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INFORMAL AND FORMAL SOCIAL CONTROL OF MENTALLY ILL PERSONS

Forms of indirect social control of mentally ill persons are presented first, through the attitudes on normal and pathological mental state, as well as prevention and treatment of mental disorders.

Subsequently, the control of mentally ill patients by legal provisions is analysed, as well as the issue of mental incompetence from a legal, psychiatric and ethical perspective.

Legal provisions regulating involuntary hospitalization are specifically analysed.

The conclusion points to a series of unsolved social, professional, normative and political dilemmas related to social control and legal provisions regarding the social control of mentally ill persons.

Key words: *Social control of mentally ill persons. – Mental incompetence. – Law and psychiatry*

INTRODUCTION

Sociologists have been researching social control of mentally ill persons for over a century (Ross 1901, according to Horwitz 1982). On the principle, only those members of the society who violate social norms, namely those who are deviant in the broadest sense of the word, are subject to direct social control. Social control in those cases is established through either informal (education, public opinion or socialisation in the broadest sense), or formal mechanisms (regulations – written norms), that is, through social institutions (police, judiciary, health-care). Social control generally means that certain measures are undertaken against particular deviant phenomena – either negative (sanc-

tions), or positive ones related to providing support in various forms of conforming a deviant person to social norms.

Intensive research this subject dates back to 1950's, when a US couple Cumming (Cumming, Cumming 1957) initiated research of attitudes towards mentally ill persons, and was continued through famous studies of Hollinshead and Redlich (1958), and Goffman (1973) and Silverstein (1968), up to more recent works investigating social and other aspects of involuntary hospitalisation in a thorough manner (Bruns 1993). Historically speaking, the most severe aspect of control of mentally ill persons were the measures imposed in Germany during the Nazi regime (1933–1945), as they executed around 100,000 mentally ill persons or performed involuntary sterilisation of several hundreds of thousands of the mentally ill, mentally retarded and epileptics. Involuntary sterilisation of the mentally retarded, truthfully speaking, was being carried out in other countries as well. Until recently, the sterilisation of the mentally ill was being carried out in France – around 30,000 women and several thousand men were sterilised, and similar was happening in the USA during the 19th century, as well as in Scandinavian countries and Canada (Giami 1998). Sterilisation was performed with the intention of the society to biologically control unacceptable consequences in violating norms of sexual behaviour of mentally retarded persons (such as public masturbation, voyeurism, etc.), but also and not so rarely out of eugenic motives, namely, with the intention of preventing birth of mentally handicapped in a wider sense, which was, doubtlessly, being done with racist motives.

According to certain authors, the issue of social control of mentally ill persons is a matter of examining social conditions of getting and maintaining the label of mentally ill, even accepting treatment in the form of psychotherapy (Horwitz 1982).

We are of the opinion that social control of mentally ill persons has two key aspects. The former being informal, related to attitudes towards mental disorders, education and generally unwritten norms of behaviour. The latter being formal, namely legal, regulated by positive laws, and related to normative regulations of treatment of mentally ill persons, including the issues of statutory definition of mental incompetence. Informal control of mentally ill persons is unavoidable issue of psychiatric sociology, since it involves analysis of attitudes towards mentally ill persons and presentation of socio-genesis of mental disorders, and to a part it is an issue of sociology of psychiatric theory and practice, without which the contents of this subtype of sociology is unthinkable.

