Declining Interest in Forensic Psychiatry: Recent Developments in Denmark

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INTRODUCTORY REMARKS

Scope of the article

It is postulated that there is a declining interest in forensic psychiatry in some countries, *e.g.* in Denmark. Can this decline be conclusively demonstrated? If so, what are the explanations? It is postulated that it is due not to decreasing interest on the part of psychiatrists, but to a change in attitude on the part of those who run the judicial system. It is further maintained that the essential cause of this development has been that psychiatry has not been able to offer generally acceptable explanations of crime, to say nothing of efficient means to fight crime. Trends in forensic psychiatry in Denmark, a country with 5 million inhabitants, may illustrate some of these problems.

Psychiatrists considered capable of impartial reports

It may be useful first to mention a difference in the American and in the Danish perception of the nature of psychiatric statements. In most parts of the U.S.A. it is — as in some other countries — held impossible for a psychiatrist to give an impartial statement. Therefore, in the U.S., an adversary principle is also adhered to when psychiatric statements are to be given in legal contexts.

In Denmark, as in several other countries, it is, however, considered possible for a psychiatrist to give an impartial *expert* statement, just like, *e.g.* a plumbing expert interviewed by the court, and that it is possible for the psychiatrist to be neutral, like a judge.

Apart from these differing conceptions of the psychiatric expert, the adversary principle is adhered to in Danish courts, with the prosecutor and counsel for the defense each giving his version of the case.

DEFINITION OF FORENSIC PSYCHIATRY: SPECIAL TRAITS AND POSITION OF THE DISCIPLINE

Forensic psychiatry is here defined as the subspecialty of psychiatry which deals with the aid which psychiatry can yield to the juridical system,

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and with the aid which the juridical system can yield to psychiatry, *e.g.* by making laws on commitment.

Forensic psychiatry shows much more divergent tendencies in different countries than such disciplines as surgery and dermatology. Forensic psychiatry is, together with social medicine, at an outer limit of the medical specialties, intertwined as it is with national, cultural, political and social developments.

Its position varies considerably in different countries. It developed after the establishment of psychiatry in the beginning of the 19th century, mainly as a subspecialty of psychiatry. In Sweden forensic psychiatry is a recognized medical specialty on par with general psychiatry and child psychiatry. In other countries forensic psychiatry still is subordinate to the older discipline of forensic medicine from which it partly evolved. In most countries, however, it is a subspecialty of psychiatry.

Forensic psychiatry may be divided into civil forensic psychiatry, social forensic psychiatry and penal forensic psychiatry.

About 4% of the psychiatrists in Denmark work full-time within penal forensic psychiatry, while the civil and social forensic psychiatry is taken care of by psychiatrists who give most of their time to work within other psychiatric settings.

CIVIL FORENSIC PSYCHIATRY

Within this field it cannot be said that there has been a declining interest, or a lack of interest. There has, since heated public discussions in the 1890's, been no special public, political or juridical interest or antagonism here, presumably because the administrative procedures have worked smoothly and have been practiced with moderation and caution by physicians, police and the Ministry of Justice.

Within civil forensic psychiatry the essential topic is commitment and detainment procedures. In Denmark during recent years there has been no serious questioning of these procedures, in spite of the fact that the works of Szasz, Laing, and Foucault *i.a.* have also been discussed by the public, and that some "antipsychiatric" manifestations have appeared on the stage and in fiction.

An as yet unpublished, thorough analysis of coercive procedures within psychiatry in Denmark (by H. Adserballe[1]) has been made, and there have been discussions within the Danish Psychiatric Society with lawyers especially qualified in these matters; furthermore, deliberations have taken place in the Ministry of Justice. The conclusion of these activities has been that there is by and large no reason to alter the present law of 1938 concerning the hospital stay of psychotic persons.

The number of commitments as a percentage of all admissions to psychiatric hospitals and psychiatric wards in general hospitals is at present 5. All other admissions are voluntary.

While the percentage of commitments has declined steadily, the absolute number of commitments, the incidence, has remained almost constant for the last 20 years, at about 2,000, or 40 per 100,000 of the population per year.

With respect to the essential features of the law, "commitment – *i.e.* admission, irrespective of the consent of the patient – to a duly authorized psychiatric department or hospital, must take place at the request of the family (or others who have to take care of the person concerned) and be effectuated by the police, if a person examined by a physician has been found to be (1) psychotic and (2a) dangerous to others and/or to himself or (2b) the physician considers that the patient is in such a state that his chances of recovery would be crucially reduced, if he were not admitted to a hospital.

