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Tales from Münchhausen's country: forensic psychiatry in Germany

GWEN JONES, Niedersächsisches Landeskrankenhaus, D-3413 Moringen, West Germany

It was with some surprise that I learnt I should be settling but a stone's throw away from Baron von Münchhausen's birthplace in today's West Germany. The house at Bodenwerder on the Weser where he was born now serves as the town hall; the Münchhausen family had obviously been influential in the area for when I began to work in the psychiatric hospital at Moringen, I found that the original building had been erected by them in 1738.

First conceived of as an orphanage for children of aristocratic families, the building was used for many years thereafter as a workhouse. However, its grimmest time came with the Nazi régime. Between the years of 1933 and 1945 the institution was enlarged and used as a concentration camp for "undesirable nationals", among whom were counted conscientious objectors and homosexuals. A plaque stands today on the High Street outside to remind us of this fact, and a room inside has been organised as a *Gedenkraum* to honour those who suffered.

From 1954 onwards, the building served as a hospital for the psychiatrically ill and it was designated as a forensic hospital in 1966. The present buildings are mainly new, and are clean, bright and modern. They contain excellent facilities. The Münchhausen building has been carefully restored and houses a school for patients as well as the nursing school.

West Germany has several forensic hospitals, many with additional outlying units. In all they contain a total of 3,400 beds, and serve a general population of 61 million. The hospital at Moringen contains 320 beds and is the responsible forensic hospital for the federal state of Lower Saxony. It generally takes in all the psychiatrically disturbed people who have committed an offence in that state, and who need treatment or to be in a secure place.

The law concerning the mentally abnormal offender in Germany is separated from the law concerning the psychiatrically ill person who does not offend. That concerning the mentally abnormal offender is contained within the *Strafgesetzbuch*, the Book of Penal Law (1975), and its basis applies throughout the whole of Germany. However, like the law concerning the ill non-offender, it is a little differently worded and interpreted in each federal state. The psychiatric expert assumes an important position in Germany. Perhaps in view of the country's past, personal freedom is very highly regarded and stringently guarded, in that it forms a basic part of the constitution. Any involuntary admission to hospital must take place through the judge and the psychiatrist has a correspondingly crucial legal role to play.

The basis of the law concerning the mentally abnormal offender is paragraph 20 of the Book of Penal Law, which describes *Schuldunfähigkeit*, that is, the inability to be guilty. This relates to all offences and may be proved when it is considered that because of mental illness, mental impairment, personality disorder or other abnormality of character, either the offender did not see that what he was doing was wrong, or when he did, could not handle himself accordingly. There is also a clause of diminished responsibility but this is not used as often as one might expect for the following reasons.

Firstly, the judgement of "inability to be guilty" is mildly worded and applies across the whole range of offences. In comparison with Britain, there is no need to avoid the Victorian McNaughton's Rule with its archaic result of "not guilty by reason of insanity". Also some German psychiatrists and lawyers find that they cannot make a distinction between diminished responsibility and no responsibility; one is either able or not able to carry guilt. Indeed some Western countries such as France, Belgium and Norway have no concept of diminished responsibility whatsoever (Langelüddeke & Bresser, 1976). And lastly, the ultimate part of clause 20, which states that an offender may be found not guilty when he is unable to act according to his insight, affords a deal of flexibility and often obviates the need to prove diminished responsibility.

Unlike the law in England and Wales, German law makes no attempt to define the term 'mental disorder'. The judge depends on the lengthy experience of the psychiatric witness, who must present a comprehensive and understandable portrait in each case. The psychiatrist is not obliged to fit his patient to a legal definition of disorder; he needs only to satisfy the Court that in his view the person concerned either was or is ill and may need treatment. This enables the Court to take a 'common-sense' approach to the case, as a result of which the authorities are inclined to offer constructive help to a wide range of offender.

A major departure from practice in England and Wales concerns the treatment of alcoholic and drug

addicted offenders. Whereas in England and Wales, alcoholism and drug addiction *per se* are not seen as diseases in legal terms, in Germany it is considered that a person who has an unresistable addiction is certainly ill and needs help. In relation to paragraph 20, it may therefore be further considered that such an offender is not responsible for his actions or at least that his ability to be responsible is questionable. This stance brings a sizeable proportion of offenders under the forensic umbrella.

Provisional research in Lower Saxony has shown that the success rate of treatment of alcoholic patients in forensic departments over a period of 42 months lay at 30%, in that 30% of the patients did not again come into the notice of the courts. Of those who had at least two periods of therapy, 77% remained abstinent over a long time. Noteworthy, however, was that apart from one case, all the renewed offences were committed under the influence of alcohol, possibly confirming alcoholism as a sickness (Koch, 1988).

There are three sorts of treatment facility in which it is planned that mentally abnormal offenders should be accommodated:

(a) the psychiatric hospital or department
(b) the withdrawal unit, which is the appropriate institute for alcoholic and drug addicts within the forensic system, other diagnoses having been excluded
(c) the sociotherapeutic unit. These units are mainly for the treatment of offenders with severe personality disorders who are sentenced to a minimum of two years' imprisonment and who have already at least two separate convictions of at least two years in total behind them. Sociotherapeutic units were conceived of in order to help the younger more violent offender as well as the chronic offender, bearing in mind that each convicted person might have a claim to social therapy.