INDIRECT OR INFORMAL CONTROL OF MENTALLY ILL PERSONS

Explicit control of mental disorder or insanity in its lay sense begins with the Enlightenment, precisely speaking the epoch of Rationalism – the end of the 18th century. Rationalism strongly and in a versatile manner opposed insanity as non-reason, as an anti-thesis of the ideal advocated by the Enlightenment. Rationalism, on the other hand, valued predictability, measurability and objectivity of human behaviour. Separation of mentally ill persons from other marginal ones (criminals, prostitutes, the homeless, vagrants) in prison settings did not, as emphasised by D. Kecmanović in his latest book „Individual or Social Disorder" („Individualni ili društveni poremećaj, 2002), mean their liberation. It was in fact the beginning of 'locking' insanity into madhouses, later on named psychiatric or asylum institutions in the widest sense. Insanity managed to get rid of the unwanted grasp of poverty, immorality, laziness and crime, but was subjugated and isolated from everything rational in the society. It underwent total derationalisation, not only in a cognitive or social manner, but also in terms of its values. Truthfully speaking, any psychiatrist as a beginner very quickly learns that an insane person is ill only for a period of time, and in a limited sphere of his psychical life, but this is not generally accepted by a wider social public. This process was opposed by anti-psychiatrists. When failing to reform the society, which, in their view was responsible for creating insanity as a medical category, as a social myth (Szasz 1980) or overall metaphor of evil, including madhouse as its institutional expression (Goffman 1973), anti-psychiatrists declared insanity revolutionary, not only for an individual and his/her family (English anti-psychiatrists) (Laing 1977), but also for the society in general (so-called socialist collective of psychiatric patients from Heidelberg and certain Italian anti-psychiatrists) (Basaglia 1978).

Mentally ill person does not behave in a cooperative manner when speaking of respecting valid social norms – therefore the society has always felt invited to impose outer will upon it, namely, the rules of mutual communication. In fact, a mentally ill person offers to the society his reality as a generally valid one, beyond generally accepted categories of social usefulness, social regulation, general well-being, in a word, beyond the semantic frame of communication. Therefore, response of the society to such state of affairs in communication with a mentally ill person is manifold, and embraces various segments and aspects of social life of a mentally ill person. A. Hollinshead and F. Redlich in their publication „Social Class and Mental Illness" (1958), and some time later Srole L. et al, in their also frequently cited publication „Mental Health in a Metropolis" (1962) used sociological field findings to point to the indirect control of mentally disturbed by the society achieved through ignoring,

then segregation, and finally moving them to lower social strata, namely, central districts of megalopolises.

F. Basaglia (1978) believes that essentially punishment of the society in the social control of insanity is due to different behaviour and thinking. In a milder form it is manifested as informal despise, derision, nonverbal gesture of scorn carrying the message that somebody is 'lunatic', then it intensifies as more or less exerted pressure on a 'strange' man to undergo treatment, while in its most serious form social control is manifested in using physical force during hospitalisation and tying a patient in psychiatric hospitals.

The control of mentally ill persons also depends on their social status. Summarising the results of a research on the treatment of mentally ill in the US, Cockerham (2002) claims that the most severe social control, that is, the cruelest treatment of mentally ill persons, is applied with patients from lower social strata, especially if they are black or are very poor immigrants. Somewhat better treatment is provided to the patients from lower economic stratum of domicile population, while the best treatment is reserved for domicile population with better spending capacity. The latter ones are treated in a discrete way, either through psychotherapy in their household settings or at specialised highly-comfortable institutions. Social control is also somewhat less strict in situations in which both a therapist and his patient come from the same social stratum or the same cultural circle, since in such a case there are social prerequisites for development of empathy, trust and good cooperation between them.

Psychotherapy, beyond any doubt, poses a sort of social control of mentally ill persons, although far more discrete and subtle than other kinds of control, since psychotherapists in a way transmit the outer pressure of the society on an individual to adjust to the existing social order, especially the social distribution of power. Psychoanalysis, in its own way, paved a way towards creating a comprehension, or precisely speaking justified the attitude that violence, namely aggression, is a natural way of establishing social order, since it, beside sexual drive, brought to the front the explanations of human nature and origin of mental problems, aggressive instinct. According to psychoanalytical opinion, covert readiness for aggressive, even destructive reaction lies in every person (Thanatos instinct or death instinct). Finally, medicalisation in psychiatry is considered, especially in anti-psychiatric opinion, a method of biological, or so-called internal control of mental patients, being a perfidious or so-called invisible internal bonding of a mentally ill person.

