradition which that Member State has adopted. The majority of the Member States whose systems have developed out of a Roman law tradition apply the concept of criminal responsibility as a basic judicial and philosophical framework for assessing and deciding on the cases of mentally disordered offenders (see table 59).

Assessing criminal responsibility in a suspect or defendant requires an extensive evaluation of the motives for committing the offence and the offender's state of volition or ability to act of his own free will. Where a suspect's responsibility is considered to be diminished or absent due to a mental disorder and where he additionally presents a public threat, Member States applying this approach would usually order defendants into forensic care. Additional prison terms may applied, depending on a variety of specific conditions.

Member States whose legal frameworks are rooted in the Common Law tradition (England & Wales, Ireland and to a certain extent some Scandinavian countries which have included features

from both legal traditions) do not apply the concept of criminal responsibility and follow a more pragmatic approach instead.
For instance the criteria for the hospital disposal of a mentally disordered offender in England & Wales can be seen as almost wholly medical in nature. For most people put on such an order, their position becomes almost exactly the same as if they were a civilly-detained patient. The patient in effect passes out of the penal system and into the hospital system. The courts retain no powers of any kind. Discharge is determined principally by medical outcome. However, patients may be detained in low, medium und high security hospitals, according to the danger they may represent.
A potential disadvantage of this approach (which is reported for instance from Sweden) is the lack of relation of treatment to severity of offence. As a consequence, patients could be kept in hospital for longer periods than they would have served in prison; or on the other hand, patients might be discharged from hospital after a short stay, although they may have committed serious offences.

Although the concept of criminal responsibility may determine different pathways to forensic detention, all Member States generally separate mentally ill offenders from mentally non-disturbed offenders and from non-offending psychiatric patients, according to the individual needs for treatment and the level of dangerousness, no matter whether the concept of criminal responsibility is applied or not.
So it may be that the application of the concept of criminal responsibility serves as a distinguishing criterion in theory only, and that it has less relevance to characterising the Member States' policies at the level of routine practice.

Pre-Trial & Trial Procedures

Placement options during the pre-trial phase are somewhat similar in the Member States. When a suspect is thought mentally ill before trial, placement in a general psychiatric facility is possible in twelve Member States, the exceptions being Belgium, Luxembourg and Portugal.
All Member States other than Belgium provide for placements in a specialised forensic facility before a trial has started. In eleven Member States, a mentally ill suspect may also be placed in a remand prison, the exceptions being England & Wales, Ireland, Portugal and Sweden. In the case of minor offences, suspects can also be bailed to their home address for outpatient treatment in nearly all Member States. The maximum length of pre-trial placement is specified by law in only five Member States, this ranging from a legally-defined maximum of 28 days in Ireland up to twelve months in Germany or Portugal.

Considering the mental health care provision in prisons, which in most Member States fails to reach the standards of general psychiatry, many mentally disordered suspects may be worse off when placed in prison during pre-trial stages, compared to non-disturbed defendants. This problem might be compounded by the absence of a limit on the duration for pre-trial placements in a striking number of Member States.

A similarly controversial question in forensic psychiatry concerns the sequence of forensic placement or treatment orders and prison sentence in cases where both are imposed. In Member States which do not categorically exempt mentally disordered persons from prison placement, the sequence is legally regulated only in seven (Austria, Belgium, Germany, Italy, the Netherlands, Portugal and Spain). In all others states where joint disposals can be imposed, the sequence is determined in each individual case at sentence.
This might be considered problematic from a security point of view. On the other hand, there are strong medical arguments for flexible individual regulations which allow the length of forensic placement to be adapted to the actual needs of the person concerned. A satisfactory solution to this tension is currently not in sight.

If both psychiatric treatment and a prison sentence are imposed on the mentally ill offender, several Member States provide for the option of counting the duration of psychiatric treatment towards the period of the sentence. It is variable, however, how much of the time spent in treatment can be counted towards the time to be served in prison. There is no consistency across the 15 Member States in this regard.

It remains debatable to what extent individual regulations get the right balance in terms of the basic right for equal treatment. However, flexible procedures may again be useful in cases where the prognosis is poor or a reoffending likely, enabling longer periods of detention both from a medical and from a public safety point of view.

In all Member States, court trials of mentally disordered offenders do not differ appreciably from those against mentally non-disturbed suspects, as far as basic rights or major constitutional features are concerned. There are no special courts or distinct procedures likely to weaken the legal status of persons concerned, to threaten human rights or to evade major constitutional principles.

Assessment

The forensic psychiatric assessment is considered a crucial element in the judicial process, pointing the way for all subsequent decisions on the sentence, detention, placement or treatment of the person concerned.

Role and tasks of the assessing expert

It is the basic task of an expert in charge of a forensic assessment to examine and describe the overall medical condition and the mental state of a suspect or defendant.

More than two-thirds of the Member States legally require a psychiatrist assess the mental state of a suspect assumed to be mentally ill. In Member States lacking a legal regulation in this regard, psychiatrists are also usually responsible for conducting forensic assessments in routine practice.

An inclusion of more than one expert may increase the quality of an assessment. This is most flexibly regulated in Sweden by distinguishing a so-called "minor forensic assessment", which does not even require the participation of a psychiatrist, from a "major forensic assessment" conducted by a team of psychiatrists, psychologists, social workers and nurses. This obligatory contribution of four experts from different professional background is unique in the Member States, of which only one-third legally define the number of specialists participating in a forensic assessment.

Commonly, a forensic assessment may be extended by the inclusion of a consideration of additional medico-legal issues, principally the ability to control one's actions, the capacity for insight, level of dangerousness and the likelihood of re-offending. The examination of these aspects, which is common practice in all Member States except Denmark and England & Wales, tends to extend the role of the psychiatrist beyond his or her medical expertise in diagnosis and treatment. Nevertheless, legal regulations in most Member States expect psychiatrists or medical experts to report on medico-legal issues.

Thus, assessments of the medico-legal state of a defendant may be subject to much greater variation than is the case when simply reaching a diagnosis for the underlying mental disorder, a process aided by well-established and internationally acknowledged structured procedures and scales.

In at least two-thirds of Member States, the assessing expert is expected in addition to reach a conclusion as to how far an offence might have been influenced by or committed as a direct consequence of a mental illness, although there is scant overall evidence as to the nature of such a relationship and there are no defined criteria for assessing to what extent a mental disorder might be connected to offending behaviour.

