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The Forensic Psychiatric Hospital

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1. INTRODUCTION

In the recent decades we witness the appearence of new terms in the professional literature; like special hospital, maximum security hospital, forensic hospital, maximum security regional unit, regional forensic unit, psychiatric prison, special patients, difficult patients, and dangerous-violent patients. The main common denominator of these term was the forensic connotation or frame. In the course of the years a forensic psychiatric network emerged which was the result of rather a spontaneous development, than a well-conceptualized, defined and organized evolution. In order to make clearer the diffuse terminology I shall use the term «forensic psychiatric hospital» or «unit», which includes all the above mentioned entities. I will use the term «forensic patient» which is one of the subgroups, of the special patients. According to my understanding the forensic patient is a mentally ill or severly disturbed person who committed a serious offence against another person or poses danger to others, and is in need to be treated in a special psychiatric unit which provides, when necessary, security arrangements.

2. JURIDICAL ASPECTS

Modlin et al (1986) quoted in their paper the Honorable Judge Frank: «Society must be protected against violence and at the same time avoid punishing sick men whose violence drives them beyond their controls to brutal deeds. A society that punishes the sick is not wholly civilized. A society that does not restrain a dangerous madman, lacks common sense.» In our decade society protects itself against violence and proves that there is no lack of common sense. At the same time society punishes the sick and mentally disordered offenders by sending them to prisons and to prison psychiatric hospitals, turning the prisons into the «new mental hospitals» (American Medical News 11/4/1983) and proves that it is not wholly civilized.

Society at large and law and mental health professionals in particular lack skill to treat the mentally disordered offender. «We are unwilling to leave them alone, yet most agencies seek to avoid responsability for their case. We confine them to prisons and to prison like hospitals where they are sometimes treated worse than other offenders. They almost always receive worse treatment than mental patients in public or private hospitals.» (Halleck, 1986)

If mentally disturbed inmates are housed and treated in the general prison, their mental pathology may cause unrest among the inmates. Transfer to the prisom hospital may restrict their human rights, because of the closed and isolated character of the institution (Arboleda-Florez & Chato, 1985). Community psychiatric hospitals are unwilling to admit hospital order

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offender patients because of their open door policy.

In the «post-therapeutic state» (Menzies, 1987) a «transcarceral system» (Menzies, 1987) developed, in which the mental health and criminal justice agencies are intermingeled and the patients are involved in two simultaneously revolving doors (Klassen & O'Connon, 1988). «Psychiatry and related professions have become a prominent force in criminal justice, as they assume a role that is virtually interchangeble with that exercised by other legal officials... forensic clinicians are able to mobilize the sources that are both legal and medical in style and substance.» (Menzies, 1987)

The separation of the bad (sane) from the mad (insane) is performed by the insanity defence procedure, wich is concerned with criminal responsability (Verdun-Jones, 1989). In the past decades in several countries (U.S.A., England, Wales, Canada and Israel) there is a tendency to restrict the use of the insanity defence procedure, or abolish it (Sweden).

According to Verdun-Jones the insanity defence has been removed in England and in Wales from the criminal process because of three possible reasons: (1) «(The) narrow interpretation of the M'Naughten rules by the judiciary»; (2) The 1983 Mental Health Act changed the indefinite detention practice of the at Her Majesty's Pleasure commited patients. The insanity acquitee gained almost the same rights secured for the hospital order patients, including acess to the Mental Health Review Tribunals; (3) The introduction of the diminished responsability concept in 1957, used in charges of murders.

Mental disorder as mitigating factor is usually applied at the sentencing stage, resulting often in issuing hospital orders, disregarded by the health authorities, because lack of available bed for the mentally disturbed offender, or unwillingness to admit him/her to the civil psychiatric hospital.

The juridical process in England and Wales developed a four-group classification structure of the mentally disordered offenders (Verdun-Jones, 1983).