"Any patient, irrespective of whether the admission has been voluntary or not, can be discharged immediately and must be discharged when he does not fulfill the conditions for retention (Exception: admissions ordered by the court, or some time-limited observation admissions required by child and welfare authorities). Any patient, irrespective of whether the admission has been voluntary or not, can be detained according to the law immediately after his admission."[2]

And with respect to duration of stay: Of all patients committed, 10% were discharged within 48 hours after commitment, and in all 31% were discharged within 14 days after admission. Only 7% remained in hospital for more than six months. Two per cent of the committed patients complained to the Ministry of Justice, and 0.5% reached the courts.[1]

A factor contributing to the tranquil situation with respect to commitments is probably the fact that there is only one psychiatric ward and hospital system – the official one, run by the counties – and that this system maintains a fairly decent standard; the possibility that the relatives of politicians, administrators and psychiatrists may at one time or another have to be admitted to these psychiatric wards and hospitals may provide one explanation of the acceptable standard.

SOCIAL FORENSIC PSYCHIATRY

Problems dealt with in social law which involve a psychiatric evaluation include, *e.g.,* induced abortion, sterilization and castration.

With new laws in 1973 permitting induced abortion and sterilization to practically all persons over 25 years of age, a heavy burden has been removed from the psychiatrists.

With regard to castration, permission from the Ministry of Justice is necessary, and this has to be preceded by a psychiatric evaluation. At present less than 10 patients a year are castrated, either the troublesome transsexuals or sexual offenders, in all cases only after their own application. Treatment with cyproteronacetate (or other anti-hormones) seems, however, to be replacing castration.

A limited, though much appreciated, psychiatric consultative service, performed by psychiatrists working full-time with the social services taking care of the abnormally unemployed, problem families, etc., has been functioning in some of the larger cities, and in a unique private organization (Kofoed's Skole in Copenhagen) which for many years has offered the unemployed shelter and facilities "with no strings attached."

PENAL FORENSIC PSYCHIATRY

General position

Penal forensic psychiatrists yield the assistance which the representatives of the judicial system ask for, and which the psychiatrists – when they are available – find it possible to yield. Certain roles are assumed and rules are established.

The interactional framework for the cooperation between penal law and psychiatry varies with time and from country to country. The background for this interaction – that is, how great a menace crime is perceived to be – also varies, as do the sanctions which society, the public, feels have to be applied on account of the crime.

At present crime is seen as a very great problem in the U.S.A., while in Denmark it is considered a smaller problem, even if heated discussions also take place here.

Let it suffice to illustrate the different background figures by stating that the U.S. homicide rate is about 10 times as large as the Danish rate, which is <1 per 100,000 inhabitants a year. The Danish total prison population, including jails, is 3,000, which would correspond to a total number of prison inmates in the U.S.A. of 120,000, whereas the actual number probably is several times as large.

The general aim of Danish forensic psychiatry has been to help the court to evaluate the responsibility, or the irresponsibility, of the offender. The goal of penal forensic psychiatry is, as the German forensic psychiatrist Mende of Munich has recently put it, to help the court exert justice in determining the degree of responsibility.[3]

The social defence school, originating from Lombroso, and later *i.a.* represented by such names as Ferri and the Swede Kinberg, took upon itself to explain and combat crime. The representatives of this school were among the specialists on crime, the criminal anthropologists, as the Italians called them. This school favoured indeterminate security measures, and psychiatrists in key positions in the judicial system participated in evaluating and sorting offenders, placing them in criminal asylums, labour camps, and special institutions for alcoholic offenders, recidivists, young offenders, etc.

As late as the 1930's Lombroso and his followers were still pessimistic in their outlook, but in the 1920's optimistic endeavours began to replace the therapeutic nihilism inspired mainly by Anglo-Saxon psychoanalysts. I will not go into later developments, into the rise of more modest expectations, modified psychotherapeutic techniques, group activities, etc.

During recent years the pendulum has swung back. Psychiatrists cannot explain crime as such, as some psychiatrists "overselling" themselves have claimed, and their treatment results have not been convincing.

Criminologists, mainly of sociological training, have taken over the explanations of what crime is, and many lawyers (and sociologists) now demand the classical equal punishments – to fit the crime (and not to fit the criminal, as the school of social defence recommended).