Although a variation of strategies has emerged in routine practice to deal with this dilemma, it is unknown, whether the much clearer medical approach by Denmark and England & Wales (whose regulations do not require evidence for a connection between offending and mental disorder but specify a hospital order in lieu of any other punishment if a defendant is mentally ill and found guilty of a criminal offence), simplifies the judicial procedures or yields better outcomes.

It would be worthwhile to examine whether the court's surrender of all power over a case as in England & Wales has any influence on security issues or standards. However, the variability of what might be considered as outcome data across the Member States prevents any comparative analyses at present.

Selection and training of experts for assessment
Different qualifications, professional training, experience and specific skills may all influence the assessment procedure and its outcome. Thus, the authority to appoint the expert and the associated selection criteria play an important role. It is the court which is authorised to select and appoint the assessing expert in more than two-thirds of Member States. Only in Finland, Portugal and Sweden is this the responsibility of other national agencies or authorities. Only in Denmark and England & Wales is the choice of expert determined by the defendant's home address, similar to the common position in general psychiatry, and this may indicate a more community-oriented approach..

There is no question that the quality of an assessment – and the far reaching consequences - vary with the experience of the assessing person and the quality of his training. Professional training in forensic psychiatry is incorporated into the university curricula or medical schools of several Member States, but intensity and standards are highly variable. The most elaborated forensic training is offered in Finland (six years subsequent to general psychiatric training) and England & Wales (three years after a three year education in general psychiatry). Germany is about to introduce an additional three-year forensic training course into the psychiatric curriculum.
Overall, experts from most Member States participating in this study complained of insufficient or absent quality standards in forensic psychiatry and were of the view that quality standards needed to be defined, standardised and formally implemented.

Reassessment and Discharge Procedures

Most mental disorders are characterised by rather variable courses, requiring regular re-assessment of the mental state in general mental health care, but even more so in forensic cases, where fundamental restrictions on personal liberty may be connected to a worsened or improved state of health.
Consequently, it is of major importance to understand how detailed national forensic laws regulate psychiatric re-assessment during forensic detentions, as well as their time-frames, comprehensiveness and scope or other crucial conditions.

Time frames for reassessment of the mental state
Regulations regarding time frames for reassessment are strikingly variable across the European Union, ranging from every six months to annually or bi-annually and up to every five or six years. In most Member States, the reassessment of the mental state of a detained person is the responsibility of the treating psychiatrist, thus allowing the closest knowledge of treatment progress and the broadest background of information to be incorporated into the evaluation of the mental state or the prediction of future progress.
However, one disadvantage might be that security considerations could be given less consideration in a close doctor-patient relationship. To entrust third parties (independent psychiatrists or other experts) with the responsibility for re-assessing the mental state of forensic patients might diminish such a risk, as is practiced to varying degrees in Austria, Belgium, Germany, Greece, Ireland, Luxembourg, the Netherlands and Sweden.

Discharge from/termination of a forensic placement
Overall, conditions or criteria for the termination of forensic placements seem to be much less formalised in some Member States than are the criteria for initiating placement or treatment. This is surprising when considering the difficulties in predicting the risk of recidivism of persons discharged from forensic care and the increased public awareness of this crucial stage of the whole process.
Moreover, in only two Member states (Austria and Germany) are discharges of forensic patients always conditional, although this could be considered as an appropriate and flexible means to balance patient rights and interests (e.g., to the shortest possible restriction on liberty) with public safety.

However, the majority of the Member States seem to favour a medical perspective, emphasising the treatment needs of the patient and safety issues as criteria in discharge decisions. One major disadvantage of this approach is its tendency to neglect equivalence. It could, for instance, con-

demn a schizophrenic patient ordered in forensic care because of a minor assault to detention for as long as his illness prevails.

Time-frames for discharges on licence/conditional discharges differ within the Member States. Although there are studies suggesting diminishing recidivism-rates as a consequence of forensic treatment, the evidence on the risk of re-offending after removal of restriction orders should be increased. Future research on recalls to hospital of restricted patients may help to decide whether to put more emphasis on this legal instrument.

Patients and Human Rights

The issue of patients' rights and human rights in the context of mentally ill offenders is a delicate subject. It is a contentious issue in most Member States and it receives considerable public attention, reinforced by spectacular cases with intense media coverage. These tend to intensify discussion as to whether the needs of the patient for treatment and reintegration into society are sufficiently balanced with the need of the public for safety. It is particularly in this context that the double role of a mentally ill or disordered offender becomes evident, his being on the one hand a patient in the mental health care system and on the other subject to the criminal system.
Thus, forensic legislation as a whole can be considered as an attempt to balance the human rights of offenders with their right to adequate treatment and with the interests of public safety.

Right of appeal/right to a second opinion
The most crucial right of a suspect or defendant concerns mechanisms of appeal. The overall right to appeal is granted in all Member States for mentally disordered offenders, thus satisfying basic human rights principles. The question here is at what stages of the process appeal mechanisms are open to a mentally ill offender. The variable and complex procedures in the Member States result in multiple starting points for appeals during the various stages of the process.
Whereas the right to appeal against sentence is unquestioned throughout the European Union, not all Member States consider pre-trial assessment or placement procedures as being eligible for appeal.

Another crucial right during trial procedures concerns the defendants right to a second expert opinion in order to participate in, and have a certain level of control over, the assessment process and thus the long-lasting consequences that may arise. This right is explicitly stated in several Member States (e.g., England & Wales, the Netherlands or Sweden in case of a so-called "major forensic assessment") and at least addressed in the respective codes or laws in others. It is likely that Member States that do not explicitly stipulate this option by law, do in fact provide such an option in practice. However, an obstacle here might be that in these countries the government will not cover the cost of a second opinion.

Defence counsel
In only four Member States is the option to proceed with a trial without a defence counsel open to a defendant, namely in England & Wales, Germany, the Netherlands and Portugal. However, it should be kept in mind that in most Member States there are no special regulations regarding mentally ill defendants.
Therefore, the case of a mentally ill defendant standing trial without a defence counsel is rare and more of a theoretical option. And, as it is the case in England & Wales, courts are cautious about letting mentally ill defendants defend themselves and grant this option only after psychiatric expert evidence proves the defendant's fitness to plead and capability of representing himself.

Basic human rights
In some of the Member States, there is special reference in national legislation to restrictions on the basic human rights of mentally ill offenders, mostly for reasons of safety. In the Netherlands, specific civil rights may be more restricted in forensic facilities than is the case for mentally ill non-offenders, e.g. regarding communication with the outside world or the care of children.
A different picture can be seen in Austria. Here, prisoners with sentences of more than one year lose their right to vote. By contrast, mentally ill offenders found "not guilty by reason of insanity" are

permitted to vote. However, mentally ill offenders who are criminally responsible and who receive a prison sentence plus a commitment for an indefinite period of time do not have the right to vote, even after finishing their prison sentence.
Apart from the above-mentioned exception of Austria, there are no long-term restrictions on mentally ill offenders following release from prison and/or the completion of forensic treatment in any of the Member States.