1. Offenders who are not considered dangerous and are in need of psychiatric treatment. The court may issue a hospital order, which is equal with civil commitment. «The court must be satisfied that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment.» In the case of psychopathic disorder or mental impairment a good treatment prognosis is required. The court may send the defendant to a community psychiatric hospital, to a regional security unit or to a special maximum security forensic hospital. The staff has jurisdiction over the treatment and discharge policy.

2. Offenders who are considered dangerous and are in need of psychiatric treatment, may be sent to a special maximum security forensic hospital by a hospital order, containing a restriction clause, which means that the offender can be released, transferred or granted leave only by the Mental Health Review Tribunal or by the Home Secretary.

3. Offenders who are considered not dangerous and are not in need of psychiatric treatment, will not be diverted into the mental health system.

4. Offenders who are considered dangerous, commited serious offences and are not entitled to a mitigated sentence, may be sentenced for life. Criminals suffering from personality disorders, resulting in sexual offences belong to this category.

The hospital order is issued for treatment purposes, but it contains therapeutic and punitive elements as well. According to Potas (in Verdun Jones, 1989): «(the hospital order) shares with imprisonment the consequences of depriving an individual of his/her liberty. Like imprisonment it offers protection to the community by separating inmates from normal societal intercourse. Unlike imprisonment, however, the aims of this disposition is to provide remedial action in the form of medical or psychiatric treatment, in an attempt to rehabilitate or to retard the deterioration of a mentally disordered person.» Because of the element of deprivation of liberty, which has a punitive flavor, it would be favorable if a hospital order should be imposed only with the consent of the offender.

Before the Mental Health Act of 1983 in England the restrictive order had ever more punitive character than the regular hospital order. The offender might spend a larger period in hospital than he/she would have spent in prison.

The Mental Health Act limited the use of restriction order, but till now 66% of the patients are subject to restrictions mostly without time limit.

Two-three decades ago, forensic psychiatrists in England recommended forced hospitalization for two-thirds of the diminished responsability offenders in a maximum security special forensic psychiatric hospital. Later on forensic psychiatric hospitals tightened up their criteria for admitting hospital order offenders, resulting in a sharp drop of the admission rate in these institutions (45%) and in a significant increase of the imprisonment of mentally disordered offenders. The prison system reacted with unwillingness to take over the responsability to treat this type of clientele and was interested to «recycle» them to the mental health system. This trend will probably lead to reworking the recommendation practice of the courts, concerning the offenders acquitted on the basis of mental disorder, and of the diminished responsability offender in order to provide them with appropriate treatment.

3. THE INSTITUTION

3.1. *The maximum security forensic psychiatric hospital*

The maximum security forensic psychiatric hospital is characterized by the combination of high security and therapy. It's official aim is to create a frame in which a double purpose is achieved: ensuring the safety of the general public and at the same time providing appropriate security environment. The hospital set-up must minimize the possibilities of the patient's destructive-assaultive behavior wich enables safe daily activities.

The debate about the necessity of the forensic psychiatric hospital is still ardent. According to Ramon and Giannichedda (1988): «...the principal justification of a special institution for mentally ill offenders is the conviction that in reality it is impossible to move the prison and the psychiatric systems toward the rights and needs of people.»

The real evidence of need were the researches dealing with the relationship between dangerousness and mental disorder. Swenson et al (in Taylor, 1991) came to the conclusion that more than half of the violent persons in U.S.A. states met D.S.M. III criteria for psychiatric disorders. Alcohol and drug addicted subjects reported more than twice violent behavior as those with Schizophrenia. 13% of Schizophrenic persons demonstrated violent behavior. It will be unjust to reach general conclusion concerning relationship between violence and disorder. It will be necessary to establish the relationship in every particular case, taking in account the special mental and situational cisrcumstances. According to the present state of art, mental disorder is associated with dangerous behavior, and some of these mentally disordered persons must be treated in the maximum security psychiatric setup (Taylor, 1991). One may add that forensic psychiatric hospital should be independent of the legal states of the patient, and should be based only on mental pathology and actual behavior.