This general development has also taken place in Denmark. Psychiatrists are no longer being consulted as experts on crime as such, and many

psychiatrists have given up the attempt to establish themselves as such experts, having realized that much crime is committed by "normal" people – as shown *i.a.* by the findings of the enormous extent of hidden criminality – and having accepted the plausibility of analyses concluding that much criminality, especially in juveniles, may even be interpreted as normal adaptational phenomena.

Penal Forensic Psychiatry at the Pre-Trial Stage

Some points about the pretrial stage:

1. For approximately the last hundred years Danish psychiatrists have not had to express opinions about responsibility or irresponsibility (or diminished responsibility). They have instead expressed their opinions in the medical professional terminology – applied in the law – as to whether the patients were psychotic or mentally retarded. It was the jurisprudence which decided whether the offender was irresponsible on account of his psychosis, etc., and which applied this term. For practical purposes all psychotic offenders have been considered irresponsible.

2. In 1930 Denmark adopted a new penal law, to a great extent influenced by the Italian Positive School, with a differentiated system of various forms of sanctions within and outside the judicial system. At its height – in 1954 – 17% of all those sentenced to more than a fine underwent a psychiatric examination resulting in a mental report to the court.

In 1974 the corresponding figure was 5%. This decrease has been due partly to a decrease in the interest of the court in such examinations, and partly to the fact that the special sanction forms, several of which were dependent on psychiatric management or participation, went out of use and were abolished by new laws in 1973 and 1975. The need for mental reports is at present mainly determined by the wish for evaluation of whether or not the offender should be transferred to the psychiatric hospital system or to the services for the mentally retarded.

Half of the reports are given by public health officers, the psychiatric education and interest of whom may be rather limited. About 10% are elaborated after inpatient evaluation, and the rest are given by subspecialized forensic psychiatrists while the offenders are under arrest or on bail.

3. The case is dealt with by the court irrespective of whether the offender is considered incompetent, as soon as the necessary police work and the psychiatric evaluation have been completed. It is considered that the counsel for the defence will take due care of the interests of the offender.

4. Only one psychiatrist is involved – he is considered an expert to the court giving a neutral statement to the judge. (It is extremely rare for forensic psychiatrists to appear in court.) The control of the content of the report, which in the U.S.A. is obtained by cross-examination, is obtained in another way:

5. All reports in important cases and all reports considered doubtful in some respect or other are sent for evaluation to the Medico-legal Council's psychiatric section. This council, made up of seven experienced forensic psychiatrists, gives an authoritative approval (or disapproval) of the report,

and thus discussions of these reports are minimized.

6. With respect to the reports, it can finally be mentioned that there has been severe public criticism about waiting times and the time taken to prepare these reports in some institutions; and the use of degrading descriptions of the offender has been fiercely (and rightfully) attacked.

The Post-Trial Stage: Treatment

After the examination stage should follow the "treatment" stage. Even if a psychiatrist is responsible for an offender – after the sentence has been chosen and formulated – it is, in my opinion, not desirable to call everything which goes on from that time "psychiatric therapy or treatment." As an example I can mention the Italian mental hospitals within the correctional system. Here the offenders are placed according to the severity of their crimes for periods of 2, 5 or 10 years; because these patient-offenders are under the administration of psychiatrists, these psychiatrists are inclined to believe that they are performing psychiatric treatment. In my opinion they are wrong. These institutions act as special branches of the prison system, even if components of psychiatric treatment may be interspersed. But the main function of these psychiatrists must be considered as that of guardians.

Treatment can be defined in many different ways. The English forensic psychiatrist Gibbens, one of the world's leading figures within the field, has in 1966, in a discussion of psychopaths, defined treatment very broadly: "Any discussion of facilities for the treatment of psychopaths must start from the fact that 'treatment' must include everything that happens to an offender as the result of conviction."[4]

I prefer a narrower definition: Treatment is planned handling of or planned activity together with a person, carried out by a treater with a professional theoretical background. (And "therapy" I consider as treatment given by or directed by physicians.)

Some people may consider these matters to be of no importance; I consider it to be of the utmost importance to forensic psychiatrists – pressed as they are – that they analyse and eventually reformulate their roles.

