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# PREVENTION AND CARE IN MENTAL RETARDATION

by

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## I CONCEPT OF MENTAL RETARDATION.

Mental Retardation is a condition that involves most specialities of medicine and in which there are numerous areas of interest to many of the social sciences which are not directly related to medicine. There are many medical syndromes that have mental retardation as a symptom, even if it is not the most important element. It is also true to say that Mental Retardation is one of the important social and medical problem facing the world today, as far as human disability is concerned. With the severe social, emotional, and economic impart it is a condition that requires the greatest degree of understanding and attention we can give it. Because of the disability that makes a person unable to obtain gainful, one can say that mental abnormality is a significant handicap in the present day society.

The criteria of Mental Retardation tends to differ in different countries depending on factors such as tradition, cultural philosophy (including the degree of tolerance for deviation), social complexity, and the availability of services. It follow from this that no single set of criteria, unless these are in the vaguest terms, will find acceptance in all countries at any one point in time. Persons with very mild retardation, for example, will often experience difficulties in an industrial urban society, but their retardation may pass unnoticed in a simple agricultural society. Differences in criteria between different cultures will apply particularly to those often near-normal ability while there will be closer agreement about the more severely handicapped. Therefore, the criterion of Mental Retardation relates not so much to the individual and his handicap but also reflects the complexity of the demands that a society makes upon the individuals, as well as threshold of its tolerance for deviation.

When we approach a problem of classification and normenclature we are confronted with a very complex and difficult task. The choice is between legal, etiological, psychometric and clinical consideration. In the opinion of the author the most practical course is to combine psychometric assessment and the concept of social competence with clinical aspects of mental retardation syndrome.

A good definition is that proposed by the American Association of Mental Deficiency: 'mental retardation is a sub average general intellectual functioning which originate during the developmental period and is associated with impairment of adaptive behaviour'. In this context it would be simpler to begin to consider mental retardation in the category of mild, moderate, severe and profound mental retardation. Along side this there is need for a quantitative assessment of intelligence. For this purpose the I.Q is used - the range is always approximate - mild: -2.0 to -3.3 standard deviations from the means of hundred, i.e. I.Q. 50-70; moderate: - 3.3 to -4.3 standard deviation from the mean, i.e. I.Q. 35-50; severe : -4.3 to -5.3 standard deviation from the mean, i.e. I.Q. 20-35; and profound: more than 5.3 standard deviation from the mean.

One of several possible ways of classifying causative factors is presented in the following tables:-

I. Factors acting before conception.

Genetic: (a) single gene
(b) multifactorial
(c) chromosomal

Other factors.

II. Prenatal

Infections - viral, parasites
Chemical influences
Nutritional factors
Physical factors
Immunological (Blood-group incompatibility)
Endocrinological disorders in the mother
Placental disorders
Intra-uterine hypoxia
Other prenatal factors

III. Perinatal

Asphyxia
Birth injury
Prematurity

IV. Postnatal

Infections
Injuries
Chemical factors
Nutritional factors
Deprivation factors(e.g. sensory,parenatal or social)

V. Unknown causes.

A study of the above table would show that are really two primary causes of mentally retardation. And probably the larger of the two is the functionally retarded. The second large group are those retarded due to organic causes. These are persons who either have a failure of development of the brain or damage to a normal brain severe enough to prevent the person functioning in the future at a mentally normal level.

II SERVICES FOR THE MENTALLY RETARDED:-

1. FACTORS AFFECTING PLANNING:

Planning of services and facilities for the mentally retarded is affected by a wide range of factors and conditions. The types of services and facilities required will be influenced by the number of individuals in the various levels of retardation— mild, moderate, severe, and profound — and in age classifications such as children (pre-school and school-age) and adults. The availability of existing services and facilities for these various levels as well as the total number of retarded served must be known in order to determine the requirements. For example, the planning area may contain facilities providing educational services for the mildly retarded of school-age but no training facilities for the moderately retarded adults. This will lead to lack of balance in planning.

This planning also needs to be related to other forms of community planning and to the social and economic trends, reflected in population growth, shift in age composition, and changes in land utilisation and patterns of commercial and industrial growth. The demand for services and facilities for the retarded may also be influenced by any shift in the content of programme of other health, education and welfare agencies. Practical and realistic planning therefore on the part of governments calls for an understanding of all potentially influencing factors.

Priorities need to be accorded to the relative needs amongst the various areas to be served and the establishment of requisite facilities.

This can be done only against a background knowledge of the availability of commuhity services such as health, education and welfare activities; and availability of community support etc.

In order to develop a sound plan for any country, it may be advisable for the governments to establish a unit within the health planning division charged with the task of developing a co-ordinated plan for the services and facilities for the mentally

retarded. This "cell" will also ensure a better co-ordination between the activities of the various government agencies and between the govern ment and the voluntary organizations interested in the field of mental retardation.

Basic approaches for tackling the various aspects of the problems of mental retardation have been defined in the more developed countries. The applicability of standard methods in use will have to be assessed in relation to the social, cultural and economic conditions of the countries in the developing regions. Out experience in Karachi suggests broad applicability of standard approaches in education and rehabilitation. The only major departure noticed is in selection of tasks in occupational training in which heavy reliance has to be placed upon cottage industries.

It may be pertinent at this stage to discuss in some detail the problems posed by retardation at various age levels.

(a) PRE-SCHOOL CHILDREN.

The first problem in this age-group is that of initial evaluation. A local hospital would be the most logical for a centre of this kind as it would be associated in the public mind as the natural source of advice; at the same time it would be easier to mobilize the services of paediatricians, neurologists, psychologists, and psychiatrists who would be already working at these hospitals.

Guidance and support to the family can also be provided from these centres. In view of the lack of facilities for residential care a large number of children can thus be kept at home.

Physical therapy, which is also required in a number of retarded because of the frequently associated neurological deficits, can be provided in these hospitals.

(b) SCHOOL AGE CHILDREN.

The first problem is again one of assessing the degree of retardation. It is essential that the school prpgramme in these countries obtain the services of psychologists who could provide the necessary testing wherever the teacher feels the need for further assessment.

Children of school age with a mild degree of retardation often languish in the same class having been outstripped by their more competitive and intelligent colleagues. Later on these children are either reject by the school or withdrawn by the disgusted parents. They therefore, form the reservoir from which juvenile delinquents

delinquents are derived. One effective and relatively inexpensive method of dealing with this problem would be the establishment of special classes for the retarded in each school.

Day programmes are required for those children of school age who cannot be retained in the special classes. By using day facilities, parents obtain some relief from the 24 hours task of care, and, through participation in parent counselling of such facilities, can obtain a better under-standing of the problems of the retarded. Thus day facilities make it possible to keep retarded at home and in the community. The number of programmes of this kind in the developing country are very few indeed, while the requirements are tremendous. This would inevitably lead to the problems of staffing these programmes. Staff training facilities need to be established. Perhaps the curriculum for such teachers will have to be modified along pragmatic lines. For the success of these programmes it is essential that the services should be freely available even to the less prosperous groups of the population.

A sheltered workshop will provide many benefits to the retarded person, his family, and his community.

Residential institutions with programmes of educational training, personal care and sheltered workshop, have a long history of service to the mentally retarded. They have changed from being largely custodial institutions to dynamic facilities for broad programmes. These include services for the severely retarded and the totally dependent as well as services for the retarded who cannot be maintained in the home or community because of emotional or behavioral problems . Residential facilities also meet the need of a community unable to support financially the services required by the retarded, or where placement in foster-homes is impractical or inadequate. In the developing countries the expectation that large numbers of resident facilities would be built in perhaps optimistic and the chances of their degenerating into custodial institutions are great. Attempts should therefore be made to keep the number of such institutions to a minimum and it is possible with modern drugs to be able to do so.

The prime need for the adult retardate is met by a sheltered workshop. This includes a programme which consists of:

i) work evaluation
ii) work adjustment training
iii) occupational training

iv) transitional or extended employment which is carried out under supervision of personnel qualified to direct these activities.

There are certain advantages in providing the mentally retarded with sheltered workshop services in programmes which include other handicapped individuals. For some of the mentally retarded, such a programme can permit boarder opportunities for socialization and widen the range of job contract that can be fulfilled. These benefits can be realised, however, only if the staff of the multipurpose workshop recognises the special need of the retarded, particularly the longer training time frequently required. The other advantage of a combined sheltered workshop would lie in the economy of providing sheltered workshops for different varieties of handicapped. This will prevent the duplication of services and facilities.

In addition to the services defined above many supplementary services are essential for the care of retarded. Generally speaking, these services are components of general community services available to the retarded and his family, as they are to any other individual or group within the community. Among these services are: preventive medical services, public health, nursing, case work, counselling, fosterhome care, income-maintenance services and insurance schemes, legal aid service and many others. Since these services are available in the developed countries to the total community they do not constitute a problem. But in the developing countries the services of this kind are practically non-existent and depending on the enthusiasm of the organization that has the resource and the financial support, these services have to be developed even for the specific purpose of that organization. Therefore, these countries will have to evolve a system by which these services are made available to the mentally retarded.

## III REHABILITATION.

The success of any rehabilitation programme would eventually be reflected in the total number of persons gainfully employed. Preparing the retarded youth for job placement is an extensive undertaking both in terms of time and subject matter. The preparation begins in the child's pre-school years where the family and community can exert a critical influence on his intellectual and personality development. It is during the child's school years

that he is introduced to the complex elements in occupational adjustment. Throughout the school years, preparation for employment should be considered as one of the several measured objective in curriculum building. It is here that the role of counselling has to be accepted as an integral part of the total programme of education and vocational preparation of retarded adolescents. Effective counselling and guidance can come through formal and informal contacts with students and thus all persons engaged in the education and rehabilitation of the mentally retarded have some degree of counselling responsibility. In most of the developing countries no counselling services of any kind are available nor is this considered one of the essential occupations necessary for community development. As a first step, therefore, these countries need to develop a training programme for counsellors.

The most important hurdle, of course, is presented by the prevalence of unemployment in most of the developing countries. Job opportunities are scarce and the rate of unemployment very high. The employers are therefore, understandably relunctant , even if they are not totally opposed, to the idea of employing a retarded or a handicapped person. An important task, therefore, of the government as well as the social agencies responsible for the mentally retarded in addition to or sometimes in place of the non-handicapped persons.

## IV PREVENTION.

The answer to the problem of occurance of mental retardation is research to find ways of prevention. This must include all sciences related to retardation. Research in such areas is at present, producing remarkable and fascinating results, and its base in recent years has accelerated phenomenally. Continuing progress can be expected from the greater increase in effort. Over the past 25 years the research in mental retardation has been remarkable. Many new syndromes have been described, and many have responded to research. Since the problem of prevention is related to both prenatal and perinatal period it would be profitable to devote some attention to the problem associated with these two periods.

### 1) Preconceptional and Interconceptional period.

A good standard of health through out childhood, adolescent adult life, and pregnancy is necessary for a successful reproduction. The physical and mental health of mother, her history of immunisation and infectious diseases, her education, all influence perinatal

mortality and morbidity. Mal-nutrition and severe anaemia influences the course and outcome of pregnancy, effect fetal growth and birth weight, and in many developing countries iron deficiency anaemia is common among young girls and specially women of child bearing age. Repeated pregnancies may also aggravate the nutritional state resulting in infants of low birth weight with severe early iron deficiency.

2) Pregnancy.

The effect of genetic factors on conception is generally known but the actual cause of the mutation of genes and chromosomal aberrations are not easily explained. Some indication is available that maternal age is related to one of the many chromosomal abnnormalities i.e. monoglism. Similarly there are many drugs which are known to effect or damage the fetus in some ways. The indiscriminate use of drugs and traditional remidies of unspecified composition in developing countries could also produce a hazard. The problem is not one of the drugs being administered to women as it is of the administration of drugs to women who become pregnant while under treatment.

Rubella in the early weeks of pregnancy is an established cause of damage to the fetus. With potent vaccine now introduced rubella could become a preventable disease. In the same manner radiation is known to produce damage to the fetus. Needless to say a careful use of X-ray will reduce this potential hazard. Acute infectious diseases of which the most important in developing countries are: infectious hepatitis, small pox, tuberculosis, malaria, syphilis and shisto somiasis. Rhesus incompatibility and prematurity are also now conditions which are amenable to treatment provided sufficient midwifery services are available. Premature labour is on the whole poorly understood. It is associated with low socio economic status and with maternal infection. Again the influence on fetal outcome that are well known to arise or become manifest during labour have received much attention. They include mechanical factors such as disproportion, unable lie, malpresentation, cord prolapse, prolonged labour, and traumatic delivery.

3) The Neonatal Period.

The course of the first few days of life is largely predetermined by heriditary factors, the maternal environment, and the effect of labour. Most of the neo-natal problems appears

within 24 hours of birth when maximum observation and care is needed. In most developed countries early neo-natal death rates below 10 per thousand have been achieved. Minkowski states that in China neo-natal mortality rate has fallen from 1.95% in 1957 to 0.75% in 1964. This will emphasise not only the importance of proper care but also encourage the belief that it is not outside the realm of possibility given the will and determination.

The question of long term sequelae of perinatal complications and of the contribution that perinatal conditions make to developmental and mental defect of childhood is difficult and complex. But it is known that mental retardation, cerebral palsy, delayed motor development, reading and learning disorders, and other school and behaviour problems are reported to be associated with long standing fetal hypoxia associated with eclampsia and knotted cord which leads to brain damage. It is also known that birth rate of less than 2000 G is likely to produce more retardation, and spastic diplegia occurs almost exclusively in children who are born very prematurely and who weigh 1500G or less at birth.

The key to the problem of prevention of those causes of mental retardation that are amenable to reduction in the present state of knowledge lies in planning and organising integrated health services for the expectant mother and her child in order to provide continuity of care. It is also necessary to increase the cooperation between doctors, midwives, nurses, paediatricians and public health authorities in planning supervising and evaluating the quality of medical care that is actually delivered to the community.

## V THE LAW AND THE MENTALLY RETARDED.

In most developed countries the laws regarding the right and previledges and affording protection to the mentally retarded are part of the mental health acts of the various countries. On the other hand very few of the Third world countries have any legislation that relates to the mentally retarded although the retarded and their families have atleast a same needs. This also provides them a unique opportunity of avoiding and repeating the well meaning errors in the development of services for the mentally retarded that have been made in most advanced countries, such as segregation, (often in isolated places), of the retarded persons: the failure to pay sufficient attention to the cureial need for training of good personnel; or the tendency to over emphasise the medical aspects of care instead of developing and activating a multi-disciplinary

approach with due emphasis on training, general and vocational education, occupatiönal day centre, sheltered workshop, planned liesure time activities as well as on medical treatment.

## VI CONCLUSION.

There is general agreement now that although the amount of mental retardation does not vary from one country to another, case finding and the amount of mental retardation coming to the attention to the public health authorities is increasing in most countries, mainly because of their changing social structure. This is certainly the situation in the EMRO region. In most countries the joint family system and the extended family which could take care of most of the mental retardation except the most severe is changing to a nuclear pattern. People are moving from the farms into the urban industrial areas, for both these reasons the amount of illness seems to be increasing because it comes to the attention of the public health authorities more readily. The other cause of increase of problem surrounding mental retardation is that, owing to the advances made in medical and social care, the severely mentally retarded have a higher expectation of life than was formerly possible and the duration of care health has therefore to be extended. This problem is further complicated by the lack of awareness in the population about mental retardation and the unavailability of facilities for the diagnosis and guidance of management of such cases. It is therefore imperative that the countries of the Region should attempt development of basic elements of services for the mentally retarded which must keep pace with general economic and social development. The success of these afforts would be directly related to the degree to which these afforts and the solutions that are envisaged reflect the local situation, be they in the area of causes, recognition of the condition or its managements.

## HARMONIZING MENTAL HEALTH LEGISLATION AND PROGRAMME OBJECTIVES: AN INTERNATIONAL SURVEY

Office of Mental Health
World Health Organization
Geneva

### IMPORTANT NOTE

This draft document represents the first step in the process undertaken by WHO of preparing a publication based on an international survey of mental health legislation and including recommendations and suggestions for the assessment and improvement of such legislation. Several stages in the review mechanism have still to be carried out: by a specially convened working group; by the Expert Advisory Panel on Mental Health; and within the WHO Secretariat. National authorities will also be consulted when necessary concerning the accuracy of data presented. A number of modifications and additions are therefore likely to be incorporated in the final version.