3.2. *Medium security regional units*

In 1975 the Butler Committee in England recommended to establish regional security units (Verdun-Jones, 1989) for patients who need a lesser degree of security provided by the maximum security forensic psychiatric hospital. Many of the patients had a history of criminal behavior, or were chronic patients with behavioral problems. Most of these patients present difficulties in interpersonal relationship. These units are small, closed, well staffed therapeutic communities (Whitehead, 1979; Fuller, 1985) allowing the patients and the staff relating to each other as human beings, without the strict security restrictions of the forensic psychiatric hospital. According to Whitehead (1979) «Not only did violence disappear, but rehabilitation became a reality». The regional units are supposed to fill a gap in the chain of psychiatric care and form the basis of the comprehensive local forensic psychiatric services (Fuller, 1985).

3.3. *Security parameters of the maximum security forensic psychiatric hospital*

The security parameters of the forensic psychiatric hospital are composed by physical, administrative and professional elements.

1. The physical security is characterized by high perimeter walls and by heavy internal physical security. Additional security is obtained by the great distance of the hospital from the original communities of the patients.

2. The administrative element means the quality and quantity of the staff. According to Taylor (1991), the main aspect lies in the quality and not in the numerical ratio. The distribution of the available staff is different from that customary in non-security hospitals.

3. The professional element is resently perceived as the main security factor. The admission criteria, the internal selection and even segregation of patients provide security. Psychiatric treatment, like pharmacotherapy, long-term psychotherapy, recreational activities and intramural community therapy became essential part of the security. «Good treatment is not incompatible with security, indeed it is essencial to it» (Taylor, 1991). A further professional element of security is the training process of the forensic staff. Special skills are necessary to cope with the long-term relationships in the maximum security environment, housing difficult, often violent patients. The most important skill is the simultaneous monitoring of the developments in the general atmosphere in the wards and the behavior of the individual patients, their interactions among themselves and with the staff members.

3.4. *The population of the maximum security forensic psychiatric hospital. General characteristics*

Steadman and Cocossa (1974) divided the clientele of the forensic psychiatric hospital, according to their legal status, into four groups:

1. The mentally ill inmates.
2. Defendants incompetent to stand trial.
3. Not quilty by reason of insanity.
4. Dangerous mentally ill patients.

My classification will be more comprehensive based on medico-legal concepts.

3.4.1. *Forensic diagnostic services*

1. Assessment for the juridical system.
2. Assessment for the correctional service, including psychiatric screening of the prison population.
3. Assessment for the probation and parole agencies.

3.4.2. *Impatient service*

For convicted mentally ill inmates, serving their terms in the prisons. The population is divided into two main groups:

1. *Long-term care patients*: (a) Prisoners serving in prison became mentally ill; (b) Chronic psychotic patients who are unable to adjust themselves to the prison conditions and are treatment-refractory; (c) Personality disordered offenders of explosive type, with low impulse control and low tolerance and frustration thresholds. They behave in a highly disruptive way in the prison; (d) Prisoners suffering from paranoid personality with high potencial for violent behavior; (e) Treatable sexual offendes, who can not be treated in the prison set-up.

1. *Short-term care patient*: (a) Temporary admission of prisoners with acute psychiatric problems, wich can be stabilized during a short-term psychiatric intervention; (b) For defendants unfit to stand trial, who suffer from acute mental illness and were found to be uncapable to follow their trial. This type of patients are hospitalized for a short or sometimes medium-term care; (c) For dangerous incompetent insanity acquittees, who are not guilty by reason of insanity. The patient generally spends a long period in the hospital. The duration of the confinement is related to the seriousness of the offence; (d) For dangerous mentally ill patients who are civilly committed to the forensic psychiatric hospital, by reason of their dangerous behaviour; (e) For chronic mentally ill offenders who are civilly committed to detention in the forensic psychiatric hospital, after being discharged from the prison. Preventive detention is practiced in Scandinavia, Holland and in the U.S.A.

3.4.3. *Outpatient Service*

1. For mentally disturbed inmates in the correctional system, whose treatment program can be carried out on outpatient basis.