Treatment in Different Institutions

Forensic psychiatric therapy can take place, in principle, in four different settings:

1. In ordinary prisons.
2. In special correctional institutions like the Medical Center for Federal Prisoners in Springfield, Missouri, the Vacaville prison in California, the Herstedvester institution in Denmark, or Grendon Underwood in England.
3. In special institutions within the health services like St. Elizabeth's Hospital in Washington, D.C., Atascadero State Hospital in California, Broadmoor in England, or the Van der Hooven Clinic in the Netherlands.
4. In ordinary psychiatric institutions.

In the Scandinavian countries there have been, and still are, strong movements to do away with the "in-between institutions" 2. and 3., which

are considered to be rigid, to be a hindrance to new approaches, and to confer double stigmatization upon inmates, thereby deteriorating the possibilities for rehabilitation.

Treatment of Different Groups of Offenders

With respect to the psychotic offenders: These are almost all transferred to the ordinary psychiatric institutions (hospitals and psychiatric departments in general hospitals, which are by now under the same ordinary county health authorities as the somatic wards). Only a very few are transferred to the maximum security institution: a special ward with 17 patients in a mental hospital in the provinces. This institution is the only such institution for the country's 5 million inhabitants. It receives both offender-patients and non-offender-patients, but only psychotics and only males.

And here it can be inserted that in Denmark – in marked contrast to some other countries – there are no separate security officers in either the special facilities in the hospitals or in the prisons. Even the prison employees or guards have rehabilitative functions.

The mentally retarded offenders are almost all transferred to the ordinary services for the mentally retarded, also the debiles. This has been the practice for the past 40 years, to a high degree due to the findings of a Danish psychiatrist Schroder,[5] who examined all inmates in the Danish prisons around 1917-1927. He found that 10% were mentally retarded. This finding is in surprisingly close agreement with the findings of the extensive study of Brown and Courtless in the U.S.A. in the 1960's.[6]

The Danish practise of transferring all mentally retarded, so that practically no retarded are now to be found in the prisons, has been attacked during the 1970's by, *i.a.,* the dynamic leader of the Danish services for the mentally retarded and also by some debiles themselves. The "normalization principle" confers, it is said, the right on mentally retarded to be sentenced in the ordinary way, *i.e.* with a time-limited prison sentence.

A census study of the patients in the services for the mentally retarded with valid court sanctions was conducted on behalf of a committee dealing with these problems. For 1.5% (290) of all patients or clients within these services such sanctions were valid. Twenty-five per cent of all the offender-patients would have preferred a prison sentence, and in 16% the responsible member of staff, a physician or a social worker, found that these patients ought to have had ordinary sentences instead.

With respect to the psychopaths, the sociopaths, and the patients with character or personality disorders: The treatment of the personality disorders as described by Stürup[7] in his book *Treating the Untreatable* (awarded the Isaac Ray prize), is still internationally accepted, and is described in recent textbooks as the model to follow in correctional work, but the sentence to "indeterminate detention in a special correctional center for mentally abnormal offenders" was abolished by amendment of the Danish penal law in 1973, at the very time the West Germans and Austrians were planning to establish institutions modelled after this pattern.

What has happened in Denmark is this: since the penal law of 1930 with

its differentiated system of social defence measures, a detention center for criminal psychopaths was established among the special institutions. In the 1950's about 400 inmates were dealt with in this way (prevalence figure), or put in another way, the 15% most difficult prisoners from the ordinary prison system were placed here (excluding the psychotic and the mentally retarded who were sorted out beforehand, as mentioned previously).

Of the "treatment philosophy" I will merely mention that all staff's work was integrated, and that there was no separate security personnel. All were responsible for security, naturally especially the guardians or attendants, but these also ran therapeutic groups.

During the 1960's a vehement campaign against the Herstedvester institution was launched, led by some lawyers. It was especially considered unjustified or inhumane to "break" a man, to make him change his personality through coercion to cooperation by means of the indeterminate sentence. Also the therapeutic results were not considered convincing. The negative attitude was so universal that it was demanded that the indeterminate sentence be either abolished completely or preserved for a very limited number of offenders. The latter possibility was chosen. Since the change of the law only up to 5 persons have been admitted to the Herstedvester per year, where previously up to 25 times as many were admitted.