This document is being circulated in limited numbers, primarily to invite comment and suggestions for necessary changes. Since it is not a definitive WHO statement, it should be neither quoted from nor distributed nor duplicated in whole or in part in its present form.

It is planned to finalize the document in the next few months.

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# HARMONIZING MENTAL HEALTH LEGISLATION AND PROGRAMME OBJECTIVES: AN INTERNATIONAL SURVEY

## Introduction

It has long been known that there is a dynamic relationship between concepts of mental illness, the treatment of the mentally ill, and the law. Social systems, through the laws, set boundaries of acceptable behaviour and define the categories of fully accountable, or mentally competent, personhood entitled to take an active part in the social, economic, and political life of the community. Those people found to fall outside these boundaries and definitions are generally considered mentally incompetent or "insane". Treatment programmes are also legally related in that they are often controlled by laws on admission and discharge, or on the use of treatment methods or therapeutic drugs, and when psychiatric services are a part of social programmes for the sick and the handicapped.

The World Health Organization is aware of the importance of mental health legislation in the overall mental health programmes of member states. Expert Committees in Mental Health over the past 25 years have called attention to the need to give attention to legal matters in various fields of mental health including mental hospitalization, the development of community-based mental health services, mental retardation programmes, alcoholism, drug dependency, and social psychiatry.

## I. Methods of the study

Initial planning for this study began with a consultation on mental health legislation called by the Office of Mental Health and convened in Geneva from 26 July to 1 August 1972. The group included Dr J.V. Ashburner of Australia, who had been a member of the Expert Committee on Mental Health in 1955, Dr P.A. Baan of the Netherlands, Dr E.F.B. Foster of Ghana, Dr P. Ratanakorn of Thailand, Dr C. Leory of France, Mrs R.H. Lowenstein of the United States of America, Dr H.R. Rollin of England, and Mr G. di Gennaro of Italy. Working with the group were staff members from the Office of Mental Health including Dr E.L. Margetts, who was secretary to the group, Mrs J. Moser, Dr R.W. Shapiro, Dr F.R. Hassler, and Dr N. Sartorius. Also attending the meetings was Dr T.A. Lambo, at that time Assistant Director-General of WHO, and now Deputy Director-General.

Background papers were prepared by Dr Ashburner and by Dr Margetts for the meeting and as a result of the consultation further work on review of the laws and on the preparation of preliminary guidelines continued over the next year.

It was decided in 1975 that a more intensive effort should be launched with a more systematic analysis of the existing mental health legislation of the world.

A contract was negotiated with the National Institute of Mental Health of the United States to support the effort, with staff contribution and facilities supplied by WHO from the Office of Mental Health (Headquarters), Regional Offices and the Health Legislation Unit (Headquarters).

A questionnaire was drafted by the Office of Mental Health in collaboration with Regional Offices. English, French and Spanish versions were produced. The information sought in the questionnaire (copy attached) was in the following areas:

(i) mental health legislation currently in force, with copies of statutes and regulations where available;

(ii) subject areas of law were access to voluntary and involuntary treatment, rights of patients, appeal procedures, inspection of and standards for mental health facilities, and administration of mental health services;

(iii) evaluation of the measures for protection of the rights and welfare of patients in such areas as prevention of improper use of involuntary commitment, exploitation of patient labour, etc.;

(iv) evaluation of the operation of the legal provisions in force;

(v) special or separate legislation for mentally retardation, alcoholism, drug dependency, and sexual deviancy;

(vi) provisions forbidding, limiting, or regulating certain modes of treatment such as electroshock therapy, psychosurgery, and the practice of traditional or folk medicine;

(vii) provisions concerning special licensing of mental health personnel;

(viii) the degree of understanding of the mental health legislation by various groups in the country;

(ix) desire for change in the law by various groups in the country;

(x) education and training programmes in mental health law for various groups in the country;

(xi) relevance and operational functioning of mental health laws in regard to mental health programmes.

The questionnaire was circulated and completed by 65 respondents in 45 countries. The respondents were drawn from the following groups.

(i) Members ofthe WHO Expert Advisory Panel on Mental Health. The Director-General has the authority to establish expert advisory panels on any subject and since 1948 over 40 such panels have been created. Panel members are selected by the Director-General after consultation with the national administrations concerned. Panel members serve on a personal basis and are not expected to represent their country officially. They receive no remuneration and may make suggestions or furnish information on their own initiative and may also be consulted by correspondence. Members ofWHO Expert Committees are also drawn from these panels.

The Expert Advisory Panel on Mental Health has about 100 members drawn from 50 countries. The majority are psychiatrists and many occupy senior positions of responsibility in mental health services of their countries. A smaller number are non-psychiatrists - sociologists and psychologists, for example. Together the membership represents a very wide range of expertise and experience in the field of mental health care. A number ofmembers have been personally involved in the assessment and drafting of national mental health legislation.

This group was responsible for completion of the largest number of questionnaires (47 from 33 countries).

(ii) WHO Representatives. In many countries (particularly those in which there is a significant level of technical cooperation and assistance) there is a resident WHO representative. In some cases such a representative may be

responsible for a group of neighbouring countries. The WHO Representative is a member of the staff of the Regional Office and reports directly to the Regional Director. He may be described as a sort of WHO 'chargé d'affaires' who keeps in close touch with the health authorities of the country to which he is assigned and keeps the Regional Director informed of any special health problems in the country. In order to complete the questionnaire, therefore, the representatives had access to national health authorities and mental health experts within the country concerned.

Seven questionnaires from 7 countries were completed by WHO Representatives.

(iii) Representatives of national mental health associations. A smaller number of questionnaires (3 from 3 countries) were completed by national mental health associations. Lay members familiar with their associations' policy in the field of legislation were responsible for completing the questionnaires.

(iv) Authorities selected by WHO Regional Offices. In a few countries, in which Expert Advisory Panel members were not available, Regional Offices made contact with experienced psychiatrists, who were asked to complete questionniares (8 from 8 countries).

Collaboration and consultation was sought from various organizations including the United Nations (Division of Social Development) the Council of Europe, the International Commission of Jurists, the World Psychiatric Association, and the International Labour Office.

The review of the mental health legislation was conducted by utilizing the statutory and regulatory materials supplied by the respondents to the questionnaire, by examination of the laws published in the International Digest of Health Legislation, and by analysis of the collections of national legislation in the Law Libraries of the United Nations and the International Labour Organization in Geneva. The research staff also reviewed comprehensively the WHO documents and reports and the available literature on the operations of the mental health laws and mental health service programmes in the countries selected for review.

The total number of countries included in the comparative legal survey was 38. Of these, 28 were classified as operating under a formal legislative system. The remainder, all developing countries, were classified as functioning under informal systems with no specific legislation covering matters of mental health treatment and hospitalization. Selection was made to include countries of varying population size, level of socio-economic development, political systems, structure and history (e.g., era of independence), cultural background, pattern of health services and development of mental health care. At least two countries were included in the survey from each region of the World Health Organization. The countries included, by region, were as follows:

African Region: Benin, Ghana, Lesotho, Nigeria, Rwanda, Senegal.

American Region: Brazil, Canada, Costa Rica, Peru, Uruguay, United States of America.

Eastern Mediterranean: Bahrain, Cyprus, Democratic Yemen, Egypt, Iraq, Iran, Jordan, Kuwait, Saudi Arabia, Sudan, Syria, Qatar, Yemen Arab Republic.

European Region: Denmark, France, Norway, Poland, Romania, Switzerland, United Kingdom.

South East Asian Region: India, Thailand.

Western Pacific Region: Australia, Fiji, Japan, Malaysia.

In federated countries it was not practicable to include an analysis of the law in every state, province, or canton. Therefore, the decision was made to include an analysis of 2 states in each federal country. An effort was made to select two jurisdictions of different characteristics and in different geographic sections of the country. Some general observations are included about these countries as a whole in some sections of the Report. Also, the Report contains a separate discussion of important legal and constitutional matters in federated states in regard to the development of mental health services.

The above listing of countries displays some imbalance in coverage which should be explained. The heaviest concentration of countries surveyed (13) was in the Eastern Mediterranean Region. This was due to selecting that area for a special project on developing countries (Part III, Section F). Cooperation in this special project from the Regional Office of WHO and from countries in that area was excellent and enthusiastic. We therefore included in our review an analysis of every country in that Region from which questionnaires or other materials were received.

In four of the Regions, the coverage is close to equal with slight differences reflecting the number of member countries in the Region. The only Region with a limited coverage is South East Asia. This is due largely to the fact that South East Asia has a relatively smaller number of countries and responses to the questionnaire were received only from the two countries surveyed, India and Thailand.

## II. Historical and contemporary perspective

### A. Historical review

#### The Early Centuries:

In the early history of man, authority and power rested in the hands of families and tribes. Those unfortunate people who were unable to contribute to the needs of the group in hunting or farming, or in heavy domestic work, were disposed of or abandoned. The legal codes which collected and preserved tribal custom such as the Code of Hammurabi about 1700 B.C. indicated that head of families could be expected to kill their deformed or demented children[1]. This principle was confirmed in later codifications down to the Code of Justinian in 529 A.D.

In later centuries, mental illness was usually attributed to magical or religious origins, particularly where the individuals exhibited bizarre symptoms of hallucination or dilusion, or acted in a violent, excited manner. It was these people also who came to the attention of public authorities or the law. They were not considered sick and were not dealt with by physicians[2].

It was the attribution of religious powers or possession by evil spirits which in the Middle Ages made these societies fear the mentally ill. They became the concern of witch doctors and exorcists. Many of the mentally ill were horribly tortured and killed. One of the great physicians of the period, Johann Weyer, fought vigorously against the condemnation and brutal execution of witches, most of them women, when there was no evidence that they had caused harm to anyone. He argued that a distinction should be drawn between the "perfect will" of the sane man and the corrupted will of a person out of his senses. Weyer was pleading essentially for the innocence of the mentally ill.

The first special institutions for the care and treatment of the mentally disordered were developed in the Islamic countries, in Fez about the year 700, in Baghdad in 705, Cairo in 800 and Damascus and Aleppo in 1270. In Europe, a few institutions were opened in the Middle Ages, but

most of the so-called "furiously mad" could be found in the jails and prisons, the workhouses and poorhouses of every country in the 1800s. Practically any oddity of speech or behaviour was enough to provoke fear of these creatures so that most of them were in chains.

In the growingtowns of sixteenth and seventeenth century Europe, the insane (along with beggars, vagrants and the destitute) were regarded as a threat to public order and custodial institutions were established, primarily as instruments of social control with little or no therapeutic function. To the extent that the legal systems noticed the mentally ill during these centuries it was to protect society from the insane rather than to offer aid or treatment to these marked people. If the individual became mentally ill in adult life and had land or other possessions, the law was used only to dispose of his or her property, often placing all or part of it in the hands of the sovereign. The legally adjudicated incompetent, stripped of possessions and any claim to protection of the law, was cast out of society, and, if considered at all dangerous, was locked into a room or stall in a private house or placed in a cage[3]. The subnormal or retarded, if they reached adulthood, might be allowed to wander as idlers or vagrants eking out a bare existence as beggars along with other severely handicapped people who were disposed of in much the same way.

Humanitarian Efforts:

It was in 1792 that Philippe Pinel struck the chains from the insane at Bicêtre[4]. He did the same at Salpêtrière in 1795. These actions were conceived in the spirit of the French Revolution, of which Pinel was a committed supporter. He urged that the mental hospital be used as a place of refuge and moral treatment and education with humane care for all patients. He would allow the use of the strait-jacket for temporary control, but only on the specific order of a physician.

Pinel and his student, Esquirol, were convinced of the need to separate the insane patients from their families and society. Pinel's famous treatise on mental illness was entitled Traite medico-philosophique sur l'Aliénation Mentale, thus beginning the identification of the insane as "alienated" from normal social contact.

Esquirol was a brilliant teacher and writer who trained many physicians from France and other countries. He was the primary psychiatric consultant in the drafting of the French law on mental health administration and hospitalization in 1838. The law became the model for similar legislation in Switzerland, England, Norway, Egypt, and Greece, as well as in the French colonies of Africa and Indochina. Though significantly amended over the years, the Esquirol-designed law of 1838 is still the fundamental legislation in mental health in France. The French psychiatrists of the nineteenth century, from Pinel to Morel, were also the founders of forensic psychiatry, especially the study of the relationship between mental illness and criminal conduct.

The Asylums:

Insane asylums were developed throughout France under the 1838 legislation and throughout England and Wales under the County Asylum Act of 1808. Kathleen Jones asserts that the importance of this Act lay in its identification of care and treatment as a public responsibility and with the "attempt to deal with the root cause --insanity-- rather than with the symptoms of anti-social behaviour"[5]. As we will see later, modern mental health legislation in some countries has returned to an emphasis on anti-social behaviour --dangerousness to others-- as the primary legal justification for any loss of liberty by the mentally ill.

In the asylum era, these large institutions, usually built in remote areas away from towns or cities, probably did give more humane care to the severely deranged than had ever been known before. Similar institutions were developed for the mentally retarded or feebleminded, but many were designated as schools in order to call attention to their efforts to educate and train the less severely retarded and physically handicapped. The first such schools were established in Abendberg, Switzerland and in Berlin, Germany in 1842. The first school for the feebleminded in America was opened in 1848 in Massachusetts.

The Commitment Laws:

About the middle of the nineteenth century, evidence of worsening conditions in the overcrowded, poorly maintained insane asylums was brought to public attention by social reformers and by writers of sensational, highly popular novels. Both the reformers and the writers pointed out the ease with which people could be hospitalized and the great difficulty of getting them out.

Mrs E.P.W. Packard, one of the most active of the reformers in the United States, had been placed in an asylum in Illinois by her husband under a law providing that "married women and children" could be admitted to a mental institution on the medical judgement of the superintendent upon the application of the husband or the parent or guardian respectively[6].

Up to 1848 there was no single law concerning the management of the insane asylums in Great Britain. It was public distrust of the administration of the institutions which caused the British Parliament to pass the Lunatics Act of 1848 which empowered a Lunatics Commission to conduct investigations of conditions in the asylums and to receive periodic reports from the superintendents on each patient under their care. The situation improved, but in the 1860s and 1870s there were further public disclosures and another expose novel, Hard Cash, by Charles Reade. In 1884, an English woman, Mrs Georgiana Weldon, after an attempt by her husband to have her involuntarily admitted to a private asylum, conducted a widespread campaign similar to that of Mrs Packard in America. She brought an action for false and wrongful commitment against the physician who had certified her as insane, won her case, and was awarded damages. The judge in the case observed that he was astonished at the way in which a person could be confined to an asylum on the statement of anybody, providing certain proprieties were met. He concluded that it was "positively shocking that such a state of things could exist"[7].

Through the efforts of Mrs Packard and Mrs Weldon and other reformers in other countries, the legislatures enacted laws to control admissions and discharge from the mental institutions. These laws were essentially designed to prevent the wrongful confinement of the sane, not to improve conditions for the mentally disordered. The criminal law was

used as the model for the new reform legislation. Thus, lunatics and the feebleminded were "arrested" in the community and brought before the courts by the police, often in leg-chains or chest-arm restraints, and "charged" under the law. After a finding of insanity, they were involuntarily "committed" to the state-operated institutions on an order of indefinite confinement until lifted by the court. No one in the general public or among the professionals operating the asylums expected many of these people ever to see freedom again.

## The Early Twentieth Century:

Neither the humane reform movements nor the commitment laws of the nineteenth century stemmed the tide of overcrowding in the asylums of the industrial countries during the remainder of the century, nor in the first four decades of the twentieth century up to World War II. Nevertheless, treatment and patient management methods were improving during the 1930s and 1940s. More patients, even among the most severely disturbed, were being discharged or allowed to return home as improved or in remission. With evidence of at least some successful treatment in the hospitals, more patients were beginning to present themselves for voluntary treatment. The social stigma of mental illness was still very strong, but there now seemed to be hope where for so many centuries there had been only despair and fear.