Leave conditions
One question which receives a lot of public and media attention and is frequently a topic of controversial discussion concerns the issue of leave conditions for mentally ill offenders. This issue highlights the special and sometimes contradictory nature of the forensic-psychiatric care of mentally disordered offenders. On the one hand, it has to aim at re-integrating the patient into society, which requires treatment conditions “as normal as possible” including leaves, on the other hand it must protect the public and help prevent reoffending in those concerned.

Although it is such a controversial issue, leave regulations are only addressed in national legislation in about one-third of all Member States, namely in Austria, Denmark (for patients with a placement order), England & Wales, Germany, Luxembourg, the Netherlands and Sweden.
In England & Wales, for example, "leave of absence from hospital" is explicitly dealt with in the Mental Health Act which, in addition, contains an advisory code, which gives more specific details as to good practice in certain leave types. However, the Code does not have the force of law. The Dutch law specifically refers to unaccompanied and accompanied leave as well as overnight stays and group leave. In Germany, federal enforcement laws provide for regulations which differ from Federal State to Federal State.
A highly controversial issue concerns decision-making about leave requests, since this is perceived by the general public and the media as an indicator as to what extent the need for public security is considered. In most Member States, it is the medical institution which decides on leave requests from mentally ill offenders, including various forms of unaccompanied leave. Naturally, the court plays a more prominent role when it comes to more extended forms of leave, such as over-night stay outside the premises.

Treatment against a person’s will
A highly disputed issue concerning the rights of mentally ill patients is that of treatment against a person’s will. Treatment against a person’s will is possible in twelve Member States. It has to be kept in mind that, in most Member States, the relevant regulations are laid down in the national health acts and concern both forensic and civilly committed patients, such as for example in Denmark and in Finland.

In most Member States, treatment of mentally ill offenders differs from treatment of mentally ill non-offenders suffering from the same mental disorder only in terms of security measures. Additional differences can be found in Austria and Finland where there are specific legal conditions for instituting or terminating treatment. In Germany and the Netherlands, the treatment aims may vary. Treatment for mentally ill offenders may have as a target reduction in dangerousness or in the risk of recidivism, which may affect treatment strategies. As reported by the experts from Belgium and France participating in this study, treatment standards in these countries are generally lower for mentally ill offenders than for civilly committed patients.

So, with the exception of Germany and the Netherlands, there are no specific indicators to be found which reflect the dual function of forensic care for mentally ill or disordered offenders, which encompasses crime-prevention.
On a judicial basis, the majority of Member States seem to take it on trust that psychiatric treatments will automatically diminish the risk of future offending. This is a particular medical concept which appears to be supported in some countries by good evidence, although the application of well-established criminal-therapeutic approaches seems to be rather scarce.
Several experts contributing to this study declared standards of forensic care in many Member States to be lower than in general mental health care, although they ought to be considerably

higher in this sensitive and controversial field. However, in some members states, such as England & Wales, patients do not receive the best available care until they enter the forensic system.

Tab. 59: Major Features of Forensic Legislation or Care in EU Member States

	Concept of criminal responsibility	Assessment of connection of mental disorder & offence	Placement of mentally ill non-offenders in forensic facilities	Specific forensic outpatient treatment available	Conditional discharge	Special forensic psychiatric training	Structure of forensic care
Austria	A	yes	yes	yes	oblig.	no	centralised
Belgium	A	no	no	yes	optional	no	federalised
Denmark	A	no	no***	yes	optional	no	community-based
England & Wales	C*	no	yes	no	optional	yes	community-based
Finland	B	yes	yes	no	optional	yes	regionalised
France	B	yes	yes	no	optional	no	sectorised
Germany	B	yes	no	yes	oblig.	yes	federalised
Greece	B	yes	yes	no	optional	no	centralised
Ireland	C*	no	yes	no	not prov	no	centralised
Italy	B	yes	no	no	not prov	no	regionalised
Luxembourg	B	no	no	no	optional	no	centralised
Netherlands	B	yes	yes**	yes	optional	no	federalised
Portugal	B	yes	no	no	optional	yes	regionalised
Spain	B	yes	no	no	optional	no	centralised
Sweden	C	yes	no	no	not prov	no	regionalised

Responsibility concept: A=dualistic (lacking or full criminal responsibility), B=graded (lacking, diminished or full criminal responsibility); C=concept not applied (*diminished criminal responsibility considered only in cases of homicide)
Placement of mentally ill non-offenders in forensic facilities: ** the Netherlands: not in judicial TSB-hospitals but in the forensic psychiatric hospitals and units within the mental health sector
Conditional discharge: oblig=obligatory, optional=individual option, not prov.=not provided, ***Denmark:
Placement of mentally ill non-offenders in forensic facilities: *** Denmark: generally not, only possible in the maximum security hospital (30 beds)
Structure of forensic care: Denmark: care is community-based, assessments are regionalised.

Service Provision

All Member States use specialist forensic facilities, general mental health care services and the prison system to place and treat mentally ill or disordered persons who have committed minor or serious offences. The degree of involvement of each of these sectors and their individual patterns of usage differ widely throughout the EU. In addition, within each of these sectors, different Member States provide a variety of service-types which differ considerably with regard to organisation as well as to quantity or intensity of care.
In England and Wales, for example, there is no absolute division of hospitals or wards into forensic and non-forensic, and there are no forensic hospitals within the prison service. Local psychiatric hospitals and secure “forensic” hospitals treat both general and forensic patients and do so on the same wards. On the other hand, in Germany, all forensic hospitals are clearly separated from general psychiatric inpatient services.

The responsibility for forensic care and even the designation of forensic facilities differs across the Member States, complicating any attempt to define categories for cross-national overviews or comparisons. A consistent, Europe-wide system of classification for forensic facilities based on

functional criteria would be preferable for a number of purposes, including research or health-reporting. Unfortunately, no such system currently exists.

Facilities

Specialist forensic facilities are the most common type of service in which criminally non-responsible mentally ill offenders are placed and treated. As an overall category, this includes specialist forensic hospitals, specialist forensic wards in psychiatric hospitals or even - as a rare option - specialist forensic departments or wards within general hospitals. Although such placements are used most frequently post-trial, they may also be used for mentally ill or disordered persons who have yet to come to trial.