2. For the aftercare of probationees and parolees, who are in need of psychiatric supervision.

4. PSYCHIATRIC DISORDERS

According to the Special Hospitals Service Authority in England (1991), in the year 1990, 62% of the patients suffered from mental illness, 25% had a psychopathic disorder, 9% were mentally retarded and 4% were severely impaired. Due to the statistics of Arboleda-Florez (1985), in a five year period between 1978-1982, the Forensic Unit of the General Hospital in Calgary admitted 40,6% of the patients with psychotic behaviour, 13,9% with disruptive behaviour on personality disorder basis, 9,9% suicidal patients, 10,9% depressive clients and 16,8% for testing. The most interesting data given by Arboleda-Florez was the discrepancy between admission and discharge diagnosis, concerning personality disordered clients. At the time of release, the percentage of patients diagnosed as suffering from personality disorder was 26,7%. The difference in percentage between the admission and discharge diagnosis can be explained by the difficulty in the diagnostic process concerning this type of patients. 7,9% of the discharged patients were diagnosed as suffering from substance abuse.

Klarsen and O'Connor (1988) came to the conclusion that the highest risk group is composed by those under 25, those with 10 or more psychiatric admissions and those with at least 10 prior arrests. Those people were predestinated to security setting.

Frank (1986) disclosed that according to his experience, violence was often displayed by patients suffering from the following disturbances: Substance intoxication or withdrawal syndroms, organic brain syndroms, paranoid, antisocial and borderline personality disorders, mania and other psychotic illnesses. Wong (in Robbins et al, 1988) added one more category to the list: the narcisistic personality disorder.

5. THE FORENSIC PATIENT

The patients admitted to the forensic psychiatric hospital are defined as forensic patients, characterized by: (1) Denying the competence and professional authority of the staff members; (2) Lack of cooperation with the hospital in general and with the therapist in particular; (3) Thwarting the professionals to carry out their tasks and practice their trained skills; (4) To prevent therapists to succeed in their professional efforts; (5) To sabotage the entire treatment process, and rejecting the professional advices; (6) Acting violently; (7) Demanding excessive attention and presenting permanently new problems; (8) Being unable or unwilling to benefit from therapy; (9) Threatening the continuity of the therapeutic relationship, or sudden premature break of the process; (10) Basic untrust, expressed by ongoing testing. (Robbins et al, 1988)

These patients consume more and larger variety of therapeutic services, need more emergency interventions and medication, are often admitted to the hospital, and frustrate their therapists.

Kermani (1981) differenciated two types of violent patients:

1. The violent-depressive personality with poor therapeutic prognosis. The main features of his personality are the following: (a) Long history of antisocial-criminal-violent type behaviour, resulting imprisonment; (b) Performing assoultive, homicidal, suicidal and self-mutilative acts; (c) Vacillation between the destructive and autodestructive inclination; (d) Expression of depression, poor self image and self-esteem; (e) Long history of substance abuse; (f) Sometimes responds to lithium, minor tranquilizers or antiepileptic treatment.

Patients belonging to this personality type are suffering from organic brain syndroms, different types of psychosis and a variety of personality disorders.

2. The assaultive psychotic patients, having a good therapeutic prognosis. These patients manifest the following qualities: (a) Became violent only after the onset of the psychosis, often without warning signals; (b) No history of antisocial-criminal behaviour, and homicidal acts; (c) Overestimation of physical strength, and functioning according to delusions; (d) No history of depression and substance abuse; (e) They respond well to major tranquilizers.

6. TREATMENT

The treatment regime in forensic psychiatric

hospital, unit or ward is influenced by two main factors: (1) The length of the stay in the hospital, wich is an average period of 8,5 years (Taylor, 1991); (2) The fact that most of the inmates are nonconsent patients.