## The Countries of Asia, Africa and South America:

The picture drawn above is somewhat restricted, being based primarily on the history of Europe and North America. Parallel strands of development of concept and practice in mental health existed in India, China and Africa (although in the latter case documentation is lacking). Comprehensive psychiatric history has yet to be written concerning these vast areas of the world. Up to only a few decades ago, it was seriously believed by mental health professionals from the industrialized countries that severe mental illness such as schizophrenia did not exist in Central Africa, South America beyond the coastal cities, or among the peoples of the islands in the South-West Pacific. It seems clear now that mental illness is ubiquitous throughout human societies on this earth and is merely hidden from professional view by different cultures at different stages in their development. As was concluded

by the WHO Expert Committee on Mental Health in 1975:

> "Well conducted epidemiological studies in several parts of the world have shown no fundamental differences either in range of mental disorders that occur, or in the prevalence of seriously incapacitating mental illness. These studies indicate that such seriously incapacitating mental disorders are likely to occur in at least 1% of the population at any one time or at least 10% of the population at some time in their lives. In the developing countries, as elsewhere, the major functional psychoses (schizophrenia and affective disorders) constitute a large part of such serious disorders, and, in addition, mental disordered secondary to infectious illnesses and other organic pathology are relatively common"[8].

In the rural areas of developing countries, remote from the few psychiatric services, mental illness goes untreated and only the most severe cases with bizarre symptoms or behaviour are noticed. Treatment by traditional practitioners is still found in many areas. Traditional systems are pluralistic, vary widely in their scope, practice and effectiveness. In some areas their positive contribution to mental health care is well established. In the urban areas of the developing countries, with the disruption of extended family ties, with rapid social change and unemployment, the problems of mental disorder are greatly aggravated. There are not nearly enough psychiatric services or personnel in any of these countries, and those which do exist ar e often centred primarily on large, custodial mental hospitals, which are unable to undertake diagnosis, treatment or follow up at the community level. New strategies are being developed to provide mental health care in the developing countries. The principles of decentralization of services and integration with general health services is now widely accepted and the WHO Expert Committee referred to above advocated the provision of "basic mental health care" by primary health workers and the development of collaboration

with non-medical community agencies, such as the police, religious leaders and local associations.

Mentalhealth law, itself untried and undeveloped in many of these countries, will be needed to play a role in mobilizing the resources and directing the personnel to deal effectively with mental illness, one of the developing world's most serious health problems.

B. International Survey of 1955

The Review of Hospitalization Laws:

In 1955, WHO published in the International Digest of Health Legislation a comparative survey of the mental hospitalization legislation of a number of countries of the world, the first such international survey ever compiled[9]. The effort was suggested by the WHO Expert Committee on Mental Health in its Third Report in 1953[10]. A circular letter was sent in early 1953 to member countries requesting copies of mental health legislation. Information was received from 40 governments. These materials, and other laws and regulations published in the Digest, along with an extensive review of available literature, were used to produce the analysis. Laws of 37 countries were listed in the publication.

The Expert Committee Report:

The next Report of the Expert Committee in Mental Health was devoted to the subject of mental health legislation[11]. First produced in mimeographed form in 1954, it was printed in 1955. Thus, in the same year, a legal survey of unprecedented international scope and a unique psychiatric commentary on the law were forthcoming from WHO.

In this section we will review briefly the findings and conclusions of the two documents.

Major Features of the Laws:

The 1955 legal survey indicated that the law in many of the countries which had previously been designed primarily to protect society from the patients was beginning to change in the direction of simplified methods of admission and discharge enabling patients to receive treatment earlier.

Considerable attention was given to changes in terminology. Words such as "insane" and "lunatic" were being replaced with "mental illness" and "mental disease" in English-speaking countries. In France, still functioning under the Law of 1838 which used the term "aliénés", the survey called attention to a Ministry of Health Circular of 1948 which

referred to "malades mentaux". In the Spanish-speaking countries of South America and in Mexico, the newer term was found to be "enfermos mentales".

Along the same lines, the modern legislation was abandoning reference to "lunatic asylum" and replacing it with "mental hospital" and "psychiatric hospital". There was also a movement away from "commitment" because of its criminal connotation and toward "admission" or "reception" in English-speaking countries, "admission" or "placement" in France, "ingresso" in Mexico, "internação" in Brazil, "aufnahme" in Germany, and "intagning" in Sweden.

One of the most important trends in the hospitalization procedures was found to be the enactment of voluntary admission laws. It was asserted that admission under such procedures then constituted the highest percentage of categories of hospitalization in several countries. Moreover, it was said that even in some countries without a legal provision for such admissions it had become "a common practice"[12]. The only statistics cited on voluntary admission, however, were for Great Britain, France, and the United States of America. Of these, only Great Britain had high percentages of voluntary admission (70% for England and Wales; 67% for Scotland). In France there were 37% voluntary admissions while for the USA as a whole the corresponding rate was only 10%.

When it came to involuntary hospitalization, it was pointed out that commitment under judicial order was still the usual method in many countries. A table set out such provisions in 12 jurisdictions. It was found to be the only method of involuntary hospitalization in Germany and Italy. In the United States of America 70% of admissions to mental institutions in 1949 were by order of the courts.

The survey described hospitalization of non-dangerous patients by the judiciary as humiliating for both the patients themselves and their families. Attention was called to laws under which patients could be admitted, usually by application of a parent or relative, or by a person living in the same dwelling, on medical certification that they were mentally ill and in need of treatment. No judicial order was required. Laws of 19 countries in this category were collected in a table under which hospitalization was for a prolonged, indefinite period. Among

them was the oldest law of all, the French Act of 1838. Another table described the laws of 8 countries which provided for temporary hospitalization on medical certification without judicial order.

The 1955 survey went on to provide a review of the laws of numerous countries in regard to other admission and discharge procedures, family care, and release on trial. Attention was also called to the special categories of mentally defectives, epileptics, alcoholics and drug addicts, mentally ill offenders and prisoners, and sexual psychopaths.

There was a thorough analysis of provisions for safeguarding the rights and welfare of patients. Notification requirements and procedures for inspection by outside authorities were discussed first, since these were the main methods of protection at the time. Procedures for appeal to the courts were then examined in regard to wrongful detention and refusal to discharge. The section ended with a survey of laws concerning protection against improper treatment.

On the whole, the comparative survey was excellent and comprehensive. The tone of the report was highly constructive in regard to encouraging simplification of the admission and discharge procedures in the interest of ready access to care and treatment. At the same time, it was careful to point out the necessity to safeguard the rights of patients with the methods then found in the laws of the countries of the world.

## The Expert Committee report on "Legislation affecting psychiatric treatment"

The Expert Committee on Mental Health was quite openly and candidly critical of the mental health laws of its day. Early in the Report it was observed,

> "Most of the existing mental health legislation is unsatisfactory, although in some countries laws based on outmoded concepts of mental abnormality, when interpreted liberally, can be made to work fairly well in practice...... The greatest single weakness is that purely legal considerations are given too much weight and medical considerations too little"[13].

In its earlier Report in 1953, the Expert Committee had been equally condemnatory of the existing law when it had called for the comparative legal survey. It was concluded in that Report that few countries had legislation based on modern psychiatric knowledge. The commitment procedures for unwilling patients were described as "archaic"[14].

Essential requirements for Legislation:

The most important sections of the 1955 Report were devoted to laying out what the Expert Committee called essential requirements for effective mental health legislation.

First priority was ascribed to recruitment and training of specialized professional staff. One of the chief problems to be solved here was said to be offering psychiatrists conditions for practice which would be sufficiently attractive and varied from a professional viewpoint. This was spelled out to mean that good doctors could not be expected to devote themselves entirely to caring for "chronic and incureable patients in inadequately staffed establishments far from intellectual or scientific centres"[15]. It was also noted that doctors and nurses should be given time to devote to extramural services and physicians should be allowed time for private patients.

Second importance was given to making legal provision for adequate facilities. These should include a full range of preventive services, community services, psychiatric hospitals, special hospitals, after-care and home-care organizations, and social and occupation rehabilitation centres. It was advocated that these institutions should not be too large. It was cautioned that specialization of institutions should be avoided on the basis of acute and chronic, or curable and incurable patients. No matter what their size, the Expert Committee believed that the institution should be under the direction of a psychiatrist.

Attention was next given to legal provisions for involuntary admission of unwilling or dangerous patients and to measures for guardianship and medical supervision of such patients. It was stressed that required treatment need not be given in a hospital but might be administered on an out-patient basis or in community facilities. As in the

comparative legislative survey, court review prior to compulsory hospitalization was severely criticized as stigmatizing the patient. The non-judicial forms of hospitalization with appeal afterward were believed to be much more desirable. The Expert Committee endorsed the principle of ready access to treatment with "easy appeal" open to a patient at any time to appeal his involuntary admission. Special attention was called to the fact that "in one country, recognized to be in the van of progressive legislation, it has been thought preferable for the appeal to be heard by a local board composed of a physician, a judge and a layman"[16]. The identity of the country was not given. (In fact, no specific laws of any country are cited anywhere in the Report.) No reference to such a procedure can be found in the comparative legislative survey. The Committee could be said to have been anticipating the Mental Health Act (1959) of England and Wales which provides for appeal to a Mental Health Review Tribunal composed in a similar manner.

The Expert Committee favoured easing restrictions on discharge of patients. It was suggested that next of kin should be allowed to discharge a patient subject to the refusal of the superintendent solely on the grounds that the patient was dangerous to himself or others. It was specifically noted that the next of kin should have the right to appeal against this action.

In a most imaginative way, the Expert Committee suggested that compulsory treatment should not be limited to hospital care, necessarily resulting in the patient's total loss of personal liberty. It should be possible, they observed, to provide such treatment under supervision in the community. It was pointed out that such methods do actually exist in the criminal system under probation or a suspended sentence for drug addicts, alcoholics, and sex offenders. It was thought unfortunate that such an opportunity, or treatment option as we might call it, was not available unless the patient had committed a crime and been apprehended before a court.

The fourth areas of concern was with the establishment of an organizational framework for the offering of community psychiatric services. In countries with a central or national health authority, it

was recommended that the responsibility for mental health services should be a part of that agency. The national body should also contain an inspectional body for psychiatric services not subject to the authority of the unit responsible for providing those services. It was again cautioned that this inspectional body should not be separate from other health service surveillance but should be a part of such a programme if it existed in the country. The Report also advocated local responsibility for locally provided psychiatric services.

The recommendations of the Expert Committee in 1955 displayed an experienced eye for the weakness of existing legal systems of that time and considerable sophistication and wisdom about what the law should contain. In the intervening years, many of the suggestions of the Committee have come to pass in many countries, particularly in regard to the movement to smaller hospitals, community-based services, and a wide range of alternative treatment and patient management methods. Many countries have simplified their admission laws in ways similar to those advocated in the Report. Not all of the suggestions have been followed, at least in specific legislative enactments. However, on the whole, the Report still reads in 1976 as a realistic and thoughtful approach to improving mental health legislation.

## C. The Intervening Decades: Years of Fundamental Change

### Developments of National Independence and Human Rights:

Much has happened in the world since 1955. The most striking change from a political and legal standpoint has been the wave of independence among the nations of the developing world. In 1955 there were 84 member and associate member nations in the World Health Organization. In 1976 there were 151. On the African continent there are now 49 nations. Most of the independence in Africa was gained in the 1960s from the colonial powers of Belgium, France, and the United Kingdom. The legal structures set up in the colonial years were largely continued in such matters as mental health legislation. So also were the methods of medical and psychiatric practice with an emphasis on the large mental hospital constructed in colonial times. Only in recent years are many of the developing countries beginning to break away from both the mental health law and practice of earlier years.

The intervening decades have also seen a growing stress on protection of human rights on the international and national levels. Documents concerning the rights of children, the rights of women, the rights of the handicapped, and the rights of working people have been produced by various organizations and groups. In the mental health field, attention has been given to the rights and welfare of the mentally retarded, the mentally ill, the epileptic, the alcoholic, and the drug dependent. Extensive legal changes have taken place in many countries as a result of greater recognition of the rights of these groups.

### Treatment and Patient Care in Mental Health:

Changes in methods of psychiatric treatment and the care and management of mental patients have also been dramatic in these years. In the middle of the 1950s the industrial countries were still recovering from the devastation and disruption of World War II. The large mental hospitals were still the core of mental health programmes in every country. The general increase in population, the greater number of

elderly people, and an increasing willingness to be hospitalized as mentally ill pushed the census of the hospitals up and up. In many countries all during the 1950s psychiatric beds constituted 40-50% of the total hospital bed capacity with a turn-over in mental beds of only 2 or 3%[17]. Construction of new mental hospitals had very low priority. The institutions were relics of the nineteenth and early twentieth centuries. In France 89 psychiatric institutions were constructed from 1840 until the turn of the century with only three opened from 1900 to 1940. In Great Britain in 1960 one historical review spoke of England's mental hospitals as prison-like asylums mostly situated well away from large centres of population and standing "like obsolete battleships stranded on some remote sandbank -- a formidable problem bequeathed by our Victorian predecessors"[18].

Despite these conditions, there was a strong current of optimism about social welfare programmes, including the field of mental health. Treatment methods were improving with the introduction of insulin shock therapy in 1930, convulsive shock in 1933, and electro-shock therapy in 1938. Surgical methods were also instituted in the late 1930s. Hospital authorities and attending physicians, along with the families of the patients, were overcoming the resistence to discharging patients as improved, though not completely well. The hospitals were developing more effective patient care and management techniques culminating in the concept of the therapeutic community within the institutional setting.

Dramatic breakthroughs were achieved in the care of psychotic patients with pharmacological agents, beginning with chlorpromazine between 1952 and 1954. In their history of that period, Alexander and Selesnick referred to the development of the psychoactive drugs as opening new horizons for psychiatry. In a very telling observation, they concluded,

> "Their use has markedly shortened the hospital stay of severely disturbed patients and has also simplified the hospital management of these patients by making them more tractable. And what is more important, the more drastic methods of treating psychotics -- electro-shock, insulin therapy, and psychosurgery --

are less frequently used. Unfortunately, most severely depressed patients respond less rapidly to the antidepressant drugs than to electroshock; nonetheless, these drugs have made it possible to humanize the hospital treatment of psychotic patients by substituting chemical for corporal restraint"[19].

Many observers have concluded that improved conditions and methods of patient management in the large mental hospitals were of equal importance in improving the prognosis for the severely ill psychiatric patients. A range of changes in institutional practice including increased patient activities, a decrease in restriction and a process of "normalizing" human relationships, were subsumed under the label "open door policy". Begun in the Dingleton Hospital in Scotland, the policy was growing rapidly by the end of the 1950s. Krapf and Moser reported that in 1957 80% of the wards were open in Scotland and about two-thirds were open throughout the United Kingdom. In 1959, 40-50% of the wards were open in Sweden, 60-80% in Canada. About 50% of the hospitals in Japan had some open wards. At a hospital in Ruanda Urundi which had been completely closed ten year before, it was reported that the hospital was operating entirely on an open-door basis. The turnover of patients was rising sharply, but overcrowding continued to plague the institutions all over the world. The Krapf and Moser study indicated that bed occupancy was from 90-130% in most countries surveyed with over 130% occupancy in Brazil, Columbia, and the Union of South Africa[20].

The mental health law changes in these years tended to reflect the therapeutic optimism. Voluntary admission was encouraged and more laws were enacted allowing non-judicial, involuntary admission based only on medical certification. The Federal Government of the United States produced and strongly advocated a so-called Draft Act for the Hospitalization of the Mentally Ill whose main feature was such a provision. This was a very significant change in legal philosophy in a nation where judicial commitment was still the common practice and where 26 of the 49 states then provided for a jury trial on hospitalization of a person charged with mental illness.

During the 1960s, however, the emphasis on simplified methods of involuntary hospitalization was reduced in the face of greater political and legal concern for the protection of human rights. Voluntary hospitalization continued to rise, however, and the British idea of "informal admission", introduced in the Mental Health Act of 1959, received support as encouraging the handling of mental patients in the same way and under the same conditions, or lack of them, as any other type of medical hospital patient.

Community-based Mental Health Programmes:

The other major development in the mental health systems during these decades has been the movement toward community-based mental health programmes. In some measure, this movement has meant a reduction in the emphasis on the larger, general-purpose psychiatric institution. However, in most countries the result has been the development of comprehensive services, including the large hospitals, but providing a very wide range of alternative modes of treatment. The new efforts are reaching a much larger proportion of the people in need of care, a clientele rarely seen by the former programmes.