All fifteen Member States included in this study provided data about their forensic facilities, with respect to admission criteria, organisational features, quality of care, bed numbers and patient characteristics. There were wide variations. Some of the less populous Member States (e.g., Luxembourg, Ireland and Austria) have one central forensic hospital that serves the whole country and which might be supplemented by minor forensic care capacities in general psychiatric hospitals, whereas more populous Member States (e.g., Germany) are characterised by a diversity of forensic provision

Clientele and patient selection

Mentally ill offenders who have committed serious offences and who are being held as criminally non-responsible (in so far as this concept is applicable in individual Member States) constitute the core clientele of forensic facilities, although there are some exceptions to this rule, most often for reasons of bed availability or security.

A substantial proportion of Member States (Denmark in parts, Finland, France, Ireland, England & Wales, Sweden) admit aggressive, violent or “high risk” non-offending mentally ill individuals to forensic facilities, also. This is done most often under civil detention orders, but this is not necessarily so in all cases. Amongst these countries, Finland, in not requiring an offending history as a major criterion for admission, has adopted one of the most straight-forward approaches, taking illness-related dangerous or destructive behaviour as the major criterion for admission to forensic care.

This variety of approaches for detaining and caring for violent mentally ill patients has not been examined further by international research. Thus, it is unknown whether one approach is more effective than, or superior to, others. From a theoretical point of view, it could support crime prevention to place and treat for aggressive or violent mentally ill patients in forensic facilities, even when their crime record is blank. In Member States doing so, there is currently no evidence for significantly increasing forensic placements.

On the other hand, a considerable rise of forensic patients over time could also indicate insufficient treatment arrangements in general mental health care for violent mentally ill, who are adequately cared for only after having committed a crime and being placed under forensic regimes.

This mechanism – for which there is some indication at least in some Member States (e.g., Austria or Germany) - would mark an inappropriate shift of care burden from general mental health care to forensic care.

Overall forensic capacities

Any valid indicator for comparing forensic care capacities across the Member States would provide a very useful tool for research or service-planning purposes. However, variations in definition of forensic beds and considerable, yet unknown numbers of undeclared beds for mentally ill offenders in general psychiatry or the prison system are serious methodological obstacles to calculating forensic bed rates or any such indicators. Consequently, recent efforts for compiling sets of European mental health indicators do not include any estimates of forensic care capacity, although such indicators would be highly preferable and are greatly needed.

So this study is the first attempt to quantify and compare specific capacities for the care of mentally ill offenders across the fifteen European Union Member States included in the survey. Despite all

problems of definition and calculation (as pointed out in the chapter “Service Provision”), the identified estimates suggest a north-south divide within the European Union, with marked differences between similarly populous countries in Scandinavian, Central and Southern Europe.

With overall forensic bed figures varying considerably with population size, lowest forensic bed rates (forensic beds per 100, 000 population) were found in Spain (1.4), Portugal (1.8) Italy and Ireland (2.2 each). The highest rates were detected in Belgium (10.3), the Netherlands (9.8) and Germany (8.6). The case of France, which is providing 0.8 specified forensic beds per 100, 000 population, may exemplify the problems in cross-boundary comparisons of non-standardized indicators, as French mentally ill offenders are most often detained under civil detention regimes. Thus, France tends not to label capacities for these persons as forensic beds.

Whether low forensic capacities in South European Member States do reflect the overall mental health care standards in those countries (low numbers of hospital beds in general psychiatry, home-based care and a considerable burden on the families) remains to be analysed.

Outpatient forensic facilities
Although outpatient care is today an integral part of general mental health care, specialist outpatient care for forensic patients is underdeveloped. Follow-up may be usual in many Member States or indeed mandatory in the case of probation orders, conditional discharge or as a general aftercare measure, but specialist services are usually lacking. Only Austria, Belgium, Germany and the Netherlands currently provide forensic outpatient services as a specific post-trial measure. In Austria these services are only for treatment during leaves, after discharge or in case of conditional criminal commitment. The Netherlands are the most well-provisioned Member State in this regard, equipping each forensic hospital (“TBS facility”) with an outpatient unit to provide forensic outpatient and aftercare, in addition to such highly specialised services as forensic home-treatment or forensic sheltered accommodation.
In some countries, informal types of forensic outpatient care are implemented, when criminally non-responsible mentally ill offenders representing no public threat are cared for on a voluntary basis by community mental health services.

Currently there is a debate among experts in England and Wales, with some considering forensic outpatient treatment as preferable, whilst others see a strengthening of general psychiatry services as a more effective alternative. Similar debates may occur among experts from other Member States. In terms of reintegration and rehabilitation, this is considered to be a major area for future reform of forensic care systems.

Outcome (Epidemiology)

Across the European Union, information on outcomes of legal interventions or judicial procedures against mentally ill offenders, such as prevalence or incidence, rates is scarce. Additionally, available data bears numerous methodological pitfalls.
Even such simple indicators as the number of court trials or court orders on mentally ill offenders are rarely provided regularly by the reporting systems of the Member States. Usually there is no national register linking the forensic psychiatric sector with judicial authorities or national health services. Even Member States renowned for their case-registers in general psychiatry (e.g., Denmark) seem to be inconsistent in their entries on the legal status of registered patients. Only Sweden and the Netherlands run officially nation-wide data bases which could be classified as forensic case registers.

Although technical prerequisites for the linkage of data-bases holding information on mentally ill offenders might already exist, there are legal obstacles to establishing such linkages in most Member States. This may prevent easy access to simple epidemiological indicators, such as prevalence or incidence, but there is also a variety of practical applications of more far-reaching relevance, which raise strong ethical and human-rights arguments against the unrestricted combining of police, court or psychiatric records. Considering such technical developments as genetic fingerprints,

there is an urgent need for defining adequate and common regulations for information linkage and access to this most sensitive data.

Total number of forensic cases in the Member States

On the current legal basis, data on prevalence and incidence of forensic cases in the Member States – as a most basic indicator for the outcome of legal procedures - was taken from a variety of sources. When available, official statistics were used, which were cross-checked by results from national studies in some cases.
Due to numerous methodological or definition problems (as described above), the reliability of figures from these sources may be reduced. From a number of Member States, figures cannot be taken as exact information, but must be considered as an approximation instead.