The society performs indirect control over mentally ill persons in other ways that are more difficult to recognise. They are related to primary prevention of mental diseases through various institutions (for

example health-care centres) that prior to the appearance of disorder symptoms undertake certain measures aimed at making mental diseases remain socially invisible or masked (which is especially successfully done in higher social strata), or aimed at preventing the appearance of these symptoms as they be undesirable form of behaviour. It is related to social work or family treatment of various sorts, in which, through social setting of treatment or through the phenomenon of group pressure, conformation to general social rules of behaviour is attained, and not only alleviation and providing solutions to so-called life problems of people. This aspect of indirect social control is even more evident in sociotherapy, treatment of mental difficulties in large groups (consisting of more than 25 members), such as therapeutic community, clubs of chronically ill psychiatric patients. This aspect of indirect social control is also visible in other measures of so-called tertiary prevention of mental disorders.

The control of mental disorders is also realised through compulsory following-up of mental health of population (so-called follow-up projects) carried out through performing control check-up of persons suspected of having mental problems, the aim of which is on one side professional and therapeutic, and on the other socio-restrictive. The society defends itself in advance from unpredictable and mentally incompetent behaviour of a potentially mentally ill person by de jure preventing such behaviour, while de facto protecting its own integrity and functioning of some of its segments (Bowers 1998).

Indirect and invisible control of mentally ill persons is also relatively easily recognised in attitudes towards them. The expression 'madness' is quite often used as a verbal 'bludgeon' in public or private disputes of both anonymous and public persons. The expression 'madness' has a sad unconscious collective pre-history in the prosecution of mentally ill women as witches during the Dark Ages and confining political dissidents to psychiatric institutions in various totalitarian regimes on the pretext of their being mentally ill. Not only were political dissidents confined to such institutions, they also bore the label of being dangerous to the whole society. It is no wonder that psychiatry today, thirty years after the anti-psychiatric wave, is still being criticised to an extent and in a way that brings into question the whole purpose of its work, which has never been the case with any other discipline of medicine. In that respect, the ruling social elite (political, but also information and media elite, even cultural) still tacitly leaves to psychiatrists not only to help, but also to control mentally ill persons on its behalf (especially if mentally ill persons, beside being mentally ill, publicly oppose that elite). The elite members then, from time to time, hypocritically and publicly attack not only the asylum psychiatry, but also true enthusiasts in mental health protection, not to mention their derisive treatment of mentally ill persons

and frightening people with unpredictable aggressiveness and bizarreness of behaviour of mentally ill persons.

CONTROL OF MENTALLY ILL PERSONS THROUGH LEGAL NORMS

The control of mentally ill persons is more noticeable in regulations related to a range of relations of the society towards mentally ill. One of the most important is the issue of so-called general danger by the mentally ill, as well as the issue of regulating offences and possible criminal acts of mentally ill. Interest in this, legal, aspect of control of mentally ill persons has extremely increased in the last 15 years, and is, justifiably, as pointed out by Legemaate (1998) brought into connection with observing human rights as an aspect of the political trend of globalisation in the world.

The concept of defining social danger of mentally ill persons is related to its three basic dimensions: 1 – danger to his/her own self (self-injury, suicidal ideas and suicidal attempts), 2 – danger of a mentally ill person to others (homicidal ideas, threats and attempts), and 3 – danger to property. The listed dangers are variously defined by penal laws of various countries, and they define conditions under which involuntary imprisonment of mentally ill persons is performed if reasonable doubt exists that a certain act has been done by a mentally ill person. In such cases what is insisted on is objective and unambiguous evidence, less often on the formulation 'beyond sound mind' (as defined, for example, by the law of certain US states).