The comprehensive mental health programmes offer a fresh challenge to the development of effective mental health legislation never before faced in the evolution of law in this field. The challenge is only just beginning to be realized.

Accommodation to the new situation cannot be achieved by further tinkering with the hospitalization procedures, or with changes in terminology and definitions. A totally new administrative structure is needed to encourage communities to set up and administer their own mental health services on a de-centralized basis. Therapists and caregivers will not 'be trained psychiatrists in most situations. In the developing countries, and perhaps in most other countries as well, mental health services will need to be integrated into generalized health services designed to deliver primary health care to all of the people.

With the bulk of the mental patients remaining in the community, or sent to health centres or hospitals only when necessary and for limited periods, the legal system will need to allow for a variety of mental health services to a range of patients with different degrees of social and legal responsibility. In most cases, every effort will be made to restrict the rights and privileges of mental patients as little as possible in areas such as automobile driver's permits, professional and occupational licenses, control of property, voting, marriage, and the custody of children. Confidentiality of psychiatric records may need to be maintained by law to an even greater extent in order not to weaken or prejudice the situation of community-based patients, at least as long as all psychiatric illness continues to carry a heavy social stigma. The continuation of these legal and political rights and privileges is not advocated on the sole basis of equalitarian principles, though these do play a part, but on the practical necessity to assure the patients a place in the community, an opportunity to work, and the means of obtaining the community-based care the new programmes offer to them.

Another important development during the period since 1955 has been the concept of mental health care as an integral part of general health services and its introduction into primary health care. It is now widely accepted that mental disorders "constitute a public health problem far too great to be handled by the psychiatrist alone" and the implications for developing countries with their particular resource constraints have been discussed in detail in the WHO Expert Committee on organization of mental health services in developing countries. These developments have yet to be fully reflected in mentalhealth laws.

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## III. International Legislative Survey:

### A. Introduction

As indicated earlier, our comparative international survey is based on an analysis of the current laws, a review of available literature, and the results of the questionnaire survey sent to members of the WHO Expert Advisory Panel on Mental Health, certain other knowledgeable observers and officials of the governments, and to the Regional Offices of the World Health Organization.

In this first section we examine a group of indicators which may help to assess the relevance of the current laws to the mental health programmes of the countries and the interest in changing the law among professional groups and others affected by the law. We then go on to examine the degree to which the legislation is understood among various population groups and the amount of training in mental health law given to different profession groups who operate under the law.

The next three sections deal with specific areas of the law beginning with programme administration at the national level. Special attention will be given to federal governmental structures under which the major responsibility for mental health programmes is at the state or provincial level. Community based mental health services will also be examined in this section. Hospitalization procedures are reviewed in detail as are protective measures for patients in and out of hospital. Each section will include discussion of practical operational problems as well as technical legal matters disclosed in our legal review and in the questionnaires. For detailed comparison between countries these sections contain a series of tables setting forth specific provisions and citations to the applicable statutes and administrative regulations.

The comparative survey also includes three special analyses in greater depth. In the first, related to the United Kingdom, we examine the movement for greater protection of patient's rights under the Mental Health Act of England and Wales which was enacted in 1959. This discussion should provide a useful catalogue of the issues which may be faced in any country in regard to matters of patient's rights and

and liberties in a mental hospitalization programme. The second is a broad overview of the general legal system of The Netherlands in regard to the effects of mental disability upon such matters as marriage and divorce, child custody, the making of wills and contracts, voting, and professional licensure.

The concluding section reviews comprehensively the mental health legislation in one region of the developing world, the Eastern Mediterranean. This analysis is of a very different order than the other two, not only in its scope of coverage, but in the different character of law and practice in these countries. Greater use was made in this section of non-legal references and the reports of experienced participants in the mental health systems of the various countries. It is hoped that this review will afford special insight into the workings of mental health programmes in the developing countries which cannot be gained in any general comparative review concentrating upon statutory structures alone.

## B. State of the Art: Some Indicators

### 1. Years of Enactment: Origins and Obsolescence:

There are fashions and cycles in mental health legislation just as there are in any other area of law. The cycles did not pass through all nations at the same time, nor in the same order. However, certain trends can be detected on an international basis. Most of the commitment laws stressing judicial or police involvement were enacted in about the middle of the nineteenth century. Emphasis on formal structures and court review continued during the remainder of the asylum era. The mentally ill and the retarded were segregated or alienated and generally lost legal capacity and civil rights. Significant change in treatment methods and in public attitude toward the mentally ill did not tend to have an effect upon the law until about the middle of the current century. The mental health legislation of many countries was significantly revised in these years. The last two decades have seen more varied and often more piecemeal changes in response to the greater complexity of the mental health systems themselves and the lesser concentration upon long-term hospitalization of the chronically ill.

In the developing countries, a different pattern is found. Many are operating under informal systems in regard to their hospitalization and treatment services. Others function under statutes of colonial origin adapted from the domestic laws of the colonial authority. These laws are generally many decades old and long since abrogated in the home country. It is doubtful that these laws were ever very applicable to conditions in the developing countries. In just a few of the newly independent nations entirely new laws specially applicable to that nation and to its mental health programmes have been adopted.

The following Table, Table 1, gives the period of enactment for the major mental health legislation in the nations reviewed which were operating under formal statutory structures. Exact years and specific citations to the relevant laws are provided in the tables which follow in later sections of this Report. A few of the countries listed in Table 1 are not included in the later tables, but were included in the questionnaire survey.

We caution the reader not to assume that recent enactment of a mental health law necessarily means that the legislative programme is functioning adequately in relation to the country's needs. Some such laws are virtually obsolete at the time of passage. Others are quite advanced forerunners which remain effective for many years. The Lunacy Act of 1890 in England and Wales was in the former category, according to Kathleen Jones[1]. The French legislation of 1838 has been a fundamental and enduring basis for both the development of psychiatric services and for access to treatment.

Keeping in mind the above caution, we can make certain observations about the current status and origins of the law in the various countries.

Among the new nations of Africa surveyed, only Sénégal was found to have recently adopted (1975) an entirely new law specifically adapted to conditions of the country and in accordance with modern psychiatric treatment and practice. Colonial origins are still apparent in the law and practice in Nigeria where the basic law was adopted in 1916 based on the British Lunacy Act of 1890 and in Benin and Rwanda where the French law of 1838 and the Belgian law of 1850 are still influential. The

TABLE 1

YEARS OF MAJOR ENACTMENT

| | |
|---|---|
| 1970 - 1976 | Canada (Alberta), Costa Rica, Saudi Arabia (Draft law, 1976), Sénégal, Sudan, United States of America (Indiana, Massachusetts). |
| 1965 - 1969 | New Zealand, Romania, Switzerland (Geneva), Syria. |
| 1960 - 1964 | Canada (British Columbia), Lesotho, Norway, Switzerland (Basel). |
| 1955 - 1959 | Australia (Victoria), United Kingdom (England and Wales). |
| 1950 - 1954 | Japan, Maylasia, Poland, Peru. |
| 1930 - 1949 | Australia (South Australia), Brazil, Cyprus, Democratic Yemen, Denmark,*** Egypt, Fiji, Uruguay. |
| 1900 - 1929 | India,‡‡ Mauritius,* Nigeria. |
| Pre - 1900 | Ghana,** France.‡ |

* Current law 1906; new law 1965, but not in operation.

** Operating under law of 1888, amended 1957; new law 1972 not in operation.

*** Amended by Order of 1957 and 1959.

‡ Frequently amended, Ministry circulars, etc.

‡‡ The basic Indian law is the Colonial Law of 1912. The same law is currently operational in Pakistan and Burma.

current law in Ghana dates back to 1888. A new law was approved in 1971 based upon the English Mental Health Act of 1959, but it has not yet been put into operation. In Mauritius the operational mental health laws date from 1858 and 1906, the latter again based upon the English law of 1890. In 1965, a new law, quite detailed and complex, based roughly on the English-Welsh Act of 1959, was enacted, but has not been implemented. The new law does not seem adapted to conditions on the island and may not come into operation. The mental health legislation of Lesotho was adopted in 1963 repealing the law in force since 1879. The new law is based on the English-Welsh Act, 1959 including the installation of Mental Health Review Tribunals. Our respondent observed that the new law was not well known in the country because it is available in only a few places and in English and, unless new mental health manpower is made available, is not apt to be implemented to any great degree. He concluded also that unless special interest in the matter was created, the law will not be changed in the next 30 years or so, either.

In the Eastern Mediterranean, many of the countries function under informal systems, but a few nations have recently adopted new legal provisions specifically applicable to present conditions. This is the case in Sudan (1975) and in Saudi Arabia, which has a draft law published in 1976. In Egypt, there is considerable interest in revising the mental health law of 1944 which is considered outmoded and not in accordance with modern public health and psychiatric service objectives in the country.

In Europe, the mental health legislation was found to be from ten to forty years old. There was relatively substantial activity around the end of the 1950s and in the early 1960s, but legislative interest has not been extensive since that time. The only country considering fundamental revision in the law at present was reported to be Poland where the current law dates from the early 1950s.

In the Western Pacific, the periods of enactment were quite varied with New Zealand and Australian laws of considerable detail and complexity passed in the 1960s and 1950s but with generally older law in other countries.

In South East Asia, our survey was limited, as indicated earlier. However, we found that India, Pakistan, and Burma were all still functioning in large part under the British Colonial law of 1912. Our correspondents in India indicated widespread interest in changing the law in that country. A legislative bill was being considered by the legislature in Punjab in 1975.

In the Americas the legislative picture was also varied. In Canada and the United States of America, there is considerable interest in mental health legislation, both in regard to protection of patient's rights and in regard to development and expansion of mental health services. New laws are being considered in some of the Provinces of Canada and one of those surveyed, Alberta, had passed a controversial new law in 1972. Many of the States in the USA have adopted new legislation during the 1970s, particularly relating to patient's rights and stricter commitment laws. This followed a wave of community mental health laws in the 1960s.

In Costa Rica, a General Health Law of 1965 contains a number of broad provisions encouraging the development of mental health services on a voluntary basis.

In South America, one finds informal systems or rather basic statutory structures in many countries. A study in 1966 by the Mental Health Information Centre of the Pan American Health Organization found voluntary hospitalization laws in only five countries: Brazil, Chile, Peru, Uruguay, and Venezuela. Our survey covered three of these countries, Brazil, Peru, and Uruguay. The laws in all three dated back some years -- Brazil to 1952, Peru and Uruguay to the 1930s. We received no reports of efforts to change the law in any of these countries, but psychiatrists and health professionals in Peru and Uruguay were reported as desiring fundamental changes. In Peru, it was reported that there was an "urgent need for adequate legislation", but that it was extremely difficult to interest legislators in the problems of mental health.

2. Interest in Change in the Law:

Another indicator of the current status and effectiveness of mental health legislation in any country is the interest in fundamental change in the law among professional and other groups who must work with the law or function under it.

Our questionnaire responses displayed dissatisfaction with some aspect of the current legislative system in a majority (28 out of 44) of the countries surveyed. The most commonly expressed complaint was that the legislation was generally outmoded and not in keeping with current needs. There were more observations that the law was too simple than that it was too complex. In very few countries was the law found to encourage expansion of services into the communities, or to make further options for care and treatment available. Many respondents noted the reluctance of the legislators and the government administrators to provide the needed financial support for an effective mental health programme thoughout the country.

We tried to probe somewhat deeper concerning interest in change by asking what groups in the country were advocating fundamental or radical amendment of the current legislation. Most frequently mentioned were psychiatrists, often from outside the government. Next were other mental health professionals. These groups were most active when they believed that the law was substantially obsolete and not aiding the movement toward more comprehensive mental health programmes. Next more frequently mentioned were social workers who wanted legal barriers removed which impeded effective services and who wished to protect the rights and welfare of mental patients and their families.

In a few industrial countries where the law is already quite sophisticated, lawyers, and also certain private groups described as anti-psychiatric, such as Scientologists, were noted as urging stricter commitment laws, protection of patient's rights, and the right to refuse psychiatric treatment.

In a few countries, the police were seeking changes in mental health legislation and penal laws on the mental disordered to aid them in handling disturbed persons in emergencies and to deal with growing

problems of drug abuse and illegal drug distribution.

We had expected mention of voluntary mental health and retardation associations and groups representing the parents of retarded children or disturbed children, but such organizations were noted in only three countries. This response may have been due, however, to the questionnaire's stress on professional groups and officials and to the background of respondents, most of whom were psychiatrists in universities, treatment facilites, or government who may not have been familiar with the legislative activities of some of the voluntary groups. Many of the countries, of course, do not have active voluntary organizations in these fields.

3. Concentration on Hospitalization Procedures:

According to the study by Krapf and Moser, one of the important indices of change in the administration of mental health programmes in recent decades has been the movement to comprehensive services for a wider range of the population[3]. In the earlier years, the concentration was on custodial care in the large mental hospitals. The newer approaches emphasize care in the community, preventive care, crisis-intervention, foster care, half-way houses, day care institutions, etc.

We attempted to examine the legislation in the countries surveyed to see if there was evidence of legal change to accompany the shift in programme emphasis. On the whole, this was not a rewarding effort. With few exceptions, the laws of the countries surveyed were concerned with hospitalization procedures, with empowering police, social workers, and others to apply for the admission of patients, and with the protection of the rights and welfare of hospitalized persons. Many countries had provisions for foster care mainly in order to establish guardianship authority, or to assure government support for the care provided.

Among the countries surveyed, a range of services and facilities were mentioned in France (Ministry circulars dating from 1948); Denmark (community-based services); Norway (a network of psychiatric nursing homes, day care hospitals, and convalescent homes coming under the statutory supervision of the mental hospitals); Sénégal (hospitals, psychiatric villages, out-patient care, family care, etc.); Canada (regional and

community services); and the United States of America (federal and state laws of considerable detail on community mental health centres, mental retardation services, alcoholism and drug addiction rehabilitation, etc).

More generalized provisions on decentralization of authority for mental health services are found in the mental health legislation of Great Britain. In Poland, mental health services are integrated into a network of over 400 local public health dispensaries in the country.

There is no doubt but that a great deal of the change which is taking place in mental health services delivery systems is not reflected in the law, even in many countries and states of federal nations with quite sophisticated and detailed mental health legislation of fairly recent enactment. The legislatures and government authorities find it unnecessary and often inadvisable to spell out these matters in the statutory law.

It may well be that this is good and proper governmental administration. It has the advantage of not locking in particular management structures which may be difficult to change at later times. However, it often means resistance to shifts in basic authority for programmes and an avoidance of specific accountability to the legislative and political system for public services needed by the people. These issues will be discussed at greater length in Part IV of this Report.

4. Movement to Voluntary Care:

Quantitative measures of progressive movement are even more difficult to discover and apply to the field of mental health legislation than administrative-structural or qualitative measures. About the only quantative measure we found available in most countries was the rate or proportion of voluntary admissions to all admissions to the mental hospitals. The significance of these figures was well expressed in 1966 by the Canadian Royal Commission on Health Services:

> "The number and proportion of all voluntary admissions is alleged to be, to some extent, an index of acceptance of and attitudes toward psychiatric treatment by the country"[4].

Measured by this criteria, progress in Canada was not very great. From the 1930s when the proportion of voluntary admissions for all of Canada was 5%, the proportion had risen to only 17% in the early 1960s. By contrast, in England and Wales since the Mental Treatment Act of 1930 had introduced voluntary admission, the rate of voluntary hospitalization had risen to 75% at the end of 1957[5].

The Krapf and Moser study in 1960 reported voluntary admissions of between 75 and 100% in Japan, Taiwan, the United Kingdom, and Yugoslavia[6]. Percentages of from 45 to 60% were found in Ireland, Portugal, Sweden, and New Zealand.

The experience in the United States of America has been one of steady growth in voluntary admissions, but they have never reached the levels of many of the countries covered in this survey. The first voluntary admission law was adopted in the USA in the State of Massachusetts as early as 1881. In 1955, however, the WHO survey reported a voluntary admission rate of only 10% for the nation as a whole. In our current study, the latest national figures were for 1972 and they showed a proportion of 48.6% voluntary admissions.