A remarkable analysis by the criminologist Karl O. Christiansen and co-workers was published immediately before the already politically determined law change. According to this analysis the results with respect to criminal relapse for property offenders could not be proved to be significantly superior to those obtained by ordinary correctional procedures. (The relatively small number of sexual and violent offenders did not allow of statistical analysis.)[8]

A Herstedvester institution run by psychiatrists is still there. But the physicians have adopted a new approach. They refuse to be engaged in decisions about the length of the stay of offenders. Offenders are transferred to and from ordinary prisons. The psychiatrists yield psychiatric therapy to those offenders who ask for it. And some released former prisoners – on parole or not – seeking shelter, are admitted voluntarily; they cannot adopt to the mental hospital milieu which in some cases may also be open to them. Ten per cent of all the admissions are now this type of voluntary admission to this psychiatric prison.

CONCLUSIONS

To summarize the Danish situation: within civil forensic psychiatry there is no decline in interest, but a status quo. No essential changes seem likely to come up in the near future, and even among lawyers the present law and practice find general approval.

The interest in and demand for social forensic psychiatry has been on the decline: The tasks within social forensic psychiatry have diminished drastically because making the decisions on castration, in transsexuals and others, is the only paternalistic role left for psychiatrists in this field.

Within penal forensic psychiatry there has been a marked decline in the interest in and use of psychiatrists. The explanation is that the previous

expectations of the judicial and correctional system with regard to the contributions of psychiatrists were not considered to have been fulfilled. Psychiatrists have withdrawn from the center of the scene in this field. Expectations are now directed to other disciplines for analyses of, for example, what crime is and how it can be controlled.

The results of research into the nature of sanctions (where punishment or repressive intentions dominate so that therapeutic strivings are subdued) must be of interest to psychiatrists, as is research into the general population's need for the exertion of punishment.

Specifically the trend has been away from the special psychiatric correctional institutions. The official policy of the Danish Psychiatric Society aims at forensic subspecialized centers placed in the centers for general psychiatry (which again should be placed within general medical and social coordinated services). From these forensic psychiatric centers consultative functions should be yielded, *e.g.*, out in the prisons.

FINAL REMARKS

I have participated in a number of Scandinavian and European discussions on the future of forensic psychiatry. The evaluations have not been so nihilistic and gloomy as some may find my points of view. It has been said that, *e.g.*, in England, Ireland and Sweden there is a great interest in an expansion of forensic psychiatry.

There has, however, been general agreement on the opinion that forensic psychiatry should not establish itself as a medical specialty of its own; it should on the contrary tighten its bonds and interactions with general psychiatry. Likewise there has been agreement about the necessity of analyses of the roles and functions of forensic psychiatry, and redefinitions of these roles at intervals. The primary medical nature of the subdiscipline must be maintained, and conflicts with this aim must be scrutinized, defined and delineated.[9,10]

References

1 Adserballe H: *Frihedsberøvelse og tvang i psykiatrien* (Detention and coercion in psychiatry). Man. 1976

2 Svendsen BB: Forensic psychiatry. Duplicated 1974

3 Mende W: *Forensische Psychiatrie*, in Müller, C (ed.): *Lexikon der Psychiatrie*, Springer, Berlin-New York, 1973

4 Gibbens TCN, in Craft M: Psychopathic Disorders and their Assessment. Pergamon, Oxford, 1966

5 Schrøder GE: *Psykiatrisk undersøgelse af mandsfanger i Danmarks straffeanstalter* (Psychiatric examination of male prisoners in the penal institutions of Denmark), Jacob Lund, Copenhagen, 1917 and 1927

6 Brown BS, Courtless TF: The mentally retarded offender. In Allen RD, Ferster EZ and Rubin JG (eds.): Readings in law and psychiatry. Johns Hopkins, 1968

7 Stürup GK: Treating the "Untreatable" Chronic Criminals at Herstedvester. Johns Hopkins, 1968.

8 Christiansen KO, Moe M and Senholt L: *Effektiviteten af forvaring og særfængsel m. v.* (The efficiency of detention of criminal psychopaths in psychiatric prison . . .), Betænkning (Committee report) nr. 644, Copenhagen, 1972

9 Working Group on Forensic Psychiatry, Siena, Italy, 13-17 October 1975. Summary Report, World Health Organization, Regional Office for Europe, Copenhagen, 1975

10 Svendsen BB: Is the existence of a forensic psychiatry justified? (On forensic psychiatry in the Scandinavian countries). Will appear in Acta psychiat. scandinav. 55, 1977. – Svendsen BB, P Anchersen, A Myerson, K Noreik, G Thorsteinsson, M Tuovinen and K-E Törnqvist: Present functions of forensic psychiatry in Scandinavia. Will appear in Acta psychiat. scandinav. 55, 1977.