Countries with democratic political systems realise their need to define issues related to problems with mentally ill persons in three different ways. These include: 1 – legal definition of a mentally ill person as posing a danger to his/her own self, others or property (force in these instances is applied in the name of protection of civil rights of others); 2 – legislation of procedure and duration of process of forced confinement and treatment of mentally ill in closed in-patient wards; and 3 – precise normative definition of force as a measure of intervention over an ill person. As for the first aspect of the problem, researches have shown that making certain diagnoses to mentally ill persons such as sexual harassment or drug addiction significantly increases probability of legal prosecution and conviction. Therefore, opinions (Graf, Eichorn 2003) that psychiatric patients are over-criminalised – especially those treated under the diagnoses of 'Personality disorder' and 'Drug addiction' – are heard more and more often. In relation to this, the criticisers of normative stipulations related to the problem suggest that instead of the conviction

to mandatory treatment at closed-type institutions, intensive care of these people should be carried out in out-patient conditions (so-called out-patient commitment programme) (Hiday et al 2002).

Psychiatrists have a tendency of declaring a mentally ill person dangerous even if the person essentially isn't, claims the well-known US sociologist Cockerham (2000) referring to several sources. The concept of posing a danger to somebody else is difficult to define, since it involves mental danger (for example mental abuse). Therefore, for example, the new Family Law of Serbia that came into force in 2005 stipulates the possibility of a prompt, without additional checking, engagement of police in the protection of women who believe to be physically and mentally abused, which was not the case with the previous Family Law.

In the majority of the US states a mentally ill person is entitled to a lawyer, to remain silent, to bail, to trial, to damages by court etc. In Serbia, two years ago, an institution of so-called 'patient's lawyer' was introduced. This lawyer is appointed by the general manager of the mental institution (therefore, the Ministry of Health Care), and is to settle disputes of patients with doctors and other medical staff. I am, however, afraid that he is too far from a real patient's lawyer, for being in an unsolvable institutional collision, since he is to get engaged against those he depends on institutionally and psychologically, on behalf of those who are, on the other hand, completely dependant on him.

In his textbook of forensic psychiatry B. Krstić (1980) lists all areas of this issue regulated by law in Serbia. They include compulsory psychiatric treatment and confinement to a mental institution, including two-fold imprisonment, namely, measures of compulsory treatment at a prison psychiatric ward, compulsory psychiatric treatment at liberty, as well as involuntary treatment of alcoholics. Referring to the latest law provisions on this issue, A. Jovanović (2004) adds another three areas. These are: statutory regulation of the role of mental illness within marriage and family relations, than the issue of deprivation of business capacity and defining sanity of a mentally ill person, which are in Serbian law defined by different enactments. Serbian law excludes the possibility of getting married in cases of mental illness, while mental illness during a marriage is indicated as a possible reason for divorce. The above author considers this statutory solution anachronistic. In our opinion – justifiably, for several reasons – a mentally ill person is also entitled to marriage and parental happiness, and the loss of these rights every persons takes as existential breakdown and/or confirmation of civil discrimination. The above-mentioned measures, at least according to the laws in force in Serbia, can be both of temporary and permanent character. Compulsory psychiatric treatment and confinement to an institution is stipulated for persons who commit serious criminal offences (such as

murders) and who suffer from permanent or temporary mental illness. In other words, the offender was, according to legal assessor's findings, at the moment of committing the offence, partially or fully mentally incompetent.