The following table, Table 2, indicates the proportion of voluntary admissions in the countries covered in the questionnaire survey where figures were given. Those where only a rough estimate was made by our respondents are specially marked. On some countries no data on admission status was available.

We caution readers that many of these figures not marked as rough estimates may also be questionable, since few countries attempt to compile nationwide figures on census and admission by categories of admission status. Also, different methods of compilation were used. In some countries, only the figures for publicly operated mental hospitals were included. In others, all hospitalizations were reflected, but only in rough estimation.

It will be noted that the countries with the highest levels of voluntary admissions were all developing countries, which may surprise many readers. The reason is not that assumed by the Canadian Royal Commission. It was due largely to the informality of the hospitalization

TABLE 2

RATE OF VOLUNTARY ADMISSIONS

| Percentage | Country |
|---|---|
| 0 - 10 | Fiji*, Malaysia*, Punjab*(India), Uruguay. |
| 11 - 40 | Agra*(India), Bahrain, Indiana(USA). |
| 41 - 60 | Argentina*, Connecticut(USA), Benin, Geneva(Switzerland), Jordan, New York(USA), Norway, United States of America, Victoria(Australia), Western Australia*, Yemen*(DR). |
| 61 - 80 | France*, Massachusetts(USA), New South Wales*(Australia), New Zealand, South Australia, West Berlin*. |
| 81 - 90 | Basel*(Switzerland), Denmark, Ghana, Iran*, Lesotho*, Poland, Rwanda*, Tasmania(Australia), United Kingdom. |
| 91 - 100 | Cyprus, Egypt*, Iraq, Kuwait, Senegal*, Sudan. |

* Rough estimate

procedures in these countries where most admissions were considered voluntary when not on police or court order in criminal or state security matters. Also, some of these countries rely heavily on hospitalization in private hospitals or the psychiatric ward of the university hospitals which admit patients voluntarily or informally.

In most countries we had only one respondent so that the figures given reflect one experienced observer's opinion. In a few countries we had from two to three respondents. In only one of these did we have difficulty in determing what figure to use as an estimate of the proportion of voluntary admissions. This was Japan. In that country we had three respondents. All agreed that the law of Japan did not authorize voluntary admissions. One respondent answered that he could not estimate any voluntary admissions, since they were not officially recognized. A second answered that there were "very few" such admissions. The third provided us with a rough estimate of 20% voluntary admissions. He reported that voluntary admissions are provided in the out-patient clinics of the university hospitals and in psychiatric clinics of general hospitals. If these are all out-patients, they would not affect the proportions, since the inquiry related to in-patient services. Therefore, no estimate is given for voluntary admissions in Japan. It should also be observed that some 90% of all mental hospital facilities in that country are privately operated. The bulk of the mental health legislation is taken up with complex provisions for the support of an elaborate social insurance system for psychiatric care. There are two types of hospitalization covered under the government-supported insurance plan, one called involuntary, the other called compulsory. These procedures are described in later sections of this Report. The private hospitals, and the patients and their families, are inclined to accept admissions under the authorized methods, since no other psychiatric care will be financially supported by the public insurance system. Under these conditions, voluntary hospitalization cannot be expected to be reported at very high proportions in Japan.

5. Human Rights:

The general movement for protection of human rights has been very strong since the end of World War II in response to the Nazi and Facist

excesses of the 1930s and 1940s. The Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations in 1948. A number of other international declarations and covenants have also been produced in these decades. At their foundation is the inherent dignity of all humanity, and from the humanity the rights are derived.

Serious problems exist for protecting handicapped persons, whether the handicaps are due to sickness, physical incapacity, mental incapacity, or social-cultural deprivation. Many of the international and national codes on human and civil rights recognize a special obligation upon governments to ensure protection of the rights and welfare of the handicapped who do not have the means to protect themselves.

There is no international declaration specifically covering the rights of all groups of the mentally ill. However, the Declaration of the Rights of the Child, the Declaration of Rights of Mentally Retarded Persons and the Declaration of Rights of Disabled Persons (copies attached) provide important principles on which the rights of the mentaly ill can be based.

Some national governments and states within federated countries have adopted special protective legislation for the mentally ill and other mentally disordered persons, such as the mentally retarded. These laws can generally be classified into two different groups: those which place the individual under supervision or guardianship as a dependent, legally incapacitated individual; and those which have given the person special opportunity to protest their hospitalization or classification, or which have made efforts to retain to the person, though admittedly mentally disordered, many or all of their civil and social rights, privileges, and responsibilities.

The first type of protective-dependency system was most applicable when the individuals covered by the designation of "insane" could be expected to be adjudicated as incompetent if they had property, and who were either under guardianship or committed to a distant, remote asylum.

The first movement against this system came with the adoption of Lunacy Commissions and the establishment of methods of appeal against wrongful commitment. The very fact of a right of appeal implied a legal capacity on the part of the hospitalized patient, at least until the

appeal was heard and the patient declared properly committed. The granting of other rights and privileges to hospitalized patients were designed to reduce isolation from families and friends, and to allow trial leaves in the community.

In the most recent changes, hospitalized mental patients are presumed to be fully legally capable unless special action is taken before the courts to have them declared incompetent. Such provisions have been enacted in various states of the USA and in provinces of Canada. Currently in Victoria, Australia the law requires the automatic transfer of control over all property of committed patients to the Public Trustee. The Report of a Committee of Inquiry into the Hospital and Health Services of Victoria (Townsend Report) published in 1975 recommends that the law be amended to require a determination of the incompetence of the patient to handle his affairs[8].

Our survey revealed few countries to have enacted special laws which grant privileges to patients in regard to receiving and sending mail, having visitors, wearing their own clothes, being paid for work done in the institutions, etc. Specific provisions in these areas will be discussed later in this Report.

## 6. Interaction between Law and Mental Health Care:

In some measure, the impact of the law is related to the degree to which it is understood in the country. An effort is being made in some countries to make mental health legislation more understandable, more accessible, to the patients and their families, to the health professionals and social welfare personnel, and to the police and judicial systems. In part this is accomplished by simplifying the content of the law and making it correspond to the actual practices in the field. In some countries, the provisions of the law are posted in the hospitals and pamphlets are distributed to explain the methods of application for admission and discharge and appeal against involuntary confinement.

In most of the countries surveyed, the understanding of the mental health legislation was reported to be limited among the general public, whether urban or rural, and among community leaders and in the press

and other media. Psychiatrists were generally found to have a high degree of understanding of the law in nearly all countries followed by police and social workers. Magistrates and lawyers had reasonably good knowledge of the legislation, probably related to specific matters coming before them. Differences by region may be of interest. Understanding of the mental health law by the general public and by the press and other media was reported to be virtually nil in the two South East Asia nations surveyed. It was reported quite limited in the African Region. In the Eastern Mediterranean and the Western Pacific, the understanding of the general public was limited, but the press was reported as somewhat more knowledgeable by some observers.

As might be expected the questionnaire results were more varied in the European and American Regions. In Europe public understanding was reported as limited in England and limited to fair in Denmark, France, Romania, and Poland. In Switzerland and Norway it was reported to be reasonably good. Press-media understanding was reported to be reasonably good in Switzerland and Norway, but only limited in England and Poland. In the American region, knowledge was reported as virtually nil in Peru for the general public and the press. In Brazil and Uruguay, the general public's understanding was reported as nil in the rural areas, limited in the urban. Press and other media understanding was reported as limited in both countries. In Canada, our respondent reported understanding as reasonably good for all groups. In the USA, public and media understanding was reported as limited in Indiana. No estimate was offered concerning other states.

Regarding the level of understanding of the law by psychiatrists, social workers, police, magistrates, and lawyers, there was very little difference reported among the regions.

We also asked about the adequacy of training given in mental health legislation to psychiatrists, physicians, nurses, lawyers, police, magistrates, social workers, and religious leaders.

In South East Asia, only psychiatrists and magistrates were reported as having adequate training. In the African Region, it was reported that

all of the groups received poor or limited amounts of training except in Ghana where it was reported that training is adequate for all but religious leaders. In the Eastern Mediterranean, only psychiatrists, social workers, and judges receive adequate training. In Malaysia, training was indicated as adequate for all but religious leaders. In Japan, training was reported adequate for psychiatrists, physicians, and social workers in the Tokyo area, but poor for others in that area and for all groups in other parts of Japan.

In Switzerland and Romania training was reported as adequate for all groups. In France and Poland it was reported as limited for all groups. The remaining European countries reported adequate levels for physicians, psychiatrists, and social workers.

In Peru, adequate training was reported only for magistrates. In Brazil it was adequate only for physicians and psychiatrists. In British Columbia, Canada, training was reported as adequate for psychiatrists, lawyers, social workers, and religious leaders.

Forensic medicine training is given in the medical schools in most of Europe with perhaps one or two lectures on mental health legislation of a general nature. More attention is given in these courses to criminal law and criminal behaviour as related to psychiatric disorders. Medicolegal courses are also provided in the majority of the law schools in Continental Europe, but attention to mental health legislation is quite limited. Very little if any attention is given to medicolegal subjects in the law schools of the United Kingdom, except for the insanity defence in criminal law.

In the United States of America and Canada, legal medicine courses are not well developed in the medical schools, but have been increasing in recent years. The law schools of the United States are currently giving considerable attention to law and psychiatry, with a good deal of emphasis on hospitalization law and the rights of the mentally ill, alcoholics, drug addicts, prisoners, etc. The subject also receives coverate in Constitutional Law and Civil Rights courses.

## B. Programme Administration

### 1. Federal Structure:

Federal governmental structure presents obvious complications for mental health programme planning and development at the national level. Health matters, including mental health, are traditionally handled at the state levels in nearly all federal countries, including those not covered in this comparative survey. Yet, the central ministry or national department of health is generally charged with promoting improvement in the mental health of the people as a whole. Legislation does have more significance in the mental health field than in most other areas, since it is concerned with behavioural matters, hospitalization laws, control of drugs and drug abuse, etc. National planning in mental health should include attention to these legal matters. Examples of alternative approaches can be derived from a study of the experience of the federated states examined in our survey.

Our analysis revealed three types of federal structure: (1) countries where virtually all mental health law of the type surveyed was found at the state level (Australia, Canada, and Switzerland); (2) countries where the mental health law was substantively the same in each state, but separately enacted or approved (India and Nigeria); and (3) one where there is considerable federal influence (United States of America).

We are sure that there is overlap in these classifications. For example, there is some federal or central government activity in the three countries of the first category, but not to the extent of that found in the USA. Some observers thought the degree of state autonomy greatest in Australia, some thought it greatest in Switzerland.

The situation in India and Nigeria was found to be quite dissimilar to the other countries in many respects. The states in each country are legally autonomous for many purposes. However, for the two states surveyed in India and in Nigeria, the mental health legislation was found to be essentially the same. In both countries the law, with some amendments over the years, dates from British Colonial times, 1912 in India and 1916 in Nigeria. There is considerable interest in both countries to adopt modern legislation specially applicable to present conditions and needs.

The Nigerian situation is highly dynamic and changing. There are now twelve states with considerable pressure for the creation of many more. The plan at present is to expand to ten new states and to move the federal capital now at Lagos to a more central location in the country. The latter move is not expected for ten to fifteen years. Programmes in mental health services in Nigeria have long been considered models for other developing African countries. Pilot experiments in community psychiatry in Aro, Abeokuta, Western Nigeria in the mid-1950s, for example, have been adopted in a number of other countries. Over a period of time, we would expect the mental health law of the various states in Nigeria to become more dissimilar than at present as new programmes and laws are adopted by the regional or state legislatures. The Federal Constitution of Nigeria reserves to the states such areas as health, education, social services, local taxation, and local police functions.

In the United States there was a wide variation in the mental health law of the fifty states, the District of Columbia, and the Commonwealth of Puerto Rico. The Council of State Governments in 1974 referred to the total mental health programmes of these jurisdictions as "the largest health system in the United States and one of the largest in the world"[7]. The annual budget for the states in 1972-1973 was nearly $4 billion and the number of patients served was over 2 million. Many if not most of the American States have revised their mental health legislation substantially in the past five or ten years. Both states included in our survey adopted radical reforms in the 1970s.

There are two ways in which the federal government of the USA has been influential in the mental health field. The first has been in providing federal funds for the support of development of new mental health service programmes, for psychiatric and behavioural science research, and for personnel training. The second has been in adopted federal laws setting standards in certain areas of mental health services, particularly community-based services, and in stimulating the adoption of model laws or uniform laws in the states in areas of mental health. The federal government has also cooperated with the states in helping to develop what are called "interstate compacts", or legal agreements among the states concerning matters of cross-state importance, such as transport of patients and return of patients to their home jurisdictions for care and treatment. Currently there is an Interstate Compact on Mental

Health and an Interstate Compact on the Mentally Disordered Offender.

One other area of national influence in mental health service programmes in the USA should be mentioned. This is the fairly recent movement of the federal level into health insurance financing. The Medicare and Medicaid Programmes in force since the mid-1960s cover mental illness to a limited degree and set standards for care and treatment which must be met in the states by public and private providers. Any future expansion of national health insurance in the United States would probably cover mental disabilities to some degree and would carry with it further federal regulation.

Some features of the type of federal or central government involvement in mental health services described above for the USA were found in other federated nations. In Switzerland, for example, intercantonal agreements and an association of the cantons function outside the central government for certain health matters such as control of pharmaceuticals. Mental health services are quite strictly a cantonal responsibility, but the Swiss federal social insurance system results in the stimulation of programme development in some fields such as rehabilitation. The insurance system has also stimulated the growth of outpatient mental health services. The federal Penal Code in 1971 authorized the use of cantonal mental hospitals and other services for treatment and rehabilitation of mentally ill, alcoholic, and drug dependent persons convicted of federal crimes.

Our comparative survey did not go into depth on matters of federalism and national policy in federated states. Our respondents were observing largely from the state level. A later legal study could well be concentrated upon a larger number of federated countries and a much broader survey of both the state and the federal levels could be conducted. It is our belief that such a study could be most useful, since there are so many federated states in the world.

It seems clear, however, even from our limited review that the alternatives in the mental health legislative field are quite extensive. Federal legal activity in this field can be found to range across the following areas:

1. Federal support of health and disability insurance schemes including mental health services with policies to encourage or require uniform, or at least adequate, levels of mental health care benefits in all states.

2. Federal standard-setting or licensing for mental health services and facilities under federally supported health and disability insurance.

3. Federal financial support of mental health research and training through grants to the states and to individuals, universities, and voluntary agencies in the states under federal law and guidelines on areas of research, eligible recipients, ethical principles, etc.

4. Federal law in areas of federal supremacy, depending on the national constitution, concerning such matters as foreign and interstate commerce in psychoactive drugs, illegal importation of dangerous and habit-forming drugs, national immigration controls on mental health personnel, transfer of patients between states, etc.

5. Encouragement of cooperation and uniform laws in the states to improve mental health services.

6. Encouragement of cooperation and uniform laws, where advisable, in behavioural areas such as alcoholism; drug abuse; sexual deviancy; child care, custody, and neglect; juvenile delinquency; and probation and parole (including mental health consultation and treatment) for criminal offenders.

Each of these areas has legal precedent in federated nations. The first three are related to national funding programmes. The fourth is a more direct, substantive area of federal legal powers. The last two involve encouraging the states to act together in a cooperative fashion without federal intervention or regulation. It should be noticed that the list does not include federal operation of mental health facilities,

such as teaching and research institutions, or specialized treatment programmes not feasible for development in every state, such as drug dependency rehabilitation, or mental retardation special schools. There are examples of such facilities in a number of federal states. We do not mean to dismiss such activities, but they do not involve legislative or regulatory activities affecting citizens and state governments within the states, which is the focus of the other items listed above. The operation of a few specialized mental health facilities, especially if located within federal territory or in the federal capital, may be considered the least intrusive form of federal activity in the health field.

## 2. Recognition of Distinctions in Mental Disorder: Scope of Legislation:

One of the major debates in mental health legislation -- and in programmes in the field -- is whether all mental disorders should be grouped together, or handled separately.

On the professional management side, the arguments abound as to whether a "medical model" should apply in dealing with the mentally retarded, with sex offenders, with alcoholics, and with drug-dependent persons. From a legal standpoint, the issues revolve around the functional capacities of the various classifications, the social consequences of the disorder or condition, and the placement of governmental authority for dealing with public programmes.