The strategy of the intervention has to be set for a long term. The first step should be the clarification of the treatability. According to the English Mental Health Law of 1985, one of the criteria of committing a person, who suffers from psychopatic disorder or is mentally impaired, to special hospital, should be the criteria of treatability (Taylor, 1991). It is highly reccommended to develop an Initial Treatment Plan and later on a Master Treatment Plan wich is reviewed every three months (Amit, unpublished paper, 1989). The plan should be discussed with each patient and if it is possible to obtain his/her approval. At the end phase of the hospitabilization a Discharge Plan should be elaborated, (Amit, 1989, unpublished paper). The treatability criteria is the most crucial issue in holding and treating these difficult, chronic and depressive patients, who are declared by the psychiatric establishment as untreatable.

Gabbard et al (1987) developed, on statistical basis, positive and negative predictors to treatment response. According to their paper, presence of anxiety and DSM axis one depression are regarded as statistically significant positive predictors, and other DSM axis one psychotic disorders as possible prediction of positive treatment response. Good academic performance, stable work and interpersonal relationships, and a supportive family are perceived as positive contributing factors.

Significant predictors of negative treatment responses are: history of felony arrest and conviction, repeated lying and an actual unresolved legal situation. Among the possible prediction of negative treatment response, forced hospitalization as alternative to imprisonment, violent behaviour and organic brain syndroms were mentioned. Two more empirical negative predictors should be added: history of substance abuse and self-mutilation.

The therapeutic tools used in the forensic psychiatric hospital are similar to those applied in general psychiatry.

The main difference are the length of the hospitalization, the intensity of the treatment and its comprehensivity. The treatment should be intensive, performed by concurrent treatment modalities. The treatment regime is built on the therapeutic community system, completed with short and long-term treatment methods, adjusted to the actual mental state of the patient and to the psychosocial requirements of a given moment. The treatment plan is developed individually and periodically revised, wich enables the therapists to update or change the therapeutic tools.

The theurapeutic tools, methods and technics applied in the forensic psychiatric set up are composed by pharmacological, psychotherapeutical, occupational, vocational and educational inputs. In the field of verbal therapies, we use dynamic cognitive and behavioral individual psychoterapy, as well as family and group psychotherapy. The special therapeutic tools adjusted to our special clientele are programs of social interaction training, anger control training, of elimination of defects in life style and social climate control.

The forensic patients' behaviour arouse the feeling of power struggle, rejection and/or countertransferance in the therapeutic and custodial staff alike. The patients and the situational interactions in the ward oblige us to create a structure in the daily life of the patients, to set firm limits of tolerance and to clarify which services will be delivered in the frame of the patient-therapist contract. The hierarchical structure of the ward must be strict in order to be able to enforce the rules promptly in the case of attempting to break the structure. The consequences of such an attempt should be implemented without delay, without further psychotherapeutic discussions and elaborations. In order to ensure the smooth running of the ward and to prevent the eruption of violence, it is necessary to show enough manpower.

The basic human attitude towards the clients should be the absolut honesty and loyalty. The basic therapeutic approach is the comprehensive one, wich comprises a great variety of methods. Our clinical experience taught us, that there is not a single drug for the treatment of violent-assaultive behavior, and no special psychotherapeutic method suitable for the violent forensic patients.

There is concensus among the professionals

that the best therapeutic regime would be the combined pharmaco-psychotherapeutic system.

7. COUNTERTRANSFERENCE

The therapeutic and custodial staff working in the forensic psychiatric hospital face problems wich are unknown in the conventional psychiatric set-up.

The most difficult task is to tolerate the long-term relationship with hostile and deviant people, who perform actual violence, and simultaneously using the relationship as a holding measure. Another difficult field is the transference-countertransference relationship. It is very hard to be exposed to a prolongued hostile transference with sexual and aggressive features, and at the same time to excersize restrain in the countertransference process. It is well known that the forensic patients evoke the most intense and problematic countertransference reactions, wich must be elaborated by the individual therapist and by the entire staff.