Under the Criminal Code of Serbia, mental incompetence as a forensic and psychiatric category relates to persons who, at the time of committing criminal offence, could neither understand the meaning of their acts, nor control their own acts due to mental illness, temporary mental disorder, mental retardation or a more serious mental disorder, in the cases of which the origin of mental problems is of no importance (Stojanović 2006). The first part of the reasons for mental incompetence (mental disorder) is of psychiatric nature, while the second (retardation) is of psychological or even biological nature, since being related to certain hereditary diseases. The status of mental incompetence is determined by a judicial procedure, and it implies determining incapacity to understand the significance of consequences of one's own actions. This incapacity includes: 1 – cognitive inability of understanding the significance of incriminating act, for which examination of mental functions of memory, learning and observation is necessary, and 2 – inability to control one's own actions, which is related to hindrance in making decisions and performing voluntary actions. The latter is more related to the inability to control emotions, namely, it points to aggressiveness and impulsiveness of various origins, and need not be related to the former definition of mental incompetence, namely to inability of understanding the significance of one's own actions (Ignjatović 2005).

Presenting German laws regulating this issue (and Serbian laws were drafted on the model of German or Austro-Hungarian laws), Hartwich (1982) notes that mental incapacity relates to four categories of mental state, which to a degree or fully exculpate the perpetrator of the criminal act from responsibility. These include: 1 – serious mental disorder (schizophrenias, manic-depressive psychoses, organic psychoses); 2 – serious disorders of consciousness also comprising affective narrowing of consciousness. The diagnosis of affective narrowing of consciousness must, according to German laws, meet the following criteria: a) the interruption of continuity of meaningful action, b) the performed act is not typical of the perpetrator's personality, c) the amnesia for performed act is evident, and d) it is evident that the perpetrator is emotionally affected by his act when the narrowing of consciousness ceases. The remaining two categories of mental states that can be enough reason for declaring a person mentally incompetent are: 3 – a high degree of infirmity of mind (oligophrenia and dementia), and 4 – so-called other serious mental alterations (serious neurosis, psychopathies and unsocialised perversions).

It should be noted that from the psychiatric point of view, mental incompetence can be stated only if the following criteria related to mental status are met: 1 – presence of disturbed mental state (the above-mentioned illnesses), 2 – the absence of free will in making decision at the time of performing the criminal act or offence (most often due to the influence of pathologically changed mental functions), and 3 – pathologically changed mental state must be permanent. The exception to the third criterion are certain serious short-term mental disorders such as delirious states, the loss of consciousness for various reasons, epileptic and hysterical deranged states. All the listed diagnoses are also used in a judicial procedure as a legal basis for the defence of persons accused of crimes.

The US law also stipulates regulations related to 'mental illness' or 'mental defect'. The law known under the title 'The Insanity Defense Reform Act' from 1984 stipulated legal effect of the above-listed diagnoses for the purposes of defence only if the diagnose was valid at the time of performing criminal act, and if it is clearly for the purposes of defence, not prosecution (Cockerham 2000).

The circle of these issues, that is, the sphere of legal regulation of the treatment of mentally ill persons also comprises the issue of deprivation of business capacity in cases of mentally changed persons, which is regulated by the Law on Marriage and family relations. This law relates to adult person deprived of the right to responsibly defend his/her own and the interests of others, for being incapable of sound reasoning due to mental illness, mental retardation or some other reason. A guardian is to be determined for such a person, and the person can be, under the Serbian law, confined to a psychiatric institution for examination, for the period not exceeding three months.

STATUTORY REGULATION OF THE PROCEDURE OF INVOLUNTARY TREATMENT

It is almost impossible to imagine psychiatry as a profession, be it admitted by psychiatrists or not, without involuntary hospitalisation. It can follow after a criminal act or a more serious offence of a psychiatric patient, or, completely independently of the above, which is not so rare. Only the latter is involuntary hospitalisation in the narrow sense of the word, since each person in every country suspected of having committed a crime or a more serious offence on the basis of admissible evidence is arrested, independently of the state of his health. Therefore, there is almost no society that has not normatively regulated this issue.

In cases of realisation of involuntary hospitalisation without a crime committed, the US law used to stipulate the following, rather complex procedure: 1 – complaint submitted by three citizens, 2 – estimation of the reasons of complaint by a hospital psychiatrist, 3 – reconsideration of the complaint by two independent experts, one of which must be a psychiatrist – legal assessor, 4 – discussion of the court representative with the lawyer representing the patient, 5 – making a judicially valid decision on involuntary hospitalisation (Scheff 1964).