In the older legislation, either no distinction was made among classifications, or "the insane" and "idiots" were disposed of by the law in the same way. Both groups were considered universally to be legally incompetent for all legal and political purposes. Both were handled by alienation from society and were committed to institutions under the same legal provisions. Even after separate institutions, or "schools", were established for the retarded or feebleminded, the law was slow to recognize any need to alter the legal procedures for admission, care,or discharge from these institutions.

Table 3 describes the current scope of the mental health laws in the countries with formal mental health legislation. Three basic classifications are used: those with general-scope legislation covering all classifications; those which combine mental illness and retardation but have separate legislation for some other categories of mental health disorder; and those which have separate legislation for mental illness and for retardation along with separate legislation for all, or nearly all, other categories.

The first classification in Table 3 was found still to be the largest with 16 jurisdictions out of the total group of 28 nations. Some of the laws in these nations recognize different categories of disorder in their definitions, but nearly all make no distinction in operation of the legal procedures. An exception is the Mental Health Act of 1959 in England and Wales where the general definition of "mental disorder" covers mental illness, severe subnormality and subnormality, and psychopathy but where the same law does make some distinctions in the general admission and discharge laws for the different sub-classifications. The sub-classifications are also separately defined in the law. Nevertheless, the Royal Commission in the United Kingdom specifically recommended abandonment of the previous system in operation for 40 years under which separate legal codes covered the mentally ill and mental defectives[8]. This recommendation was accepted by Parliament. The single new law was enacted in 1959 to cover all mental disorders of whatever character. We have therefore listed the **English-Welsh Law in the first** group.

On the other extreme is the Indiana law in the United States. In that jurisdiction, the legislation used the term "mental illness" to cover all categories, specifically including "mental retardation, epilepsy, alcoholism, or addiction to narcotic or dangerous drugs"[9].

The second classification in Table 3 includes countries which utilize a general-scope definition of mental disorder including retardation, but which have also enacted special legislation applicable to at least one other disorder or condition such as alcoholism or drug dependency.

The third classification was the most difficult to determine. Each of these countries has at least some special legislation establishing

separate programmes for mental illness and for mental retardation and also for all, or most, of the other classifications. Some of these countries do retain a general-scope law which may cover broad categories of mental disorder, but they function largely under separately identifiable laws and programmes for each group of patients or residents.

Table 3 reveals a widespread adoption of special treatment and rehabilitation laws for alcoholism and drug dependency, both among the most active areas of new legislation in the entire mental health field.

Provisions concerning "alcoholics" and "drunken offenders" can, of course, be found, not only in mental health legislation, but in the criminal law, motor vehicle law, labour law, insurance-programme legislation, and in public health laws. A general review of this field was recently completed at the WHO Office of Mental Health in Geneva[10].

The Scandinavian countries have long been pioneers in developing treatment programmes and legal control measures in the field of alcoholism and alcohol abuse, but many other countries are now applying new legal measures to cope with this very serious health problem. Among the current trends are efforts to remove criminal penalties for chronic or public drunkeness and to deal legally with the disorder as a medically and psychologically treatable illness rather than as a crime. An Alberta, Canada law of 1970 specifically defines alcoholism as an illness. In 1971 a Uniform Alcoholism and Intoxification Treatment Act was adopted in the United States of America by the National Conference of Commissioners on Uniform State Laws. Under this law, criminal penalties for public drunkeness are repealed and programmes of treatment and rehabilitation are installed. The Act has received strong support from the federal government which now requires the states to have adopted this law or similar legislation in order to be eligible for certain federal highway construction and maintenance funds. Also, the federal government has made substantial demonstration grants to various metropolitan areas or states to aid in the installation of programmes in the alcoholism and alcohol abuse fields, especially as related to road accidents.

New legislation related to drug dependency has been adopted in a number of countries in the past ten years, largely in response to the

TABLE 3

SCOPE OF MENTAL HEALTH LEGISLATION

BASIC SYSTEM

General Scope: Benin; Canada (British Columbia); Cyprus; Democratic Yemen; Ghana; Iran; Kuwait; Lesotho; Nigeria; Romania; Saudi Arabia, (Draft Law); Sudan; Syria; United Kingdom; United States of America (Indiana).

Combines Mentally Ill and Retarded, but Separate Legislation for some other Special Categories: Australia (South Australia and Victoria); Brazil; Canada (Alberta); Egypt; Japan; Malaysia; Peru; Poland; Switzerland (Basel and Geneva).

Separate Legislation for All, or nearly All, Categories: Costa Rica; Denmark; France; Norway; United States of America (Massachusetts); Uruguay.

SPECIAL CATEGORIES

Combines Alcoholism and Drug Addiction: Australia (Victoria); Brazil; Norway.

Alcoholism and Alcohol Abuse: Australia (South Australia); Costa Rica; Denmark; Egypt; France; Poland; Switzerland (Basel, Geneva); United States of America (Massachusetts).

Drug Dependence and Drug Abuse: Australia (South Australia); Costa Rica; Egypt; France; Japan; Malaysia; Peru; Senegal; Switzerland (Basel,Geneva); United States of America (Massachusetts); Uruguay.

Sexual Deviancy: Australia (South Australia); Denmark; Egypt; Norway; Switzerland (Basel); United States of America (Massachusetts).

spread of drug use in the 1960s. The earlier laws dealt largely with serious addiction or dependency upon the narcotic drugs. Later laws have also covered the so-called "softer drugs" such as barbiturates and amphetamines. Most of the laws have established specialized treatment and rehabilitation programmes, some of them compulsory, but they are less apt to have removed criminal provisions than in the alcoholism field. However, many of the laws allow treatment and rehabilitation to replace entirely, or to some extent, the criminal sentence of a person found guilty of illegal possession and use of drugs where the person is also found by medical examination to be drug dependent.

There has been extensive activity in the field of international narcotic drug control in the United Nations agencies and among the nations of the world. The Single Convention on Narcotic Drugs has substantially replaced earlier treaties in the field. The Convention on Psychotropic Substances has also been adopted by a number of nations since its initial approval in 1971. The Commission on Narcotic Drugs of the UN formulates United Nations policy and coordinates efforts of the international community in the field. The United Nations Division of Narcotic Drugs, located in Geneva, serves as the substantive Secretariat for the Commission on Narcotic Drugs. In 1971, the United Nations established the Fund for Drug Abuse Controls, also headquartered in Geneva. At WHO, a number of important Expert Committee reports relating to drug dependence have been issued since 1969.

Special attention has also been given to drug abuse and drug dependency, as well as to efforts to encourage cooperation to develop more uniform laws on control of drugs, in the Public Health Division and the Legal Department at the Council of Europe, headquartered in Strasbourg [11].

A great deal of attention has been focussed on drug problems in the United States of America so that some observation of legal changes in that country in recent years should be of interest. In 1970 the National Conference of Commissioners on Uniform State Laws adopted the Uniform Controlled Substance Act. It has been adopted in most of the American states and it substantially revises the law in this field. A National Commission on Marijuana and Drug Abuse, which made reports in 1972 and 1973, has had much less success in encouraging the states to adopt its recommendations, especially those relating to removing or reducing

penalties for private possession and use of drugs[12]. A number of states have, however, adopted laws establishing drug dependency treatment and rehabilitation programmes.

It will be noted also in Table 3 that six of the countries surveyed have adopted mental health laws in the field of sexual deviation. One of the most noted specialized institutions in forensic psychiatry in the world, Herstedvester Detention Centre, Glostrup, in Denmark, has long given particular attention to the treatment of sexual offenders under indefinite criminal sentences.

The legal provisions on sexual deviancy are probably the most diverse of all of the special laws in legal philosophy and medical-psychological therapeutic techniques. Some of the laws in the Scandinavian nations authorize sterilization and castration of sex offenders. Sterilization is also allowed in some of the American states, but not in either of those jurisdictions included in this review. The USA (Massachusetts) law is representative of a wave of special laws passed in the USA in the 1950s and 1960s to provide compulsory confinement, usually for an indefinite period, for sexual deviants. The original Massachusetts law was amended to limit coverage to sexual offenders who were "dangerous"; i.e. who used force in their sexual actions toward others, or who sexually abused children. There is a special institution in the state for these patients under the charge of a well known forensic psychiatrist.

## 3. Community Mental Health Care :

As mentioned earlier, one of the most striking of all of the changes made in the delivery of mental health services in the past two decades has been the increase in community-based programmes and facilities. It will be recalled that this area was the fourth-named of the essential requirements for mental health legislation in the 1955 Report of WHO Expert Committee on Mental Health. The Committee suggested: "setting up of a specialized health service, i.e., a community psychiatric service"[13]. Later in the Report, the Committee spoke of centralized and locally operated programmes in mental health.

Some of the earliest evidence of legal change to community services can be found in French enactments over the years. In 1944, an Order was promulgated establishing a plan for the organization of a "colonie familiale", or a special centre for placing former patients in foster homes in the community. In a Ministry Memorandum in 1955, a programme of support for community mental hygiene centres was established with central governmental funding on a sliding scale up to 80%. In the 1960s, a master plan was adopted to modernize the mental hospitals and to operate them on a "sectorization basis", gathering the patients by sectors of the departments in France so that hospital and community follow-up services could be coordinated effectively. Under a Memorandum of 15 March 1960, community mental health centres have been established in each department and in each city of over 20,000 inhabitants. Regulations within the national social security system have supported mental health treatment services in the community centres.

A number of countries have enacted laws or placement of patients in foster homes. Changes have also been made in guardianship laws in order to facilitate earlier discharge of mental patients or retarded persons, or in order to be able to keep such people in the community and out of hospital entirely. A few countries, such as Ghana, have enacted specific legislation on aftercare of patients in the community.

In some countries, the operation of mental health services is effectively decentralized as a part of general laws on government structure, or as part of the law on the national health services, or the public health clinic system. A basic decentralization to the states or provinces is found in federal nations, of course, but it is found also in many central governmental nations also where health services are regionally or locally operated.

Very few of the countries surveyed, however, were found to have provided specifically in their mental health legislation for locally operated (and funded) community mental health centres offering a wide range of legally required services. The great majority of our respondents reported that the mental health laws, and the governmental funding programmes, did not prohibit but also did not authorize or encourage the development of community based services. In seven countries it was

reported that the law did seem to bar such programmes being operated by local governments, (Brazil, Cyprus, Fiji, Ghana, India, Nigeria, Thailand).

The 1975 law in Sénégal specifically provides for the establishment of psychiatric villages in each region to be made up of the mentally ill and their families. Such programmes exist in other African states, but are not specifically mentioned in available legislation.

In the USA, community mental health services, often grouped around a locally operated "centre" with a citizen-board in charge of the policy of the centre, developed as an outgrowth of child-guidance centres when these facilities began to be expanded to deal broadly with family problems. Special laws were adopted in a number of states during the 1950s which greatly stimulated the growth of community mental health services, usually operated by country governments under grants-in-aid by the state governments. The Council of State Governments in 1959 produced a model for a state community mental health act based closely upon the Minnesota law of 1957. The entire field received further stimulus when in 1963, the federal government passed the Community Mental Health Centres Act which provided for grants-in-aid to establish centres throughout the country. The law required such facilities to offer a wide range of comprehensive, community mental health services. At the present time, community mental health centres are operating in all 50 of the American States with many of them also offering services for the mental retarded, also with federal governmental funding.

## 4. Time Devoted to Legal Involvement:

In some of the psychiatric literature, one finds complaints that mental health legislation is deficient when it requires too much time of

psychiatrists and other clinical personnel to be spent on complying with legal formalities. The Expert Committee Report in 1955 noted that in many countries, before admission of patients "numerous legal formalities have to be satisfied"[17]. In regard to discharge, "cumbersome procedures" often had to be observed[18]. The Committee also mentioned "frequent and often unnecessary reports sent to a general authority by those in charge of the hospital"[19].

Our questionnaire included a specific question about the time devoted to medicolegal matters by psychiatrists under the current legislation in the respective countries. Table 4 summarizes the results. Also, we asked if there were psychiatrists specializing in medicolegal work in the country. These responses are also summarized in Table 4.

As can be seen, few complaints were expressed concerning excessive time spent on medicolegal requirements. However, many respondents interpreted the question as referring only to court appearances, not to the filing of administrative reports and complying with hospitalization procedures.

Some specialization in medicolegal work was found to exist in most of the countries, but it was generally limited to a few psychiatrists. Exceptions were noted in France and in Massachusetts in the United States where there were large cadres of specialists in forensic psychiatry. University medicolegal institutes were also active in forensic psychiatry in Denmark, Japan, and Poland. There were a few forensic psychiatrists in the United Kingdom working in prison programmes and probation outpatient services. The predominant activity of the forensic psychiatrists in all countries was in criminal cases. Very few were involved in civil-court matters or in civil commitment procedures, except in the Scandinavian countries.

The group of respondents to our questionnaire included only a few forensic psychiatrists. The responses which our respondents were able to provide to this area of our inquiry were admittedly largely impressionistic. A more thorough examination into these matters in each country might well produce other data of considerable worth in an overall evaluation of the impact of mental health legislation on the operation of

TABLE 4

TIME OF PSYCHIATRISTS DEVOTED TO MEDICOLEGAL QUESTIONS

| | % of psychiatrists specializing in legal questions | % of time of hospital and other psychiatrists | Other comments |
|---|---|---|---|
| GHANA | None | Not over-burdened | |
| NIGERIA | | | |
| Western Nigeria | | Only psychiatrists working in statutory institutions for compulsory detention spend time on medicolegal questions. | Part of their overall responsibility and duties |
| Lagos | | Psychiatrists working in a government mental hospital - too much. | Psychiatrists are required to go to court to testify. "Time wasted". |
| SENEGAL | None | 1 afternoon per week | Time devoted to testify in court. |
| BRAZIL | There are specialized psychiatrists (especially in mental hospitals which are annexed to prisons). | | These psychiatrists and others are asked to testify in courts frequently. |
| URUGUAY | Some, who work for the technical forensic and criminal institute. | Around 500 reports from psychiatrists working in main mental hospital; 500 or so from private psychiatrists in other cases. | |
| CANADA | Some | They may be required to take part in court cases. | |
| USA | | | |
| Massachusetts | Division of Legal Medicine in Department of Mental Health has approximately [illegible]0 psychiatrists, mainly half-time, in court clinics and prison work. | Very little for majority. | |

| | % of psychiatrists specializing in legal questions | % of time of hospital and other psychiatrists | Other comments |
|---|---|---|---|
| USA | | | |
| New York | 1 expert on forensic psychiatrists in Department of Mental Health. | Some time. | |
| Connecticut | 1 psychiatrist in some hospitals full time. | 15% of time | |
| INDIA | | | |
| Punjab | None | | 10% of new admissions are medicolegal cases. |
| Uttar Pradesh | | | Medicolegal cases are not frequent. |
| THAILAND | One forensic psychiatric hospital. | | Forensic hospital responsible for court cases. General hospitals: very few court cases admitted. |
| FRANCE | A number of forensic psychiatrists throughout France: in Paris in 1975 there were 48 out of 862. | Very little but varies. | Expert evaluations for courts. (Mainly written) (Annual list of psychiatrists authorised to do these). |
| POLAND | Some University departments specialized in forensic psychiatry. | 25% | |
| NORWAY | None<br>Recent tendency for courts to appoint psychiatric experts. | Sometimes considerable amount of time. | Satisfactory system. |
| DENMARK | Some in special departments for legal psychiatry and 2 special prison departments. | Not very much time. | Considerable time taken by sociolegal questions. |
| RUMANIA | Commission of medicolegal psychiatry provides expertise in medicolegal cases. Medicolegal Institutes. | | |
| SWITZERLAND | | | |
| Geneva | 1 forensic psychiatrist in prison programme, medicolegal institute. | | Psychiatrists in post-graduate training provide expert evaluations. |

| | % of psychiatrists specializing in legal questions | % of time of hospital and other psychiatrists | Other comments |
|---|---|---|---|
| SWITZERLAND | | | |
| Basel | In the clinic 1 forensic psychiatrist. | 50% in general clinic. | |
| UNITED KINGDOM | Few forensic psychiatrists. | Little time. | |
| EGYPT | One medicolegal consultant. | | |
| IRAN | Psychiatrist attached the medicolegal department of the Ministry of Justice, otherwise no specialised psychiatrists. | Some requested to testify in court. | |
| IRAQ | None | Committee of 3 psychiatrists spend 2 mornings weekly on mentally ill offender cases at Shammayiah Mental Hospital.<br>Committee of 3 psychiatrists in Directory of Psychiatric Health, 2 meetings per week; deal with minor legal problems of patients. | |
| KUWAIT | No forensic psychiatrists. | | |
| AUSTRALIA | | | |
| S.Australia | Senior psychiatrist in charge of forensic services. | Most psychiatrists do some reports for the courts. | |
| Victoria | Some | | No vexatious litigation. |
| Tasmania | | Considerable time-(alcohol, road offenses, compensation, forensic psychiatry). | |
| N.S.Wales | | 20% of administrators time.<br>10% of clinical psychiatrists time. | |

| | % of psychiatrists specializing in legal questions | % of time of hospital and other psychiatrists | Other comments |
|---|---|---|---|
| FIJI | None | 1/6 of the time. | |
| JAPAN | One department of forensic psychiatry, Tokyo Medical and Dental University's psychiatrists also placed in prisons, family courts, juvenile correctional institutions. | Majority of senior psychiatrists spend some time on evaluation and testimony for courts. | |
| MALAYSIA | None | Varies | Some submit only an affidavit to the court; others have to attend in person. |
| NEW ZEALAND | Some; one full-time within the Justice Department. | | |

mental health programmes at different levels. It is our belief that the formalities required by law can be very effective, not only in safeguarding patients involved in the system, but in assuring administrative accountability for programmes, gathering important statistical information, and providing the foundation for effective mental health planning and evaluation. These areas will be further discussed later in this Report.

