also the most serious ethical imperatives of the institution and ultimately the law. Such a story could be told in many sorts of setting – against the rigid mores of Russian high society in the nineteenth century, as in *Anna Karenina* (Tolstoy, 1970), or against the petit-bourgeois moralities of provincial France, as in *Madame Bovary* (Flaubert, 1902). In all these stories the same message emerges: a society will tend to destroy any woman who mounts a serious challenge to its sexual and social arrangements.

This is precisely what Stella Raphael does. The problem of drawing from psychiatry here was, in part, to establish the personality and pathology of the man with whom Stella falls in love. He is a sculptor called Edgar Stark, a man who murdered his wife and was diagnosed as having a severe personality disorder with features of morbid sexual jealousy. Edgar, however, is a far more robust character than Spider and has none of Spider's difficulties with women; not, at least, until he knows them well.

It was important to examine the effect of Stella's act of transgression on the psychiatric community I have described. Stella does not get away with it. She is destroyed by her transgression, and the means of that destruction involves a display of the formidable social power that the profession of psychiatry has always enjoyed. Psychiatrists, of course, have discretionary powers with regard to an individual's freedom. The question became: what does it look like when that power is abused or when that power is mobilised in the defence of patriarchal arrangements? Or, still more alarmingly, what does it look like when the power of the psychiatrist is mobilised for purposes of his/her own?

This is more or less as far as I have got in thinking about psychiatry as an element of the novel. It is hard to know how to sum up. In terms of the stages that a novelist might pass through in dealing with a psychiatric theme, my own experience suggests that first comes research, leading to understanding, or at least an insight adequate to get one writing (such as Laing's poetic image); and ending in the organisation of the material

into a coherent narrative. This is what a writer technically might do, but to what end – merely to entertain? More than that, I think. There are thousands out there who are 'dying of thirst in a world of wet', and they, those with mental illness, are the loneliest and most stigmatised minority in our society. People must be educated about mental illness and cease to despise or demonise those who suffer it. In this regard, novelists and psychiatrists have much in common. Both attempt to make sense of human experience, particularly when that experience is at its most disordered. To explain such disorder, and strip it of its threat and horror, is to hasten the acceptance of those with mental illness in the community. The novel, I believe, can be a powerful tool for promoting such understanding.

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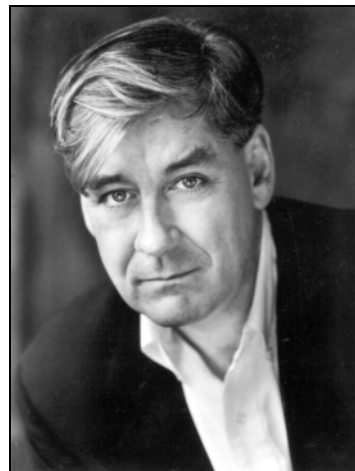
PERETZ BARAK AND HARVEY GORDON

Forensic psychiatry in Israel

Israel is a nation of ancient and contemporary interest. Its population is made up of approximately 5 million Jews, 1 million Arabs and a few other small minorities. As in the Arab world more generally, most Arabs in Israel are Muslim, with a small percentage being Christian (Bin-Talal, 1995). More than 2 million Arabs also live on the West Bank and in Gaza (Abdeen & Abu-Libdeh, 1993), currently under partial autonomous Palestinian rule and the foci for ongoing negotiation of a potential Palestinian State. Close links have historically existed between Arabs and Jews in the Middle East, notwithstanding current military and political conflict (Goitein, 1989). The city of Jerusalem is

held in reverence by all three of the monotheistic religions.

Mental health legislation in Israel

Israeli law is an amalgam of Ottoman Turkish, British and Jewish sources (Rabinowitz & Zur-Weissman, 1994). With the founding of the modern State of Israel in 1948, secular influences predominated and the sphere of Jewish law was confined to the personal status issues of marriage, divorce and burial (Bin-Nun, 1992).

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New Israeli mental health law in 1955 replaced the Asylum for the Insane Act of 1892 passed during the Ottoman Turkish Empire. British influences on the 1955 legislation were considerable. In 1991 it was replaced by the Treatment of Mental Patients' Law, the principles of which are broadly consistent with its counterparts in Western Europe and North America, taking account of aspects of patients' civil rights, including access to health records and provision of mental health tribunals. One notable difference in Israel is that civil patients are detained by the office of the district psychiatrist (Bar-El *et al*, 1989), rather than by a range of psychiatrists and social workers as in Britain.

Mentally disordered offenders (MDO) in Israel may be admitted to a hospital by order of a court. The Israeli law provides only for detention of patients suffering from mental illness, there being no legal category of psychopathic disorder as there is in England and Wales. People with learning disabilities who require detention are dealt with separately under different legislation. All decisions about transfer, discharge or leave of absence of detained MDOs are made by the mental health tribunal, there being no equivalent in Israeli law of the restriction order.

The English concept of diminished responsibility under the Homicide Act (1957) is reflected in similar, though not identical, Israeli legislation, the Law of Punishment (1977) and an amendment to it of 1995 (Margolin, 1998), which enable a sentence other than life imprisonment for certain homicides. Israel is virtually alone in the Middle-East in having no death penalty except for crimes of genocide.