Time series for the annual number of cases in forensic care from 1990 onwards were available for more than two-thirds of the Member States. Originating from variably populous countries, total numbers not surprisingly differ widely across the Member States. So comparing these estimates across national boundaries does not make much sense, but time series of total numbers of forensic cases at least allows conclusions to be drawn regarding trends or tendencies within each country.
Throughout the 1990s, the annual number of cases (point-prevalence) in Germany, the most populated country in the European Union, rose high above the levels in other Member States.

Total frequencies from Germany and other countries (e.g., Denmark, the Netherlands) show either a fast growth or a less steep but consistent increase (Austria, Belgium). Time series from other Member States show a U-shaped prevalence (e.g., Italy) or even decreasing numbers (Portugal, Greece). So the annual point-prevalence does not suggest a common trend for the Member States during the 1990s. National estimates seem to be influenced by a diversity of external factors, which must be analysed separately for each country.

Prevalence rates

Prevalence rates (forensic cases per 100,000 population), which allow for cross-national comparison, also vary widely (from 21.7 cases in Denmark in 1999 down to two cases per 100,000 population in Greece in 1996). This variety supports the hypothesis of specific national characteristics as a dominating influence on legal outcomes.

By way of example, the striking Danish prevalence rate, which is the highest of all Member States (annual growth approx. 6-7%), was concluded by Danish experts not to be an effect of changes in legislation or diagnostic routines, but of national de-institutionalisation policies, supporting a rising criminal behaviour in schizophrenic patients. However, there are countries with a similar steep increase, although on a lower overall level. The doubling of prevalence rates (Germany, Austria) or even an three-fold increase (the Netherlands) during the 1990s may have been influenced by different factors.
Lowest prevalence rates are found in Southern European Member States (Greece, Italy, or Portugal; time series for Spain not available), suggesting a need for further investigation as to whether this is related to the reduced capacities in forensic service provision found in these Member States.

So, all in all, a common European trend is hard to discern, although a tendency towards slowly rising forensic prevalence rates (court decided cases) during the 1990s may be observed in most Member States.

Incidence (newly admitted cases per year)

Time series on incidence (newly admitted forensic cases per year) or on incidence rates from the Member States show a more variable pattern than prevalence rates. In most less populated Member States, the incidence hardly exceeds 100 cases per year. Again Denmark marks an exemption here, with incidence figures mirroring the steep increase of prevalence rates. Rising incidence rates over time (indicating more admissions to forensic care than discharges) may suggest security aspects are being accorded more attention in forensic care and/or trials against mentally ill offenders. To what extent this is justified by a real increase in the dangerousness of forensic detainees or in the number of severe crimes committed by mentally ill requires further examination, as does the

issue of whether the increases hint rather at a growing public fear of mentally ill offenders independent from the actual offence rate .

Length of stay

Data on the duration of episodes in forensic institutions are scarce throughout the Member States, although this is a most crucial indicator in evaluating forensic placements against the background of a decreasing mean length of stay in general psychiatry all over Europe.

However, a high proportion of new admissions into forensic care in a given year may allow conclusions to be drawn as to discharge frequency and thus as to whether there is an increasing or decreasing mean length of stay under forensic care regimes. According to this rather rough indicator, Belgium seem to experience the fastest turn-around of mentally disordered offenders in forensic facilities. England & Wales and Sweden also show a high proportion of annual admissions, suggesting a shorter mean length of stay for mentally disordered offenders than most other Central European and Scandinavian Member States (Austria, Germany, Denmark, Finland, the Netherlands) which have similar proportions of new cases per annum (between 15 to 30 % annually).

However, in Belgium, the Netherlands, Sweden and England & Wales, the proportion of new admissions seem to decrease during the 1990s, indicating a trend towards longer forensic placements.

Re-offending

No routine data seem to be available for re-offending in mentally disordered offenders discharged from forensic facilities, although this would provide essential information for the effectiveness of legal procedures or forensic care in terms of prevention. Conclusions as to the need for forensic aftercare could be drawn from such estimates. It is strongly recommended that indicators for repeated offending or recidivism be incorporated into national health or judicial reporting systems.

Characteristics of mentally ill offenders

Details on the psychiatric diagnoses of forensic patients are also not a primary concern for the reporting systems of the Member States. Collecting and recording diagnostic data would not encounter cross-boundary definition or standardisation problems in contrast to most other indicators discussed here, given the widespread use of ICD-10 or DSM-IV diagnostic schemes.

Available diagnostic data suggests considerable differences in key patient groups in forensic care in the Member States. Schizophrenic or other psychotic states seem to be the most frequent disorder that patients in forensic care suffer from. The proportion of patients with addiction disorders and personality disorders varies the most between Member States, personality disorders being the core group in forensic care in the Netherlands, whereas being only a minority in most other Member States.

The share of females among mentally ill offenders in forensic care is low and does not exceed 15-17% in those Member States which were able to provide information. This is not surprising, since violent or criminal behaviour is known to be much more prevalent in male mentally ill. There is no information available as to whether forensic service provision in the Member States is adapted to the specific needs of female patients.

Only a minority of criminal statistics from the Member States provide information as to what proportion the mentally ill comprise of all offenders who commit serious or minor crimes, although this is of major interest to the public and to the mass media which give extensive coverage to spectacular crimes by mentally ill. When data is available, definitions are usually not harmonised, so that a European overview as to how far mentally disordered persons contribute to national criminality must inevitably lack reliability.

Nevertheless, according to figures contributed by experts collaborating in this study, proportions seem to be low, and there are Member States like Ireland where none of the persons indicted for murder (n=26), robbery (n=678), assault (n=2058) or sex offences (n=715) in a given year (2001) were found to be mentally disordered or unfit to plead.

However, when focussing on on murder alone, the proportion of mentally ill among the perpetrators seems to be considerably higher than for serious offences in general. According to data provided for this study, in 2001, six out of 38 murders in Austria (15.8%) were committed by non-responsible

mentally ill offenders. In Sweden, it was as high as 35 out of 135 (25.9%) in 2002, and in Belgium 34 out of 176 (19.3%) in 1999. According to studies from Germany, the proportion of the mentally disordered among murderers may have doubled since the 1960s. Definitions may vary here also, especially concerning the inclusion of manslaughter into this category.
These findings are out of line with some studies from the UK, the US or New Zealand which report much lower, constant or decreasing proportions of mentally ill among murderers. However, it is likely that changing legal criteria or assessment routines may considerably bias such long-term comparisons.