Countertransference is an integral and unseparable part of every therapeutic process. The positive outcome of all kind of psychotherapies depends on the simultaneous understanding of the transference and countertransference reactions. In the forensic psychiatric hospital the countertransference is more complicated. The hospital is staffed by multiprofessional personnel belonging to various specialty subgroups. The staffmembers react to inmates in different ways, depending on their particular role in the hospital structure and in the therapeutic process. Other decisive factors influencing the reactions toward the patients are: the professional maturity of the staff member, his/her professional subgroup affiliation and the quality of the therapist-patient relationship. The difficult patient of the forensic setting evoke divided countertransference reactions, even splitting in the individual staffmembers and among the therapists as a group.

In order to cope with all the aspects of the daily therapist—patient relationships and interactions, it is suggested to adopt in the forensic psychiatric setting Winnicott's concept of objective countertransference wich means «the analyst's love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation.» (in Colson, 1990)

The ongoing therapeutic process with our patients is not restricted to the intrapsychic sphere, but is carried out simultaneously on the interpersonal and community level. In other words, the patients who are functioning mainly according to the «agito ergo sum» principle, extended the therapeutic frame to their surroundings. That means, that the countertransference stimulating area became larger. The approach of Winnicott allows us to cope with this extended transference-countertransference situation.

In the following I will present the result of Colson's study (1990) wich deals with the countertransference reactiontypes concerning the difficult (forensic) patients, regarding to four factors obtained by factor analysis.

First factor: *Psychotic withdrawal*; wich indicates the lack of involvement of the patient in the therapeutic process. The most problematic area in the treatment process is the interpersonal aspect. The patients are in regressive state, express psychotic symptomatology and have difficulties to change. The predominant reactions of the staff are helplessness, hopelessness, confusion, anger and provocation. Their reactions push the therapist to find new ways to involve the psychotic patients in the therapeutic process.

Second factor: *Severe character pathology*, wich means behavioral manifestations. These patients are controlling, demanding, verbally and sometimes physically hostile, who sabotage the treatment process. They divide the staff by their highly manipulative behavior. The therapists expect more from these patients, than they are able to offer and benefit from the therapeutic process. The most problematic in the treatment is the structure and the control aspect. The predominant reaction of the staff is anger, wich may influence the admnistrative, disciplinary and therapeutic decisions, and may cause to certain patients and therapists to perceive structural measures as punitive.

Third factor: *Violence-agitation*, wich is manifested by impulsive, violent behavior. The patients evoke in the staff the feeling of

dissatisfaction with teamwork, wich leads to inability maintaining an organized, shared and cohesive treatment plan. The predominant reaction of the staff is characterized by striving to develop a coordinated therapeutic program. Other reactions of the team are divided. The psychiatrists feel confused and helpless. The social workers express sense of positive engagement. The activity therapists demonstrate anger and the nurses reaction is divided. The majority of them react with fearfulness.

Fourth factor: *Suicidal-depressed behavior*, characterized by depressed, self abusive suicidal conduct. In the treatment process they vacillate between progression and regression. The team unconsciously prefers depressed patients to violent clients. The predominant reactions of the team are protectiveness and positive interest in the patient. While social workers and nurses express a wide range of feelings, psychiatrists and activity therapists have no consistent emotional reactions.

In an earlier study Colson et al, (1986) reached the conclusion that all the above mentioned mental health disciplines shared the anger and positive engagement elements.

Anger was most highly related to psychiatrists and social workers, and some overlap existed between both of these professions concerning the helplessness and confusion elements. For nurses and activity therapists anger was connected with helplessness. Fear appeared only for nurses and social worker. According to the study, anger, fear and helplessness lead to extensive treatment difficulties.

8. CRITICS AND ISSUES FOR DISCUSSION

Although forensic psychiatric hospitals are registered and admnistered as medical institutions, «the special hospitals are most accuratly understood as prisons for the mad, the incorrigibly bad and the unintelligibly dim» (Ramon & Giannichedda, 1988). The existence of forensic psychiatric hospitals arise several crucial questions. A few of them will be mentioned.

1. The prisoner is sentenced to a determined term, whereas the stay in the forensic psychiatric hospital is undetermined. This anomaly was attacked in 1966 by the US Supreme Court in the Baxtroom v. Herald case. The court ruled that «mentally ill persons could not be held in a maximum security hospital longer than a criminal sentence, without a hearing on the substantive issues of that commitment» (Amit, 1989, Unpublished paper).

