

Mental Health Care in Correctional Settings in European Countries: France, Switzerland and Scandinavian Countries

FRANCE

The article by Pierre Lamothe, a psychiatrist with legal expertise, discusses the reorganization of psychiatric services that has occurred in French penal institutions in recent decades. The government has had to change its health services as a result of fewer psychiatric hospitalizations and an increasing number of offences by mentally ill persons.

Before 1977, most prisoners requiring psychiatric services were incarcerated in *maisons d'arrêt* with offenders who did not require mental health services. These *maisons d'arrêt* generally housed persons awaiting trial, drug addicts, juvenile delinquents, and offenders serving short sentences. Offenders serving long sentences were incarcerated in central maximum security prisons or medium security correctional centres.

In 1977, the first of 17 *centres médico-psychologiques régionaux* -CMPR - (regional medical-psychological centres) was built as an annex to one of the larger *maisons d'arrêt*. The name of the centres was legally changed to *Services médico-psychologiques régionaux* (SMPR) in 1986. However, the original name (CMPR) is retained in this article.

Now, when offenders are admitted to a CMPR, the psychiatrists introduce them to quasi-traditional therapeutic techniques that will teach them how to help themselves for example, visualization therapy, interpretive psychotherapy, support therapy, and individual or group relaxation.

A new technique that has emerged in recent years uses the body as a means of expression. A biofeedback therapist shows the patient how the body can be used in non-aggressive and respectful ways when interacting with others.

According to the author, the medical-psychological centres have allowed the French prison system to respond more effectively to the special needs of mentally ill inmates.

Lamothe, P. (1988). "Problèmes quotidiens de psychiatrie pénitentiaire à travers les changements du paysage psychiatrique et pénitentiaire de la France," *Criminologie* XXI, no.2, 63-81.

SWITZERLAND

The agreement on prison sentences that was concluded in 1969 among 26 Swiss cantons provided for the establishment of special institutions for mentally ill patients. As a result of this agreement, the Centre de sociothérapie pénitentiaire La Pâquerette and the Quartier carcéral psychiatrique (QCP) were built to house this special-needs population.

Marie-Jeanne de Montmollin, of the Institut de médecine légale in Geneva, examines both of these

establishments in her article. However, as the QCP opened only in 1988 and houses a maximum of seven patients on a short-term basis, the present article focuses on the operation of the La Pâquerette facility

When it first opened in 1979, the La Pâquerette centre operated as a sociotherapeutic day clinic for offenders who had problems functioning in the regular inmate population of the Geneva prison. In 1986, the La Pâquerette centre increased its program capacity to allow more inmates to participate. Inmates can now stay at the facility, rather than visit on a daily basis to attend the program.

In order to be admitted to the program, inmates must apply to the management of the centre and of the prison where they are incarcerated. The La Pâquerette centre accepts only inmates who are suffering from severe personality disorders with sociopathic traits, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III).

The majority of the patients treated at the centre are impulsive, are violent repeat offenders, display sexual deviance, anxiety and depression, and feel they have not accomplished anything in life. The major crimes of inmates who have stayed at the centre for more than four months since its opening have been murder, attempted murder, serious bodily injury, sex offences, arson, robbery, property offences and drug offences.

The main objective of the program is to teach offenders to take responsibility for themselves. The first step is to require the inmates to make a commitment to the program. They must sign a renewable four-month contract committing them to active and positive participation in the centre's activities and to good conduct. Inmates can be expelled from the program for committing a serious infraction. For less serious infractions, inmates may be barred from certain daily activities.

Patients are encouraged to participate in discussions, listen to others and talk about themselves in order to learn to express their feelings and emotions and relate to others in non-violent ways.

Therapists, inmates and other staff members attend general meetings three times a week to discuss and address problems related to community life. Decisions on the centre's internal operation are arrived at by a majority vote. Other, more structured meetings, held twice a week, are designed as a forum for patients to discuss their personal problems with therapists. Treatment also takes the form of general activities (crafts, sports, religious services, etc.).

A great deal of emphasis is placed on the social reintegration of the offender. After patients have successfully completed the program, they are introduced to other activities that are more specifically designed to familiarize them with the realities of daily life in the community. Rather than being released immediately into the community, patients are prepared gradually for reintegration. They are sent on escorted outings and are taught the basics of life on the outside. The reintegration process is very similar to psycho-social programs offered in Canada.