Major Findings

- The legal frameworks for the processing and placement of mentally disordered offenders vary markedly across the fifteen European Union Member States included in this study in line with variations in their legal systems .
- The complexity of judicial or procedural regulations reflects the complexity of the problems that have to be addressed when assessing, trying, detaining or sentencing offenders with mental disorders.
- Codes or acts in the Member States concerning mentally disordered offenders are spread amongst health laws, mental health laws and penal codes in a non-systematic way. Many of the currently applicable rules descend from ancient laws for mentally disturbed criminals, frequently revised and adapted over decades or centuries to reflect the constantly evolving national legal or penal systems. Due to this, significant cross-boundary patterns did not evolve in the European Union.
- Court procedures are particularly variable and provide numerous differing pathways pre- or post-trial into the mental health care systems, specialised forensic systems or the prison- and other penal systems. There are different discharge procedures for forensic patients, and in some Member States discharge procedures incorporate obligatory conditions or release on licence.
- It is difficult to identify obvious categories into which the various legal concepts of the Member States for placing and treating mentally ill offenders can be characterised. A differentiation is visible according to which legal tradition each Member State has adopted (e.g., common-law countries vs. roman-law countries) in that a greater medical role is seen in the post-trial phase in Member States influenced by common law traditions. However, this is of minor importance in the overall challenge to achieve appropriate treatment and safety standards for detained mentally disordered offenders. There is no evidence for the superiority of one of these two basic legal traditions over the other.
- There are no uniform concepts as to which mental disorders are covered by forensic legislation across the Member States. Legal definitions of mental disorders are vague and do not relate to modern psychiatric classification systems, thus providing no practical guidelines for assessment or decision procedures. Particularly variable is the inclusion of addiction and personality disorders into the legal frameworks.
- There are no clearly defined national or European indicators as to the effectiveness of legal concepts or of current practices for detaining or treating mentally disordered offenders. Reoffending rates in people discharged from forensic detention would probably provide the most useful information, along with psychiatric estimates for treatment success. Information on this is currently available only from a minority of Member States, however, and is in need of international standardisation and implementation, which is to be strongly recommended.
- Generally, a set of European indicators should be developed, covering and standardising the most basic data in the field (service provision, outcomes, prevalence, incidence, length of stay, disorders, types of crimes, reoffending rates). Plans should be made for their implementation in all Member States.
- Additionally, international research on the issue should be encouraged. This would be likely to focus the development of adequate interdisciplinary working and could contribute basic evidence to the field of a type which is currently lacking.

- Forensic service provision varies markedly across the Member States. Number of facilities, beds or places, diversity of forensic services and quality of care are extremely variable, sometimes even within Member States. Regarding forensic bed provision, there is a distinct north-south divide in the fifteen included countries, with particular low capacities in South-European Member States.
- There are different ideas around the inclusion of forensic care and the detention of mentally ill offenders in the general mental health care system, ranging from strict separation to full inclusion.
- The overall quality of forensic care seems to be poor compared to current standards in general mental health care, although clear quality indicators are lacking. Outpatient forensic care and forensic aftercare seem to be particularly underdeveloped.
- Only a minority of Member States consider forensic psychiatry as a medical speciality. Standards in forensic training are extremely varied.
- Underprovision for mentally disordered offenders appears the case in many Member States. Due to capacity problems, the post-trial placement of (criminally not responsible) mentally disordered offenders in prison occurred in some Member States, although not legally encouraged. This is likely to add to the already increased stigmatisation of mentally ill offenders.
- The role and responsibility of psychiatrists in the process is complex and variably defined across the Member States. It often exceeds basic medical expertise (in assessing the mental state and applying psychiatric treatments) and may extend to predicting the criminal prognosis and guaranteeing the safety of detainees and that of the public.
- There is no indication that the Member States' legal frameworks for placing and treating mentally disordered offenders violate basic human rights principles as laid down in the various human right conventions.
- There are variable definitions of the role of mentally disordered suspects or defendants during court procedures, for instance regarding attendance, legal representation. The provision of an independent expert or representation by an additional counsel is in some Member States dependant on the defendant's ability to pay for it.
- Although epidemiological figures are hard to compare across boundaries, there seems to be a tendency towards slowly rising forensic prevalence rates (court decided cases) in most Member States during the 1990s. However, it is unknown to what extent the available estimates or time series on which this conclusion is based are methodologically biased by variations in case definitions, recording routines etc. No correlation could be detected between changes in forensic legislation and the outcome in terms of prevalence or incidence rates.
- Currently, a cross-boundary harmonisation of legal concepts or basic features (diagnostic criteria; terminology; time frames; placement, re-assessment and discharge procedures) appears hard to achieve.

Appendix 1 - List of Tables and Figures

Tables ***page***

Tab.1	Comparative Classification of Legal and Health Care Systems in EU-Member States	21
Tab. 2:	Most relevant Laws regulating Forensic Cases, Year of most recent Modification	36
Tab. 3:	Legal Terminology for describing the Mental State in relevant Legislation within the Member States	38
Tab. 4:	Mental Disorders covered by Forensic Legislation	40
Tab. 5	Minimum Age of Criminal Responsibility in the Member States	41
Tab. 6	Concepts of Criminal Responsibility in Mentally Disordered Offenders incorporated into the Legal Frameworks of Member States	42
Tab. 7:	Placement Options Prior to Trial	43
Tab. 8:	Limits on Pre-trial Placement Specified by Law	44
Tab. 9:	Consequences of Being Unfit to Plead	45
Tab. 10:	Regulations for Sequence of Treatment and Prison Sentence	46
Tab. 11:	Most Common Sequence of Psychiatric Measures and Prison Sentence	47
Tab. 12:	Duration of the Treatment Counted Towards the Length of Prison Sentence, where Both are Imposed	47
Tab. 13:	Assessment of the Mental State as legally defined Prerequisite for a Trial	48
Tab. 14:	Evaluation of additional Issues as Part of the Forensic Assessment	49
Tab.: 15	Additional Conditions or Circumstances to be Assessed	50
Tab. 16:	Correlation of Mental Disorder and Crime	51
Tab. 17:	Entitled Authority for Appointing the Forensic Expert	51
Tab. 18:	Number of Experts Contributing to the Assessment	52
Tab. 19:	Particular Professional Background required for Forensic Assessment	53
Tab. 20:	Specialist Training in Forensic Psychiatry	54
Tab. 21:	Reporting Formats of the Assessment of the Mental State	54
Tab. 22:	Responsibility for Psychiatric Reassessment	56