## C. Hospitalization Procedures:

### 1. Introduction:

The material in this section brings up to date the comparative international survey produced at WHO in 1955.

There is a good measure of difference in the two studies, however, as befits the passage of some 21 years. For example, extensive coverage is devoted herein to the developing countries. Analysis is provided of countries with informal methods of mental hospitalization as well as those with formal legislative structures.

Our questionnaire survey sought information on actual operation of the mental health legislation, as well as on the functioning of the less formal systems. Useful observations were obtained. However, the analyses in these sections of our Report are necessarily concentrated upon the content of the provisions, the internal checks and balances, and the protective mechanisms of the laws and procedures. Changes are discussed in relation to expressed policies of the governmental inquiries and reports suggesting the reforms. Obviously, a deeper analysis of actual practices would have been highly useful. However, the significance of the actual law, the specific terms of the legislation, remain of great importance. Modifications in mental health administrative practices usually remain only that - accommodations within limits, but not substantial departures from the basic legal and political policy set out in the legislation. Radical change in governmental practice, as well as in legal language, is almost always accomplished by legal enactment. Resistance to change is generally expressed through adherence to the existing provisions of the law. These principles apply generally to public administration, but they are most fundamentally observed in such areas as mental health legislation which for some 100 years has been very

highly structured and detailed regarding operations and administration, especially in regard to hospitalization, management of institutions, reporting and surveillance, and court review or appeal. No other medical field has experienced such detailed and extensive legal-governmental controls and surveillance, nor is any other area apt to undergo such control in the future.

2. Classification of National Systems:

It has been thought useful to attempt to group the legal systems studied into rough categories of complexity and legal formality. In part this is a response to the widespread interest expressed in most reform movements in this field to "simplify" the mental health legislation to make access to care and treatment for all people freer and less cumbersome. An examination of Table 5 will reveal the degree of success, or failure, some nations have had in these efforts.

Four categories are utilized in the classification. The nations grouped as "complex" are those with the most lengthy hospitalization codes and with a relatively large number of alternative methods of admission, including at least two different modes of involuntary hospitalization. These nations all have at least one emergency procedure. In almost all of these systems, cross-references are made from one procedure to another, providing for considerable complication in interpretation.

The two middle groups are referred to as "intermediate". These nations all have formal legislative systems. They are less complex, however, than the first group, primarily because they have fewer hospitalization procedures. Confusing cross-references are less necessary. In many cases, these laws are quite old. The newer reform legislation tends to add complexity, not to reduce it, no matter what the intention of the proposers.

The last classification lists those countries without formal legislative structures governing mental hospital or other forms of psychiatric care and treatment. The systems in operation in these countries were simple and uncomplicated. As the later sections indicate, these nations tended to rely heavily on what are identified as voluntary admissions and police-escorted hospitalizations. Considerable discretion was found to be rested with the administrators of the mental hospitals.

TABLE 5

CLASSIFICATION OF NATIONAL SYSTEMS

Complex Legislative Systems: Australia; Egypt; Fiji; Japan;* Malaysia; Uruguay; United Kingdom; United States of America.

Intermediate Legislative Systems I: Canada; Democratic Yemen; France;** Ghana (new Act, 1971); India; Lesotho; Peru; Romania; Switzerland.

Intermediate Legislative Systems II: Brazil; Costa Rica; Denmark; Iraq (draft law); Nigeria; Norway; Poland; Sénégal; Sudan; Syria.

Informal Systems: Bahrain; Benin; Iran; Jordan; Kuwait; Qatar; Rwanda; Saudi Arabia; Thailand; Yemen.

* Mainly because of complex and detailed social insurance laws rather than admission procedures.

** Combines oldest law (1838) with extensive administrative decrees.

3. Voluntary Access to Care:

The movement toward voluntary care countinued to be strong all during these past two decades, both by increase in the percentage of patients admitted voluntarily as in-patients (see Part III, Section 4) and in the even greater degree of utilization of alternative modes of care in the community, most of which was delivered on a voluntary basis.

Table 6 summarizes the procedures for voluntary hospitalization in the countries surveyed. Both the formal legislation systems and the informal non-legislative systems are analysed in this table.

We found three different voluntary admission systems operating in the countries surveyed: (1) countries where there are clear legal provisions authorizing voluntary or "informal" admission; (2) countries where there are legal provisions only for involuntary commitment, but where voluntary patients are administratively admitted; and (3) countries where there is no law for any hospitalization, but where voluntary patients are informally admitted. To complete the picture of practical operation, we should note that the first two of these systems were found also in countries where very few, if any, voluntary in-patients are accepted, at least in public mental hospitals, though they may be found in the psychiatric wards of general medical or university teaching hospitals, or in private psychiatric facilities not covered by law.

Among both the countries with formal legal systems and those with no legislation, but informal or administrative access to treatment, we discovered very little actual difference in the requirements for admission, though relatives of patients were perhaps more often mentioned as authorized to admit adult patients in the informal systems. These informal non-legislative systems were also found to place no restrictions on the patient discharging himself. The South American countries, even though operating under formal legislative systems, also did not restrict discharge.

Many countries in both systems allow relatives to discharge the patient, but many require that the relative assure the hospital that the patient or mentally retarded person would be cared for upon return to the community.

TABLE 6

VOLUNTARY ACCESS TO CARE

| AFRO | Legal Basis | Written Application by | Med. Certificates | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| GHANA | The Lunatic Asylums Ordinance 1888. | No legal provision<br>By patient himself in writing. | | | By patient himself on 72 hrs written notice. | |
| | The Mental Health Act 1971. | By patient himself in writing. | 1 medical certificate by a medical practitioner. | | By patient himself on 72 hrs written notice.<br>By Chief Administrator; on written application of a relative or other person 72 hrs beforehand. | |
| NIGERIA<br>Lagos and W.Nigeria | Lunacy Law, 1916; amendment 1959(W.Nig.) | No legal provision<br>Treatment on out-patient basis. Application by patient or psychiatrist or other medical practitioner. Attendance at Psych. Dept. of teaching hospitals. | | | At will. | |
| SENEGAL | Law No.75.80 of 9 July 1975 Art. 1,2,4,6. | Application by patient himself. | Diagnosis justifying voluntary treatment. | Monthly medical visits of the patients (= periodic review). | At will. (Patients can be required to stay only for the period necessary for treatment and periodical consultations). | If a patient refuses to follow the treatment plan and is extremely agitated or seriously depressed, he can be brought in for med. exam. and necessary treatment. |

| | Legal Basis | Written Application by | Med. Certificates | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| AFRO: | | | | | | |
| RWANDA | Informal (90% voluntary admissions). | | | | | |
| LESOTHO 90% voluntary patients | Mental Health Law of 1963; section 5. | Patient or relative. | One medical certicicate. | The relative must accept responsibility of patient shen discharged. | On request by patient or relative on 7 days notice. | The Medical Officer can instit e proceedings f compulsory ad ssion. |
| | Section 4. | No formality required. | | | | |
| BENIN | Informal | Patient's family. | | Agreement by the family to the treatment given to the patient. | | |
| AMRO: | | | | | | |
| BRAZIL | Decree No.24559 of July 3 1934 + amendments in 1961, 1974. | Patient himself. | One medical certificate. | | At will. | |
| URUGUAY | Law No.9581 of 8 August 1936. | Patient himself or legal representative. | Medical certificate by the admitting medical officer. | Statement by patient or legal representative. Certificate of admission by hospital medical officer. | At will | Can be changed to commitment by informing the judge and the psychopaths General Supervisory Board. |
| PERU | Law No. 11272 and Executive Decree of 14 October 1952 amended in 1963 and 1966. | Patient himself. | Not specified. | | At will. | |
| COSTA RICA | General Health Law of 1973. Book I, Ch.II, Sec.23. | Patient himself | | | Medical discharge or application by patient or his family. | |

| AMRO: | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| USA: Massachusetts | Mass. General Laws, Ch.123, Sec.2,10,11.<br>Laws of 1970, Ch.888<br>Statutory and regulatory. | Patient, if over 16 years<br>Parents or guardian of patient under 18 years. | Not required | None | At will of patient or parent or guardian. | Superintendent may require voluntary patient to give 72 hrs notice of withdrawal, can order examination and file for involuntary commitment. |
| USA: Indiana | Indiana Code, Ch. 9, Sec.2.<br>Public Law 154 of 1975. | Patient or by parent or guardian if under 18 years. | Not required. | Admission only to state owned or operated facilities. | Patient or parent or guardian may request release in writing, superintendent must release within 5 days. Superintendent may release at any time if hospitalization no longer advisable or necessary, or if he determines discharge will contribute to most effective use of the hospital. | Within 5 days notice provision, superintendent may make petition for court commitment. |

| | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| AMRO: | | | | | | |
| CANADA | | | | | | |
| British Columbia | Mental Health Act of 1973, Sec.22.<br>Statutory and regulatory. | Patient over 16 years, parent or guardian under 16 years.<br>Application for admission includes consent to electroshock treatment. | 1 Physician | Special provisions, section 21, provides facility director shall not admit patients of any category unless suitable accommodation available for care, treatment and maintenance. | 72 hours after receipt of application from patient or parent or guardian, director must discharge. | |
| CANADA | | | | | | |
| Alberta | Mental Health Act of 1972.<br>Statutory and regulatory. | "Any person" may be admitted as informal patient in accordance with rules of the facility<br>Any person at least 16 years may, if capable of expressing his own wishes, be admited as informal patient despite objections of parent or guardian. | Not required | None | At will on written notice.<br>Superintendent shall also discharge an informal patient on certication by 2 therapists. | Informal patient may be changed to formal (involuntary) at any time on basis of medical certification by "two therapists" as under formal admission. |
| SEARO: | | | | | | |
| INDIA | Indian Lunacy Act of 1912.<br>Section 4(1). | Patient himself. | Not required. | Consent of 2 visitors | At will with 24 hours written notice. | |
| THAILAND | Informal | Patient himself or relative or guardian. | Not required. | No admission without the relative's agreement. | | |

| EURO: | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| FRANCE | Law on Mentally Ill, 30 June 1838.<br><br>Regulations on "sectorization" 1960 - 1975. | No legal provision<br><br>No formality required. Admission in "open services". | Not required | Admission is provided through policy of "sectorization", or admission to area of hospital for own community. | At will, even against medical advice | |
| POLAND | Instruction No. 120/52 of 1952. | At the request of patient himself. | By out-patient physician at hospital (may be head of admitting hospital). | Requires formal consent of patient. | On request, with a certificate of sufficient health issued by Director or treating psychiatrist. | |
| ROMANIA<br>Very large majority of voluntary. | Decret 246/958 and Ord. M.S.1005/1958 Ord.M.S.126/972 and 74/1973. | Free access to treatment by patient, no formality. | Not required. | | | |
| SWITZERLAND<br>Geneve | Law of 14 March 1936, and 1959. Art.21,32, 27. | Patient has to sign an admission form as proof of his consent. | 1 medical certificate. | All admissions are notified to the Board of Psychiatric Surveillance. | At will, unless dangerous to himself or to others. | If dangerous to himself or to others, the Board of Surveillance can change the patient's status into involuntary hospitalization. |
| SWITZERLAND<br>Basel<br>Article 4. | Law of Dec.21 1961. | Written or oral request by the patient. | Not required. | | By superintendent with the advice of psychiatric commission which has to give its decision within 14 days of request. | |

| EURO | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of status |
|---|---|---|---|---|---|---|
| UNITED KINGDOM | Mental Health Act of 1959, Part I,§5, statutory and regulatory. | No written application required. Informal admission by patient and by parents or guardian for patient under 16 years. | Not required. | No mention of admission to general hospitals, but includes NHS hospitals and mental nursing homes. | At will, but see restriction in "change of status". | Responsible medical officer can retain an informal patient for 72 hours to make application for involuntary hospitalization. |
| DENMARK | Law of 1938. Law of 1933 Order No.229 of 9 September 1957. Law of 1959. | By patient himself | Medical certificate from a general practitioner. | | At will. | |
| NORWAY | Law No.2 of 28 April 1961. §4. | By patient himself in writing. | Not required. | Decision of admission left to the superintendent of hospital | Right to be discharged within 3 weeks on patient's request. | Not possible. |
| EMRO | | | | | | |
| EGYPT (99% voluntary) | Mental Health Act of 1944. Art. 21. | Written application by patient himself or guardian. | Not required | Report within 2 days by hospital director to board of control on the condition of the patient. | At will on written notice. | Possible when the mental condition of a voluntary patient so requires, provided procedure for involuntary hospitalization is followed. |
| CYPRUS (100% voluntary at General Hospital in Nicosia). | The Mental Patient Law of 1931. | No legal provision<br>No formality (only neurotic and mild psychotic cases are admitted to wing of General Hospital in Nicosia). | Not required | | | |

| | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| EMRO: | | | | | | |
| IRAN (90%-100% voluntary) | Informal | No formality, free access to treatment. | | | | |
| IRAQ (Almost 100% voluntary). | Informal | Voluntary access available for all | | | | |
| | Draft Law | Written application - above 18 by patient; under 18 by a parent or guardian. | 1 medical report. | | At will. For minor, at request of parent or guardian. | |
| KUWAIT (95% voluntary) | Informal. (Agreement between health authorities and police authorities). | By patient or his family. | | Signature of a special form for consent to treatment. | When condition has improved. Trial discharge. Discharge granted against medical advice. | |
| YEMEN | Informal | | | | | |
| DEMOCRATIC YEMEN | Aden Laws, Chapter 87. Lunacy Ordinance of 20 July 1938. | Request by patient or family in writing. | Not required. | Consent of patient or family required. Consent of 2 visitors. | At will on 24 hrs written notice. | |
| QATAR | Informal. | Request by patient or relative. | | | | |
| BAHRAIN | Informal. | Patient and family have complete access to treatment. | | | At will. | |
| JORDAN | Informal. | Patient himself or family. | | | | |
| SUDAN | Public Health Law of 1975. | No legal provision. Informal admissions. | | | | |

| | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| EMRO: | | | | | | |
| SYRIA | 1954 Decree 1965 Regulations | No legal provision. | | | | |
| SAUDI ARABIA | Informal | Request of patient or relative. | | | On request after permission of specialist or after recovery. | |
| | Draft Law. | By patient or person responsible for him. | | Agreement of the Director of Hospital. | By order of the Director of hospital when sufficient improvement or on request of patient's family. | Possible provided that procedures for involuntary hospitalization are followed. |
| WPRO: | | | | | | |
| AUSTRALIA South Australia | Mental Health Act 1935-1974, Part VI, Sect. 137. | Above 16, request signed by patient himself. Under 16, by parent. | + medical certificate. | Notification within 48 hrs of reception to Director General - medical examination within 24 hrs. | At will with 72 hours notice. | Possible conversion into involuntary hospitalization. |
| Victoria *Admissions to "informal" hospitals. | Mental Health Act of 1959, Sect. 41 and informal.* | Above 16, request signed by patient himself. Under 16, by parent or guardian. | + medical certificate. | Notification to the Chief Medical Officer within 72 hours of any admission. | -On request on 3 days written application; -on order of superintendent or chief medical officer; -leave of absence possible for up to 3 months. | Possible change of status. |
| FIJI (Only 2% voluntary). | Law on Mental Treatment of 1967, Art.16,17. | Written application - above 18 by self; under 18 by parent or guardian. | Medical examination in hospital after admission. | Within 48 hours the superintendent will send written notice to board of visitors. | At will on 72 hrs notice. | |

| WPRO: | Legal Basis | Written Application by | Med. Certificate | Other formalities | Discharge | Change of Status |
|---|---|---|---|---|---|---|
| JAPAN (Very few, up to 20% voluntary). | Mental Health Act of 1950. No legal provisions on voluntary access to treatment. | No formality required. | | | At will. | |
| MALAYSIA (Very low, 5-10%, voluntary) | Mental disorder ordinance of 1952, sect.39. | Written application by patient himself. | Not required. | | At will upon written notice 7 days beforehand. | Possible change of status by a magistrate on application by the visitors. |