Crime in Israel

Taking account of differences in the size of the populations, recent figures for convictions for homicides and rape are both higher in Israel than in England and Wales (Gordon *et al*, 1996). Convictions for violent crimes by Jews across the world have always been regarded as low. The higher crime rates of Jews in Israel than elsewhere are likely to be owing to social factors. Social class differences in Israel between Jews from Europe (and via North America) (Ashkenazim) and those from Arab and Asian societies (Sephardim) may underpin the higher levels of delinquency and crime in Israel (Hasson, 1993). Higher rates of drug misuse have also been recorded in Jews in Israel from such oriental origins (Portowicz *et al*, 1987). Rises in levels of domestic violence by Ethiopian Jewish immigrants to Israel have also been recorded (Westheimer & Kaplan, 1992). Organised crime from the former Soviet Union more generally has been felt to have penetrated Israel. Though ethnic background is not recorded specifically for those convicted of crimes in Israel, crime figures for Israeli Arabs are not thought to be disproportionately high. Indeed, crime figures in Arab countries generally tend to show relatively low rates compared to neighbouring nations of Christian persuasion (Neopolitan, 1997). There may, however, be some elevation in 'crimes of honour' in some Muslim communities, involving the killing of young women who have

formed sexual relationships of a culturally disapproved nature (Stendel, 1996). The issue of the role of ethnicity in general and forensic psychiatric practice in Israel is complex, reflecting similar debates in Britain and elsewhere (Kaye & Lingiah, 2000).

Perhaps the most prominent crime in recent Israeli history was the assassination of Prime Minister Yitzchak Rabin in November 1995. The perpetrator, Yigal Amir, sought at his trial to argue that he had acted legally under Jewish law in that the peace process was risking Jewish lives (Green, 1995). The court, however, rejected such a defence as Israeli criminal law is not based on Jewish law, and instead concentrated on legislative issues of premeditation and intention (Povarsky, 1997). At his trial, the court accepted evidence from three forensic psychiatrists that Yigal Amir was not suffering from mental illness or indeed any other mental disorder (Zabow, personal communication, 2000). In March 1996, he was convicted of murder and sentenced to life imprisonment. The presence of intensely held religious and messianic motivation at a time of rising social conflict was sufficient to account for the assassination of the Israeli Prime Minister, without any factor of mental illness in the perpetrator. This is a pertinent reminder to the public that concern about homicides by people suffering from mental illness needs to be kept in context of the relevance of a range of other factors associated with homicides in the community (Taylor & Gunn, 1999).

Facilities for the MDOs in Israel

Throughout Israel there is a comprehensive system of psychiatric hospitals and out-patient clinics for those suffering from mental illness. There are a total of 6005 psychiatric beds, providing one bed per 1000 of the population (Israel Ministry of Health, 2000). Hospital and community psychiatric facilities provide care for patients of Jewish, Arab or other origin. Until 1997 MDOs found not guilty by reason of insanity were admitted to a private psychiatric hospital that offered a degree of security, while convicted prisoners who suffered from mental illness were transferred to the hospital wing of Ramle Prison. In 1997 a new forensic psychiatric unit was opened in Sha'ar Menashe Hospital in Hadera, north of Tel Aviv. The new unit is located within the grounds of a general psychiatric hospital, thus avoiding any geographical or professional isolation that may have pertained in the special hospitals of Britain. The Israeli unit has 128 beds and in practice provides a level of security that is mid-way between medium and maximum. The Israeli unit is gender-integrated, although the number of female patients is very low. The staffing of the unit is similar to secure hospitals in Britain, except for the presence of a professional discipline known as clinical criminologists, whose training blends aspects of academic criminology, sociology, psychology and health sciences. The clinical criminologists play a role in providing treatment, although boundary disputes may occur with clinical psychologists. The Sha'ar Menashe forensic unit is still in

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its relative infancy and it will be necessary for it to create an effective research base for its patient population.

Training in forensic psychiatry in Israel

Child psychiatry is the only designated sub-speciality in psychiatry recognised by the Israel Medical Association. In 1995 the Israel Forensic Psychiatric Association submitted a proposal for forensic psychiatry to be recognised as a sub-speciality (Silfen & Levy, 1995). However, in the absence at that time of any established training schemes in forensic psychiatry and any comprehensive secure facilities within the health sector, the proposal was not accepted. A postgraduate training scheme in forensic psychiatry was then established in 1997 at Tel Aviv University, the course being of 2 years' duration on a day-release basis, and has included up to two visiting lecturers from Britain. About 40 Israeli psychiatrists have now completed the Israel Diploma in Forensic Psychiatry and interest in the field is growing. There are as yet, however, no professorial chairs in forensic psychiatry in Israel, the advancement of the proposed sub-speciality having been driven by general psychiatrists with a special interest, including two who are professors of clinical criminology.

Future developments

Forensic psychiatry is developing in Israel with an established postgraduate programme and the evolution of a new secure facility for MDOs within the health sector. There is a need to develop a more comprehensive research base, which may be facilitated by the eventual recognition of forensic psychiatry as a designated sub-specialty. Links in forensic psychiatry between Britain and Israel have been developing, with conferences having now been held on four occasions in both countries. Palestinian psychiatrists have attended three of these. If peace was to reign on its borders, mutual links in forensic psychiatry would also probably develop further between professionals in Israel and its Arab neighbours.

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special articles

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Almost an electronic patient record and almost free
The CLinically Useful Enquiry System (CLUES)

AIMS & METHOD
This paper describes a project to make all the patient letters held on secretaries' computers available 24-hours a day to improve patient care and risk management. Following a system audit a solution using existing resources was constructed.

RESULTS
The implementation of a uniform coherent patient letter naming and filing convention (the CLinically Useful Enquiry System) allowing rapid access to letters to support effective care without massive cost or disruption.

CLINICAL IMPLICATIONS
This process can be quickly, simply and cheaply replicated in any organisation with a network supporting e-mail and has the additional benefit of making transition to a future paperless system fast and economical.