Tab. 23:	Time-frames for Post-trial Reassessment of Mental State	57
Tab. 24:	Obligatory Assessment of Mental State Prior to Discharge	58
Tab. 25:	Equivalence between Severity of Offence and Length of Stay as Decisive Criteria for Timing of Discharge from Forensic Placement	59
Tab. 26:	Times-frames for Discharge on Licence / Conditional Discharge	59
Tab. 27:	Legal Regulations on Discharge on Licence / Conditional Discharge	60
Tab. 28:	Right to Appeal	61
Tab. 29:	Right for an Independent Expert covered by Law	62
Tab. 30:	Counsel against Defendant's Will	63
Tab. 31:	Trial without Defence Counsel	63
Tab. 32:	Decision-making on Leave Request	64
Tab. 33:	Decision-making on unescorted Overnight Stay off Premises of Forensic Facility	65
Tab. 34:	Involuntary Treatment Regulations as Specified in the Laws	66
Tab. 35	Post-trial Placement of Mentally Ill or Disordered Offenders (whose Criminal Responsibility is Diminished or who are Non-Responsible)	68
Tab. 36	Placement of Dangerous Mentally Ill Patients (Non-Offenders) in Forensic Facilities	69
Tab. 37	Availability of Specialist Services for Forensic Outpatient Treatment	70
Tab. 38	Availability of Specialist Forensic Services for Specific Disorders or Patient Groups	71
Tab. 39	Prison Placement of Mentally Ill or Disordered Offenders	71
Tab. 40	Forensic Bed Capacities Across the Member States	73
Tab. 41	Regulation	74
Tab. 42	Financing of Forensic Placement or Treatment Episodes	75
Tab. 43	Forensic Facilities in the Private Sector	76
Tab. 44	Preventive Detention	76
Tab. 45	Lifelong Placement in Forensic Care	77
Tab. 46	Total Number of Forensic Cases across the Member States	79
Tab. 47	Prevalence Rates (Forensic Cases per 100,000 Population)	82
Tab. 48	Incidence (New Admissions to Forensic Care per Year)	84
Tab. 49	Share of New Admission on all Forensic Cases per Year in %	85

Tab. 50	No. of Criminally Non-responsible Mentally Ill Offenders in Custody in Germany	156
Tab. 51:	No. of TBS-patients and influx and efflux in the Netherlands 1965-2002	192
Tab. 52:	Suspects and Convictions in Portugal 1992-2001	202
Tab. 53:	Inmates in Portugal 1992-2001	203
Tab. 54	Length of Stay for Forensic Patients Discharged in Sweden in 2001	221
Tab. 55	Age and Gender of Patients in Forensic Care in Sweden in 2001	221
Tab. 56	Country of Origin of Patients in Forensic Care in Sweden in 2001	221
Tab. 57	Most Severe Crimes of sentenced Forensic Patients in Sweden	221
Tab. 58	Diagnoses of Patients in Forensic Care in Sweden in 2001	222
Tab. 59:	Major Features of Forensic Legislation or Care in EU-Member States	232

Figures ***page***

Fig. 1	Declared Forensic Beds per 100,000 Population (Forensic Bed Rates) in EU-Member States	74
Fig. 2	Total Number of Forensic Cases across the Member States	80
Fig. 3	Prevalence Rates (forensic cases per 100,000 population)	81
Fig. 4	Most Recent Prevalence Rates (Forensic Cases per 100,000 Population)	83
Fig. 5	Incidence Rate (New Admissions to Forensic Care per Year and 100.000 Population)	84
Fig. 6	Gender of Persons in Forensic Care	86
Fig. 7	Diagnostic Groups of Mentally Disordered Offenders	87
Fig. 8	Proportion of Serious Offences Committed by the Mentally Ill	88
Fig. 9	Proportion of Murders Committed by the Mentally Ill	89
Fig. 10	Prevalence of Mentally Ill Offenders in Austria 1979 – 2003	93
Fig. 11	Incidence of Criminal Commitments NGRI and Prison Sentences. Austria 1990- 2001	94
Fig. 12	Forensic Service Provision in Austria	97
Fig. 13	Judicial and Placement Procedures for Mentally Ill Offenders in Austria	98
Fig. 14	Judicial and Placement Procedures for Mentally Ill Offenders in Belgium	103
Fig. 15	Forensic Service Provision in Belgium	104

Fig. 16	Judicial and Placement Procedures for Mentally Ill Offenders in Denmark	120
Fig. 17	Forensic Service Provision in Denmark	121
Fig. 18	Judicial and Placement Procedures for Mentally Ill Offenders in England & Wales	134
Fig. 19	Forensic Service Provision in England & Wales	135
Fig. 20	Forensic Service Provision in Finland	143
Fig. 21	Judicial and Placement Procedures for Mentally Ill Offenders in Finland	144
Fig. 22	Judicial and Placement Procedures for Mentally Ill Offenders in France	150
Fig. 23	Forensic Service Provision in France	151
Fig. 24	Judicial and Placement Procedures for Mentally Ill Offenders in Germany	158
Fig. 25	Forensic Service Provision in Germany	159
Fig. 26	Judicial and Placement Procedures for Mentally Ill Offenders in Greece	165
Fig. 27	Forensic Service Provision in Greece	166
Fig. 28	Judicial and Placement Procedures for Mentally Ill Offenders in Ireland	174
Fig. 29	Forensic Service Provision in Ireland	175
Fig. 30	Judicial and Placement Procedures for Mentally Ill Offenders in Italy	182
Fig. 31	Forensic Service Provision in Italy	183
Fig. 32	Judicial and Placement Procedures for Mentally Ill Offenders in Luxembourg	188
Fig. 33	Forensic Service Provision in the Netherlands	195
Fig. 34	Judicial and Placement Procedures for Mentally Ill Offenders in the Netherlands	196
Fig. 35	Judicial and Placement Procedures for Mentally Ill Offenders in Portugal	205
Fig. 36	Forensic Service Provision in Portugal	206
Fig. 37	Judicial and Placement Procedures for Mentally Ill Offenders in Spain	213
Fig. 38	Forensic Service Provision in Spain	214
Fig. 39	Conditions for Sentencing to ”Forensic Mental Care with an Order for Special Assessment for Discharge” in Sweden	217
Fig. 40	Number of Patients in Psychiatric Compulsory Care (LPT) and Forensic Psychiatric Care (LVR) on Census Day 1988-2002 in Sweden	219
Fig.41	Gender of Patients in Forensic Psychiatric Care in Sweden 1991-2001	220
Fig. 42	Forensic Service Provision in Sweden	223
Fig. 43	Judicial and Placement Procedures for Mentally Ill Offenders in Sweden	224