In Italy, legal enactments stipulate even more prominent role of individual citizens in making such a decision.

In Serbia, an integral law on mentally ill persons is to been enacted, and it is to regulate the area probably according to the standards of laws regulating the matter in the EU countries. In practice, a procedure similar to the US one is applied in Serbia – the court makes a decision on involuntary treatment, most often after the patient had already been involuntarily hospitalised with the support of police, when three signatures are provided on the referral to hospital treatment in which a possibility of application of force is noted.

It is interesting that forensic psychiatrist A. Jovanović (2004) is of the opinion that the authorities of the psychiatrist on duty should be even broader, counting on his good intentions (bona fide). We respect this argument, but still prefer a team to decide on involuntary hospitalisation not only for the sake of prevention of subjective mistakes made out of good intentions, but also due to neutralisation of possible outer social pressures on experts to decide on involuntary hospitalisation of a patient. A team of experts is not only more objective in assessing a need to apply force, it also more efficiently withstands para-expert social pressures (primarily the influence of socially powerful individuals and organisations).

In Serbia, involuntary hospitalisation is regulated by the Law on Non-litigious Business. The law stipulates that, if someone has been sent to involuntary hospitalisation against his/her own will, the health-care institution is to report the hospitalisation to the court on the territory of which the institution is located. The report consists of the statement by the authorised person of the institution and is to be made in the presence of two literate witnesses with business capacity who are neither employed with the institution, nor related/married to the involuntarily hospitalised person. Within a month, the court is to make a decision if the involuntarily hospitalised person is to be kept for treatment at the institution for an unspecified period of time, but not longer than a year or two years (Jovanović 2004).

In 1991 Austria enacted the law stipulating that the competent judge consent regarding involuntary hospitalisation must be obtained within four days. It is interesting that this regulation was at first taken by

psychiatrists as a bureaucratic burden, resulting in a drop of number of involuntary hospitalisation in the period of two years after the law had been passed, but the number later on rose to the level of involuntary hospitalisations prior to enacting the law (Haberfellner, Rittmannsberger 1996).

Italy has the most rigorous laws regulating the conditions of involuntary hospitalisations of mentally ill persons. The situation is similar in Great Britain, as the description 'dangerous to one's own self and others' is not enough for involuntary hospitalisation of the person qualified so by an expert.

INSTEAD OF A CONCLUSION

Concluding the issue of social control of mentally ill persons, it should be emphasised that psychiatry was given the task by the society to name subjective states, namely to attach them a connotation that implies the need for direct social control, not only by monitoring outer behaviour, but also by monitoring intimate world of people diagnosed as mentally ill or observed as dangerous to themselves or their surrounding. In this Focault saw a sort of social perversion, while Bruns (1993) saw pathologisation of all human life. The fact that the society defined by law details of this procedure, normative formulations and persons authorised to carry it out (legal assessors in Serbia must complete general professional education and must swear an oath), only determines precise details of, but does not cancel less obvious aspects of social control of mentally ill persons, especially those into which the society easily projects its own violence from other spheres of social life.

When the social control of mental disorders is concerned, regardless of how the motivation of the society to undertake it is explained, it is important to take into consideration its following aspects:

- First of all, it is carried out by means of knowledge, the general cultural and civilisation knowledge, according to which insanity negates the very rational essence of the society and relations within it understood as the common sense does. Such an attitude is passed on consciously through certain aspects of cultural heritage, and unconsciously through Super-ego of an individual, namely attitudes towards mentally ill persons acquired early in one's life, namely through identification of children with their parents at their pre-school age.
- Social control of mentally ill persons is most often carried out through professional – psychiatric, psychopathological and psy-

chotherapeutic knowledge. This professional knowledge refers to therapeutic and humane pretext related to the need to control those psychiatric patients who subjectively suffer and seek the help of professionals, and pose at the same time a potential danger to themselves and others.