Between August 1, 1979, and April 30, 1988, 123 inmates participated in the program; of that number, 23 did not complete the program - 10 quit and 13 were expelled. Of the 55 offenders who completed the program after a stay of longer than four months, 20 were convicted again within two years of their

release, 19 disappeared, and 16 had not recidivated at the time this data was collected.

De Montmollin, M.-J. (1989). "La prise en charge des délinquants mentalement anormaux dans le cadre du concordat sur l'exécution des peines et mesures entre les cantons romands (Suisse)," *Revue internationale de criminologie et de police technique*, March, 308-329.

SCANDINAVIAN COUNTRIES

It is well known that, compared with the Western world, the Scandinavian countries have very low rates of incarceration, especially for serious offences, such as robbery and assault. The management of mentally ill offenders in these countries is also unique.

Although each monarchy has its own penal code and legal process, there are similar approaches in dealing with mentally ill offenders.

A common principle in Scandinavian penal codes is that persons found to be not responsible for their behaviour cannot be punished. There is no consensus, however, on the criteria for identifying criminal responsibility and classifying people as insane or severely mentally deficient. In Denmark and Sweden, for instance, the ability of offenders to understand the implications of their conduct is a criterion for criminal responsibility, whereas in Norway, this is not a criterion. Although sanctions can be omitted for these offenders, special sanctions are applied in most cases.

When mentally ill offenders are found not liable for punishment, they can be sanctioned to preventive detention institutions, which are part of the prison system and run by the department of justice. In 1989, the prison system in Norway provided 133 preventive detention beds, some of which were occupied by general population prisoners. Sweden and Denmark, on the other hand, did not provide this type of accommodation.

In the same year, beds in psychiatric units accommodated 139, 22 and 65 mentally ill offenders in Denmark, Norway and Sweden, respectively. Mentally ill offenders found not liable for punishment can also be committed to psychiatric institutions run by the health authorities as part of the regular mental health services delivery system. The mental health care system provided special maximum security psychiatric wards of 25, 15 and 373 beds for the respective countries.

As Professor Georg Hoyer indicates, mentally ill offenders found not liable for punishment are usually ordered to an initial maximum length of confinement. This order can be renewed an unlimited number of times if the authorities deem it necessary. A potential drawback noted by Hoyer is that the offenders may spend more time in confinement than if they were sentenced to regular incarceration.

Mentally ill offenders who are found liable for punishment are treated by health services established within the prison and under prison administration. According to Hoyer, these offenders are often left with other inmates who object to their presence and staff who are not qualified to deal with their acute problems.

If not placed with other inmates, mentally ill offenders found liable for punishment may be referred by the courts to involuntary treatment programs. In Denmark and Sweden, mentally ill offenders undergo treatment within the mental health services, whereas in Norway they spend their treatment time within the prison system.

Mentally ill offenders who are referred to these involuntary treatments often suffer from behavioural disturbances such as psychopathic disorders and borderline states, substance abuse and mild mental disorders. In Sweden and Denmark, involuntary treatment can be applied instead of punishment or in addition to it, as it is in Norway.

There is an ongoing debate in Scandinavia about whether the small number of mentally ill offenders found liable for punishment should be referred to regular mental health services because they suffer from medical problems. Courts and prison administrations argue that public mental institutions cannot provide the level of custodial security required to care for mentally ill offenders. Revision of the Scandinavian penal codes, currently under way, will focus on the transfer of management of mentally ill offenders.

Professor Hoyer points out that Scandinavian and Western countries face similar problems in the management of mentally ill offenders.

Hoyer, G. (1988). "Management of Mentally Ill Offenders in Scandinavia," *International Journal of Law and Psychiatry* 11,317-327.

The above articles seem to indicate that mental health care for mentally ill offenders is as important in European countries as it is in Canada. It is interesting to observe the similarities in the management of mentally ill inmates. Like many other countries (including Canada), France experienced a deinstitutionalization of its psychiatric hospitals in the 1970s. In 1977, the French Government made sweeping changes in health care services to the country and the prison system, and made provisions for the ever-increasing number of mentally ill offenders populating the prisons.

In Switzerland, mental health care for mentally ill inmates closely resembles some of the therapeutic programs and approaches used in the Regional Psychiatric Centres of the Correctional Service of Canada.

And at first glance, Scandinavia's categorization of mentally ill offenders - those who are responsible for their actions and those who are not resembles the Canadian model. It is interesting to see that the Scandinavians are revising their management process with respect to this clientele in order to shift the responsibility for the mental health care of offenders from the prison system to the regular health care system.