Appendix 2 - List of Experts and Collaborators

Austria
Univ. Prof. Dr. Hans Schanda
Justizanstalt Göllersdorf
A-2013 Göllersdorf 17
Tel: + 43 2954 2411 305
Fax: + 43 2954 2411 206
e-mail: hans.schanda@meduniwien.ac.at

Belgium
Prof. Dr. P. Cosyns
Head of Department of Psychiatry
University Hospital Antwerp
Wilrijkstraat 10
2650 Edegem
Tel: + 32 3821 39 38
Fax: + 32 3825 16 41
e-mail: Paul.Cosyns@uza.be

Roel Verellen
University Forensic Centre
University Hospital Antwerp
Wilrijkstraat 10
2650 Edegem
e-mail: Roel.Verellen@uza.be

Denmark
Dr. Peter Kramp
Clinic of Forensic Psychiatry
Blegdamsvej 6B
DK-2200 Copenhagen N
Tel: +45 3536 0366
Fax. +45 3536 1388
e-mail: pk@retspsykiatriskklinik.dk

Finland
Riittakerttu Kaltiala-Heino, Docent, MD, DrMedSci, BSc
Tampere School of Public Health
33014 University of Tampere
Tel: +358 3 247 3511
e-mail: Riittakerttu.Kaltiala-Heino@uta.fi

France
Dr. Pierre Lamothe
Medicin-Chef du SMPR
Service Medico-Psychologique Règional
12 Quai Perrache
F-69272 Lyon CEDEX
Tel: +33 4 7837 5891
Fax: +33 4 7240 9101
e-mail: pierre.lamothe@ch-le-vinatier.fr

Dr. Frédéric Meunier
Service Médico-Psychologique Régional
12 quai Perrache 69272 LYON Cédex 2
Tel : ++33 4 78 37 58 91
Fax : ++33 4 72 40 91 01
e-mail : frederic.meunier@ch-le-vinatier.fr

Germany
Prof. Dr. Michael Osterheider
Psychiatrische Uniklinik Regensburg
Forensische Abteilung
Universitätsstr. 84
93053 Regensburg
Tel: +49 (0)941/9411081

Bernd Dimmek
Westfälisches Zentrum für Forensische Psychiatrie Lippstadt
Eickelbornstr. 21
D-59556 Lippstadt
Tel.: +49 (0)2945/981-2054
Fax: +49 (0)2945/981-2059
e-mail: B.Dimmek@wkp-lwl.org

Greece
Dr. Giorgos Ar. Alevizopoulos
University of Athens, Faculty of Nursing
Dept. of Mental Health and Behavioural Sciences
Community Mental Health Centre of Zografos
42 Davaki-Pindu Str.
157 73 Zografos
Athens
Tel.: + 30 1077 18320
Fax: + 30 1077 18320
e-mail: galev@cc.uoa.gr

Markos D. Skondras, M.D.
Department of Justice, Correctional Services
Forensic Hospital of Korydallos
Terma Nikiforidou Str.
181 10, Korydallos
Athens, Greece
Tel: +30210 4976745
Fax: +302107230782
e-mail: mskondr@otenet.gr

Konstantinos Zacharakis, M.D.
University of Athens, Faculty of Nursing
Department of Mental Health and Behavioral Sciences
Community Mental Health Center of Zografos
42 Davaki - Pindou Str.
157 73 Zografos, Athens,Greece
Tel:+30 2107718320
Fax: +30 2107481174
E-mail: zacharak@otenet.gr

Italy

Dr. Angelo Fioritti
Direttore Programma Salute Mentale e Dipendenze Patologiche
Azienda USL Rimini
via Coriano 38
I-47900 Rimini
Tel. +0541-707740/ 707778
Fax: +0541-707079
e-mail: afioritti@auslrn.net ; salmen2@iperbole.bologna.it

Ireland

Dr. Dermot Walsh
Mental Health Research Division
Health Research Board
73 Lower Baggot Street
Dublin 2
Tel: +353 1 676 1176 or -353 1 635 4355
email: dwalsh@hrb.ie

Luxembourg

Dr. Jean-Marc Cloos
Clinique Ste Thérèse
Rue d'Anvers, 39
L–1130 Luxembourg
Tel: +352-26.12.23.21
Fax: +352-26.48.14.24
e-mail: cloosj@pt.lu

Romain Thillman, Psychologist
Centre Hospitalier Neuropsychiatrique
Avenue des Alliés, 17
L-9002 Ettelbruck
Tel: +352-2682-1
Fax: +352-26.82.26.30
e-mail: romain.thillman@chnp.lu

Philippe Penning, Lawyer
Boulevard Royal, 25B
B.P. 282
L–2012 Luxembourg
Tel: +352-47.38.86
Fax: +352-22.25.84
e-mail: ph.penning@legalex.lu

Dr. Jean-Marie Spautz
Medical Director
Centre Hospitalier Neuropsychiatrique
Avenue des Alliés, 17
L-9002 Ettelbruck
Tel: +352-2682-1
Fax: +352-26.82.26.30
e-mail: jean-marie.spautz@chnp.lu

The Netherlands

Dr Cathy H. de Kogel
Department Crime Prevention and Sanctions
Research and Documentation Centre,
Ministry of Justice
P.O. Box 20301
NL-2500 EH, The Hague
Tel.: +31 (0)70 370 6587
e-mail: c.h.de.kogel@minjus.nl

Portugal

Miguel Xavier, MD, PhD, Professor of Psychiatry
Department Psychiatry and Mental Health
Faculty of Medical Sciences-UNL
Campo Mártires da Pátria, 130
1169-056 Lisboa
Tel./Fax: + 351-21-3644651
e-mail: xavierm@sapo.pt

Bernardo Barahona Corrêa, MD
Department of Psychiatry
Hospital San Francisco Xavier
e-mail: bernardo_correa@gmx.de

Spain

Prof. Francisco Torres-González
Coordinator de la Red MARISTAN
Departamento de Psiquiatria
18071 Granada
Tel: +34 958 272651
+34 958 240703
Fax: +34 958 275214
e-mail: ftorres@ugr.es

Sweden

Helena Silfverhielm, MD, LL
Medical Adviser
Socialstryrelsen
National Board of Health and Welfare
SE-106 30 STOCKHOLM
Tel: 0046 85555 3389
e-mail: Helena.Silfverhielm@sos.se

United Kingdom
Dr. David V. James
North London Forensic Service
Camlet Lodge
Regional Secure Unit, Chase Farm Hospital
The Ridgeway
Enfield EN2 8 JL
Tel: +44 (0) 208 967 1062
Fax +44 (0) 208 967 6510
e-mail: david.james5@ntlworld.com