2. The large forensic psychiatric hospital are organizationally and professionally isolated from the national mental health network. «They are characterized by a corrective feedback» (Ramon & Giannichedda, 1988).

3. The hospitalized patient are often dislocated from their family and their social surroundings, making difficult to plan an affective family, social and vocational rehabilitation program.

4. The level of security restrictions is equal for most of the patients. The concept of differencial security seems to be complicated for the custodial staff and probably even for the treatment team. According to Taylor (1991): «Of the 702 patients in the 1990 special hospital census rated as still requiring maximum security alone»... «Many of these patients pose relatively special high risk» to certain type of people «with whom they have had intense relationship, but they pose low risks to more neutral... figures».

5. Forensic psychiatric hospitals contain long-term populations. The average length of stay is 8,5 years (Taylor, 1991; Uys, 1991). The therapeutic element is unproportionally short related to the extremely long stay in the hospital. Emphasis is lead on custodial care. Chemotherapy is applied as main treatment modality, and psychotherapy is neglected, or poorly performed. There is no well designed activity for the inmates, and they are understimulated.

6. The patients behavior is evaluated during the hospitalization, on the basis of their index offence and not according to their progress in therapy. The staff observes institutional behavior and not psychodynamical developments.

7. The staff of these hospitals is in danger to be cut off from the main stream of mental health and becoming isolated, marginalised and building up ghetto like professional life. Therefore therapeutic staff must be subjected to high standards of training and to very intensive personal and group supervision. The

forensic hospital has to develop strong links with the local Mental Health Services and professional organizations, and seek university affiliation and accreditation. The forensic psychiatric hospital should become the source of forensic psychiatric liason and consultation for the entire mental health system. It should be the adequate facility for training in forensic psychiatry and clinical criminology for the medical, criminal justice, correctional and rehabilitation professionals. At last but no least, the forensic psychiatric hospital is the ideal place for qualified forensic research activity.

All these activities are accurate measures to prevent the marginalization of the forensic psychiatric staff and to turn the profession into prestigeous challenging subspeciality, wich possesses the capability to work with the dangerous-violent patient simultaneously within two differently conceptualized systems; in the judicial and health network. The professionals working in the general health system are unable to treat patients in terms dictated by a non-medical system. Their main activity is merely to restricting the patients.

9. FURTHER DEVELOPMENT

The theoretical and practical questions concerning the further development of the forensic psychiatric hospital are related to seven main issues.

1. If there is justification to maintain the isolation and special quality of the forensic psychiatric hospitals, located inside and outside the prison system?

2. If there is justification to conserve the over-regional character of this hospital type, or it would be preferable to build regional forensic institutions? The regional forensic catchment area concept may terminate the dislocation of the patient from his/her social set-up.

3. If there is justification to prefer running large security hospitals to ward-like units? In smaller units the continuity of care is better secured than in a large hospital. Planning, design, organization and quality assurance of treatment programs are better carried out at ward level. The main question is if it would be possible to find sufficient resources and staff for these units?

4. If the time is ripe to provide full range of forensic psychiatric services on one site, or as separate units or part of the national community mental health services? This kind of organization will be able to solve one of the main bottle-necks of the system; lack of after care facilities. 16% of forensic psychiatric hospital patient are still held because of the refusal of the general psychiatric after care units to treat these patients (Ramon & Giannichedda, 1988). The comprehensive units will be competent to carry out all kinds of forensic out patients activity, including crisis intervention, ambulatory forced treatment and delivering services for the local jails and regional prisons.

5. If the time is mature to abandon the «worst contingency planning» concept (Ramon & Giannichedda, 1988) and introduce the differential stage-oriented security system? This means either to build different security level units on different sites or provide stage-security facilities within one forensic hospital.