- Social control of mentally ill is carried out through institutions of psychiatric character employing people with socially verified licence to diaglose, treat and limit certan social, professional, even political rights of mentally ill persons. It is forgotten that they, at the same time grant privileges to persons with mental problems (sick-leave, disability pensions and other rights ensuing from social welfare and health care), which is, according to some, a sort of more perfidious control of mentally ill persons.
- A drastic form of social control is carried out as a semi-involuntary or involuntary commitment of mentally ill persons to psychiatric institutions. This form of social control of mentally ill persons is, truthfully speaking, regulated by law throughout the world. Involuntary hospitalisation, assisted by police, can be realised only with the previously or subsequently obtained consent of experts and competent court to which under the law the 'case' is to be reported. However, numerous questions raised by this procedure remain unanswered.
- The continuity of social control of mentally ill persons is maintained by tying patients in literal sense (tying to bed with belts, or, formerly, by using a straight-jacket that were tied at the patient's back), and, more recently, by 'tying' patients in a different sense – by 'fixing' them with high doses of neuroleptics or anti-psychotics.
- The most drastic form of social control of mentally ill patients are found in the measures of compulsory treatment at prisons' psychiatric hospitals (the measure of compulsory treatment in confinement) where patients are monitored in a two-fold manner – both as criminals and mental patients – by creating a prison within a prison.
- Social hypocrisy, in which the visible aim of the treatment is reducing personal suffering, while the invisible is the control of social adjustment of clients, that is, patients in the society, is maintained through follow-up of patients in socio-therapeutic forms of treatment, through ordinary psychiatric check-ups, or by applying more sophisticated procedures. It should be remembered that the adaptation as the aim of therapy is also explicitly

marked in psychoanalysis and behaviourism, the most widely-spread and most developed psychotherapeutic modalities worldwide.

- The least researched and sociologically probably the most interesting form of control of mentally disturbed persons in a wider sense of the word is the control of personality features of socially unacceptable violent behaviour of certain social communities. Sociologists have directly taken part in this form of social control. T. Parsons (Gerhardt 1991) created the so-called programme of denazification of Germany, the aim of which was mitigation or elimination of paranoid features of Germans' characters. The programme was initiated by the USA at a political conference entitled 'Germany after the War', held after the Second World War. This gathering initiated a range of social actions, primarily in the sphere of education, but also in other areas of social life of Germany. They comprised a mixture of two types of measures, obviously in psychological sense devised after the well-know principle of 'stick and carrot'. The former (stick) is related to repressive measures, such as banning the activities and organisations with Nazi ideology, then elimination of Nazi contents from educational programmes, as well as removal of fascist-oriented teachers from schools. The latter (carrot) is related to measures of undertaking permissive actions, or actions of rewarding all forms of democratic behaviour and strengthening democratic institutions of the society in general. The question remains if the programme was related only to prevention of certain psychopathological features of population of a country (aggressiveness, paranoid and narcissistic behaviour), or to general manipulation of the society with certain democratic or some other political aims, wrapped in an ideology cloak. In other words, the question remains to what an extent the control of violence in one country was an expression of demonstration of power (bordering on violence) of another, much more powerful country.
- What remains to be done in Serbia is to enact laws that would amend negative experiences from the past psychiatric practice, and would enable mentally ill persons to exercise their right to refuse any sort of forced treatment, in accordance with their human rights, not only in a political, but also in a generally humane sense. This process has already begun in the legislation of many European countries (Netherlands, England, France, Austria, Greece and others) by defining legal and medical requirements in the procedure of solving such a sensitive issue.

Therefore, the law-making and mental health care professionals of our country are to creatively adjust the existing foreign experiences to the conditions in psychiatric service in Serbia.

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