The law for the provision of withdrawal and sociotherapeutic units became valid in 1975 under the aegis of the Socialist-controlled government of Herr Schmidt. Since its inception, the *Bundesrepublik* has always had coalition governments whose ministers cooperate in a way that would be unimaginable in Britain. The present coalition is, however, controlled by Chancellor Kohl's conservative Christian Democrats who are unfortunately not planning the building of any further sociotherapeutic units for the time being, and thus most candidates continue to be housed within the prison system. Nevertheless the situation in Germany is in advance of that in Britain, where Grendon Underwood and Barlinnie are the only comparable units and are anyway part of the prison system.

Prerequisites for the ordering of the accommodation of a patient in a hospital or other forensic unit apply to the mental state of the patient at the time of the hearing and include the likelihood that the patient would continue to be dangerous were he not admitted to hospital. There are limits on the time for which patients may be kept involuntarily and these are five years and two years respectively for the sociotherapeutic and withdrawal unit orders. Hospital orders have no time limit. The Court may review the patient's case at any time it wishes, but it must do so each six months for alcoholic offenders and each year for other mentally abnormal offenders.

Even though German offenders are more likely to be cared for by the psychiatric services than are offenders in England and Wales, no clear distinction is made here between the concepts of illness and badness. The patient may be seen as being both ill and bad and the judgement of the Court and his further treatment may reflect this. As a consequence he may be accommodated either in a hospital or in prison according to his condition at the time.

This flexibility in outlook is effected by the *Parallelstrafe,* which is the parallel sentencing of certain of the more dangerous patients to restriction of freedom (i.e. prison sentence) at the same time at which a hospital order is made. At first sight it seems rather strange to sentence a patient to this, especially if he has been deemed not able to be guilty, but the system functions as follows.

Normally the *Parallelstrafe* runs from the time of expiry of the hospital order, and may be administered in one of the following ways:

(a) if the patient is no longer either ill or dangerous, he will be released on probation
(b) if he continues to be dangerous but not ill, or when ill then further treatment is unlikely to maintain, cure or improve him (e.g. a personality-disordered offender who remains disordered despite efforts at therapy), then he will be detained within the prison system
(c) if he continues to be suffering from a treatable illness, he will be re-referred to hospital.

On the other hand, should treatment be considered impossible or very difficult at the time of making a hospital order, then the patient may serve or partly serve a prison sentence before entering hospital. Should the patient's mental state favourably change during imprisonment so that further treatment in a secure place becomes unnecessary, then he will be passed on to the probation system. The range of treatment and management possibilities is therefore very varied, but a disadvantage exists herein because some of the probation officers are inadequately trained in psychiatry and are not always in the best position to help their clients. A case for better cooperation between probationary and medical follow-up has been made (Rasch, 1986).

To British eyes, it might seem odd to think of gaoling patients. One need, however, only look at

British prisons where 40% of the inmates have serious drinking problems. One would also have to compare very unfavourably our overcrowded prisons and Mr Douglas Hurd's hope that the practice of 'slopping out' may cease in three years' time, with the situation in the prisons of Lower Saxony. Here, although the number of prisoners has been reduced this year from 6,041 to 5,072, the number of cells has increased from 5,887 to 6,093, the extra cells being used for recreation, hobbies and visits (Remmers, 1989). Most of the cells have their own toilets. Indeed many of our patients claim they would rather be in gaol than in hospital, as they have found the former more comfortable. I, on the other hand, have seldom seen such a well-appointed hospital.

In general the German system cares for its forensic patients flexibly, leniently and well. Baron von Münchhausen expected his audience to be broad-minded. Perhaps like that audience, we too could broaden our minds and consider other ways in which we could offer assistance to some of the more disadvantaged members of our society. Certainly we could improve our facilities.

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Psychiatric presentations to an accident and emergency department

JOHN DUNN, Senior Registrar, Department of Psychological Medicine, Hammersmith Hospital, Du Cane Road, London W12 (correspondence); and RENUKA FERNANDO, Clinical Assistant, Pembury Hospital, Tunbridge Wells, Kent

The nature, management and disposal of patients who present to casualty departments and receive psychiatric diagnoses by the assessing doctor are areas that have received scant attention by psychiatric researchers. The aim of this study was to analyse the records of such patients to see how they had been managed, in particular to document the degree of psychiatric intervention provided or offered, and to see what follow-up arrangements, if any, had been made.

The study

The hospital studied is located at the northern tip of its catchment area. It serves one of inner London's poorer boroughs and is close to a major train terminal. It has a busy casualty department, where over 50,000 patients are seen each year. There are both psychiatric in-patient and out-patient facilities on site, with two further in-patient units in the north and south of the district. There is a resident on-call psychiatric registrar, who can be called to assess patients in the casualty department outside of hours. During the hours of 9 a.m. to 5 p.m. the same on-call registrar can be requested to see urgent psychiatric referrals from the casualty department in the out-patient department.

All the casualty cards for the first six months of 1986 were scrutinised (n = 25,651). Information was recorded only on those patients who were judged by the casualty officer or the duty psychiatrist to be suffering from a psychiatric disorder. Patients with a psychiatric history who presented with a physical problem were excluded. Patients intoxicated with