6. It is time to establish appropriate set of criteria for criminal or civil commitment to the forensic psychiatric hospital, which should include the following elements: (a) The presence of mental illness or serious personality disorder; (b) The patient is not appropiate for hospitalization in a mental health facility because of disruptive behavior; (c) The mental condition of the person requires security measurement in order to prevent endangering others.

7. If it is time to establish a university department of forensic psychiatry and clinical criminology, which will be responsible of the training and supervision of forensic personnel and for conducting forensic research?

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ABSTRACT

Recently we witness in several countries the spontaneous emerge of forensic psychiatric networks. The units of the network admit mentally ill or severly disturbed offenders who are in need of treatment in special units equipped with security means. The hospital orders are issued in the various countries by legal or medico-legal agencies. The hospital order is issued for treatment purposes, sometimes without the consent of the patient, but it contains therapeutic and punitive elements as well.

The forensic psychiatric network, which is composed by the maximum security-hospitals and by the medium security regional units, is characterized by the combination of security and therapy. The security parameters of the forensic psychiatric institute constitute physical, administrative and professional elements. The professional one is recently perceived as the main security factor. The offender-patients who consume more and larger variety of therapeutic services, need more emergency interventions and medication, are characterized by feeling of basic untrust and frustrate their therapists. In spite of these characteristics, the basic human attitude towards the clients should be absolut honesty and loyalty. The basic therapeutic approach is the comprehensive one, which comprises a great variety of methods.

The staff working in the forensic units faces problems unknown in the conventional psychiatric setup. It is difficult to tolerate a long-term relationship with hostile people who perform actual violence and simultaneously using the relationship as a holding measure. Another difficult field is the transference-countertransference relationship. It is well known that the forensic patients evoke the most intense and problematic countertransference reactions, which must be elaborated by the individual therapist and by the entire staff. In the paper we present the results of Colson's study (1990) which deals with the countertransference reaction types concerning the forensic patients. Anger, helplessness, confusion, hopelessness and positive engagement.

RESUMO

Nos últimos tempos, verifica-se a emergência espontânea de redes de psiquiatria forense em diferentes países. As unidades da rede admitem delinquentes doentes mentais ou com graves perturbações e que têm necessidade de tratamento em unidades especiais, equipadas com meios de segurança. As ordens de

internamento hospitalar são emitidas, quase sempre, pelas autoridades legais ou médico-legais, por vezes sem o consentimento do paciente, tendo em conta não só o aspecto terapêutico mas também o punitivo.

A rede de psiquiatria forense, que é composta por hospitais de segurança máxima e por unidades regionais de segurança média, é caracterizada pela combinação de segurança e terapia. Os parâmetros de segurança das instituições de psiquiatria forense são constituídos pelos elementos físico, administrativo e profissional. A componente profissional é vista, actualmente, como o principal factor de segurança. Os pacientes delinquentes que consomem uma mais ampla variedade de serviços terapêuticos, precisam de mais intervenção de urgência bem como de medicação, caracterizam-se pelo sentimento de desconfiança básica e são frustrantes para os terapeutas. Apesar destas caracteristicas, as atitudes humanas básicas em relação aos clientes deveriam ser a honestidade absoluta e a lealdade. A abordagem terapêutica de fundo é a compreensão, que contém uma grande variedade de métodos.

Os técnicos que trabalham nas unidades forenses são confrontados com problemas desconhecidos nos quadros psiquiátricos convencionais. É difícil tolerar uma relação de longo termo com pessoas hostis, que têm comportamentos realmente violentos e que, simultaneamente, usam a relação como uma medida de *holding*. Outra área de dificuldade é a que respeita à relação transferencial e contratransferencial. É sabido que os pacientes forenses suscitam as reacções contratransferenciais mais problemáticas e intensas, que devem ser elaboradas quer pelo terapeuta individual quer pelos técnicos em geral. No presente artigo, apresentam-se os resultados do estudo de Colson (1990) que aborda tipos de reacção contransferencial em relação aos pacientes forenses: Ira, sentimento de intolerância, confusão, desespero e restrições reais ao envolvimento.

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