The most frequently discussed, and most imitated, new departure in this area during these past 20 years was undoubtedly the British adoption of an "informal" admission system. Voluntary admission had been pioneered in the United Kingdom. It had first been made available through administrative measures in parts of Scotland during the last decade of the 19th century. This experience led to recommendations for reform of the more rigid laws applying in England and Wales, and as a result, the Mental Treatment Act was enacted in 1930, by which "voluntary admission" became legal. The percentage of voluntary patients had risen dramatically so that the Royal Commission in 1954-1957 placed it at 75% in England and Wales in 1957 with some hospitals as high as 90%. Nevertheless, the Royal Commission was disturbed at reports that some patients were refused voluntary admission at some hospitals because the patient was believed by the staff not to be able to make a specific request for care and did not seem to understand his situation and need for treatment. A written application for admission made and signed by the patient was required under the 1930 law, as was the patient's formal notice of intention to leave the hospital. The Royal Commission recommended and the Parliament enacted in the 1959 law a method of admission generally known as "informal" under which no requirements may be imposed on the patient to make an affirmative request for care and treatment and where the patient is not required to make out and sign admission forms.

The new idea was highly popular with psychiatrists and other physicians at the time. It struck the fancy of mental health administrators in many countries. It seemed a clear and ringing departure from the tight restrictions of the legal systems so long imposed on the mental hospitals. The admitting doctors could now make the decisions on admission and mental institutions could begin to become like other "hospitals" for sick people with no legal controls on who could be admitted and under what circumstances.

Another appealing feature of the new system was that it seemed to require no legal change for its installation. If a hospital administrator wanted an "informal admission" procedure, all he needed to do was to instruct the admissions office not to require patients to make out papers or forms. The patients were not listed as "voluntary", even where

the hospital had such a legal method of hospitalization. The Royal Commission had given its opinion that the British hospitals need not wait for a change in the law to adopt the method[20]. The Parliament impliedly agreed with this view, since the new law does not contain a specific procedure for informal or voluntary admission per se. It contains, very early on in the law, a declaration of policy asserting that the Act shall not be construed as preventing such a programme:

> "Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained"[21].

The informal system was quickly adopted in a few of the American states. Some administrators installed it without legal authorization and often without informing state officials that they were doing so. A number of countries within the British Commonwealth have amended their laws since 1959 to install an informal admission procedure.

The change in Great Britain was not, however, to prove as dramatic as it first seemed. The informal patients were held to be covered by all of the same restrictions as all other in-patients in the mental hospitals in regard to civil rights, driver's licenses, communication by post and telephone, having pocket money, etc. Also, their right to leave the hospital at will, which seemed clearly spelled out in the above statement of policy in the Act, was abridged in another section of the law which continued the former law allowing the medical officer in charge of the patient to retain any informal patient for 72 hours pending making an application for his formal involuntary admission[22]. The latter change can be made at any time and does not require that the patient request discharge. Also, the change to involuntary status is made without prior court review or application to a court or tribunal.

It would seem clear that a compromise was reached in the Parliament. One side achieved enactment on a new "informal admission" and got most of the publicity. The more conservative doubters retained the hold on the patients which could be applied when needed with recalcitrant patients or persons thought dangerous to release.

Voluntary or informal admissions have risen in England and Wales, but not into percentages in the 90s as was earlier predicted. By 1972, the informal category was at 84%.

Other nations following the British example have tended to enact admission procedures entitled "informal" rather than to adopt policy statements on the matter.

Costa Rica, however, in its General Health Law adopted in 1973, has a Chapter on "Rights and Duties Relating to the Restoration of Personal Health" and therein adopted a general policy statement encouraging voluntary access to care:

> "Mental patients and persons dependent on drugs or other substances, including alcoholics, may submit voluntarily to specialized out-patient or in-patient treatment provided by the health services; they must undergo such treatment whenever competent authority deems it necessary to order such treatment, following the procedures and subject to the requirements laid down in pertinent regulations"[23].

As some aid to understanding the law in practice as well as on the statute books, we suggest that the reader of Table 6 also be aware of the percentages of voluntary admissions for each of the countries listed earlier in Table 2. Where the differences are most significant, or are at variance with the legal implications, we have listed the percentages of voluntary admissions directly onto Table 6.

4. Involuntary Hospitalization:

This category of involuntary care covers those procedures which authorize an indefinite commitment without limitation of time, and where a time-limit is not specified. It also includes procedures which have limits of time but where there is no restriction on renewals. There are two tables, one covering the nations with formal legislative systems (Table 7), and the other covering the informal systems (Table 8).

In this section will be found the most dramatic change in the hospitalization procedures which will be recorded in this survey. It concerns the movement toward compulsory hospitalization on medical certification alone without prior judicial or administrative tribunal review.

It will be recalled that this form of hospitalization was strongly supported in both the Expert Committee Report and the international comparative legislative review in 1955. At that time, there were 12 jurisdictions in this category among the 37 countries surveyed.

In 1975, however, we found 32 countries with at least one procedure for involuntary hospitalization on medical certification alone out of 38 in our survey.

There is every indication that in the countries which have this method, it is the most heavily used procedure for prolonged hospitalization. In 11 countries of the 32, it is the only compulsory method of admission for prolonged care and treatment. **The oldest legislation of this kind is the French law of 1938.**

TABLE 7

INVOLUNTARY HOSPITALIZATION

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AFRO: | | | | | | | | | | | |
| GHANA<br>Old Ordinance, 1888. | Good cause to suspect and believe that some person is a lunatic and /or proper subject for confinement | Information on oath by any informant. | Magistrate order | 1 Medical Certificate. | | Not specified. | | | -By Magistrate order under written request.<br>-By the Director of Medical Services. | At the discretion of the Director of Medical Services. | |
| Mental Health Act of 1971. | Expedient for the welfare of the person believed to be suffering from mental illness or for the public safety. | Information by any informant on oath. | Magistrate order. | 2 Medical recommendations from which one shall be from a psychiatrist. | | Temporary treatment: not exceeding 6 months.<br>Prolonged treatment: not exceeding 18 months, renewable. | To the Mental Health Review Tribunal. | | -At expiration of period specified by Magistrate.<br>-By Mental Health Tribunal, notwithstanding order of Magistrate.<br>-Magistrate order under request by Chief Administrator. | | |
| NIGERIA<br>Lagos and W.Nigeria<br>Lunacy Law of 1916. | Person suspected of being a lunatic and a proper subject for confinement. | Information on oath by any informant. | Magistrate order. | 1 Medical Certificate by qualified medical practitioner. | | Not specified. | To the visiting committee appointed by the state commissioner. | | -Magistrate order with a Certificate of Sanity issued by either the superintendent or 2 medical practitioners. | By Governor (State commissioner) order (only if some other person takes charge of patient). | |

| AFRO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NIGERIA (Contd.) | | | | | | | Appeal for release can be iniated by psychiatrist, relative or patient through psychiatrist, to Governor. | Governor's order (or State commissioner) whether recovered or not. | | | |
| SENEGAL<br>Law No. 75-80, of 9 July 1975. | If patient has committed a criminal offence or when his behaviour is dangerous for himself or public safety or if he refuses to be treated. | Written request by the Prefect. | Judicial order by Court based on facts and concensious of the police report. | Medical Certificates (numbers not mentioned). | Pending the judicial decision the patient is temporarily detained in the special infirmary of the specialised closed-in institution. Period not exceeding 2 weeks. | Not specified. | | | When it seems that the patient's condition allows him to be treated on a voluntary basis, request by the hospital director; by any interested person; by public prosecutor to the Court for a discharge order. | Possible under some circumstances. | |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AFRO: | | | | | | | | | | | |
| LESOTHO Mental Health Law of 1963. | Allegation that the patient is suffering from mental hyper-disorder, expedient in the interests of the patient or for the protection of other persons. | Responsible relative. | Authorization (approval) by the permanent Secretary of Health. | Recommendation of a medical officer. | -Recommendation from medical officer in charge of hospital within 14 days. Can either discharge patient or recommend detention. -All patients must be reported, when discharged, to the permanent Secretary of Health and District Administrator. | 1 year. Renewable yearly after examination by medical officer in charge of mental hospital within 2 months prior to date of renewal. | To the Lesotho Mental Health Tribunal, by or in respect of a patient to be detained against wrongful detention; -against refusal of discharge (within 28 days); -against lack of adequate attention. | | -Order for discharge made by the responsible medical officer for patients *under observation*. -Made by the responsible medical officer, the permanent Secretary of Health or the responsible relative of patient approved by the medical officer, for patients detained in pursuance of a medical recommendation. -By the Mental Health Review Tribunal. | | |
| AMRO: | | | | | | | | | | | |
| BRAZIL Decree No. 24559 of 3 July 1934, Amendment, 1961, 1974. | Suicidal tendency, serious agression to another person, behaviour troubling social life, immoral actions. | Husband, wife, relative, superintendent of hospital psychiatric out-patient department, welfare board, legal representative, interested party. | -Police authorities; -confirmation by court decision. | 1 medical certificate. | | Not specified. | | | On request by some person who applied for admission, by superintendent. | | |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AMRO: | | | | | | | | | | | |
| URUGUAY<br>Law No. 9.581 of 8 August 1936. | Patient dangerous to himself or to others. | Husband, wife, relative, interested party, legal representative. | -Medical prescription.<br>-Police decision.<br>-Judicial decision.<br>-Public Assistance Bodies. | 1 Medical Certificate of disability signed by 2 physicians within 10 days before admission. | Signed declaration by relative or legal representative. Notification of detention within 24hrs to Psychopaths General Supervisory Board and to relevant judge for incompetence procedures. | Not specified. | To the Psycopaths General Supervisory Board. | | By Superintendent, at any time, at will or on request of relatives or legal representative or on medical advice, when patient is not dangerous. | By Medical Director of hospital, for period not exceeding 3 months. Renewable up to 2 years. | |
| USA<br>Massachusetts<br>Mass.Gen. Laws, Ch.123.<br>Laws of 1970, Ch.888. | Failure to hospitalize would create likelihood of serious harm. | -Applicant (not defined in statute; provided in regulations).<br>-Petition by superintendent of faculty. | District Court.<br>Hearing on request of patient. | Not required on application, but a district court at hearing may order independent medical examination on request of the person or his counsel. | Right to court-appointed counsel if indigent. Hearing can be at hospital if justice determines. | 6 months on first order of commitment, 1 year on subsequent commitments (patient entitled to court hearing prior to further commitment orders). | Appeal of decision of district court to Appellate Division of district courts on matters of law as in civil cases. | At least on admission, once during first 3 months after admission, once during second 3 months, and annually thereafter. Review shall include....(see text for further elaboration). | Superintendent can discharge at any time. See also required decisions on discharge at periodic review. | Interim community leave allowed by superintendent at any time. | After periodic review, can be changed to voluntary status. |
| Indiana<br>Indiana Code, Ch.9, § 2.<br>Public Law 154 of 1975. | Temporary commitment.<br>Dangerous (substantial risk he will harm himself or others) or gravely disordered (in danger of coming to harm because of | Superintendent, health officer, police officer, relative, friend, guardian, and spouse. | Probate court; can order treatment plan for patient within 15 days of admission. Superintendent can refuse admission, even if court ordered, if adequate space, treatment staff, and treatment facilities are not appropriate to needs of patient. | Not required on application, but a physician may be appointed by the court to examine the person and report to the court prior to the hearing. | Right to be represented by counsel. Right to appear at hearing and present and cross-examine witnesses; court can waive presence at hearing if injurious to health | Temporary (up to 90 days).<br>Regular commitment (indefinite, yearly renewal. | | Court hearing annually as request for renewal of regular commitment; court may order more than one review each year on good cause shown. | Superintendent or attending physician can discharge at any time; must notify court which terminates commitment. | | |

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| AMRO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| USA<br>Indiana<br>./. | inability to provide for his food, clothing, shelter, or other essential human needs.<br>Regular commitment<br>Person who appears to be suffering from a chronic mental illness which is reasonably expected to require custody, care, or treatment exceeding 90 days. | | | | or well-being. | | | | | | |
| CANADA<br>British Columbia<br>Mental Health Act of 1964, §§ 23-24.<br>./. | Requires care, supervision, and control for own protection or welfare of others. | Near relative, person who has knowledge of him, any peace officer, or anyone who has reason to believe he is mentally disordered. | -Director of facility who can refuse to admit unless appropriate facilities etc. are available.<br>-Judge in chambers. | 2 physicians. | | 1 year, renewal for 1 year, then at 2 year intervals. | Person, near relative, or anyone on his behalf may appeal to judge in chambers prior to commitment, or within 3 months of admission<br>-Also, patient can request hearing after 30 days in hospital | | Director of hospital or observation unit may discharge a patient from his unit. | Director of hospital may release on leave for designated purposes for stipulated periods of time on such conditions as he may prescribe. | |

| AMRO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CANADA British Columbia ./. | | | | | | | before special hearing review body. (Specify members) | | | | |
| Alberta<br><br>Mental Health Act of 1972. §§ 13-22. | In a condition presenting danger to self or others. | None required; action is by the 2 therapists.<br><br>Police officer can apprehend and take to hospital if mentally disordered, danger to self or others, and acting disorderly. | -No court review; 2 therapist's certificates.<br><br>-If person refused examination therapists can get court order for examination.<br>-Police officer can apprehend person. | 2 Certificates, at least 1 by physician, other can be from "therapist" licensed under this Act (see text discussion). | | On first certificate, 1 month; second certificate, 2 months; third certificate, 6 months; each subsequent renewal certificate, 6 months (each by 2 therapists). | Review panel can hear one appeal during each certificate period. Party can be present unless adverse effect upon health.<br><br>Appeal to Supreme Court within 1 month of decision by Review Panel. | By consequence of certification on renewal by 2 therapists mentioned under "length of stay". | Facility director may discharge where ordered by Supreme Court, by Review Panel, or by certificate of discharge by 2 therapists. | | |
| COSTA RICA<br><br>General Health Law of 1965. | Treatment deemed necessary by "competent authority". | | "Competent Authority". | | Any commitment must be reported by Director of establishment to Supreme Court of Justice. | | | | Medical discharge or application by patient or family. | | |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AMRO: PERU Executive Decree of 14 October 1952. Amended in 1963 and 1966. | Mental patients who are a danger to themselves or to others | -The patient himself; -his relative or legal representative; -police authority; -any other person provided that documentary evidence is produced that the patient is dangerous, neglected or badly treated. | | One medical certificate made no more than 20 days before admission. | | Not specified. | Appeal against refusal of discharge to Mental Health Council. Appeal against improper commitment or treatment to Mental Health Council. | | By medical superintendent when there is no longer any need for detention. | Provisional discharge granted by medical superintendent upon application by relative or representative of patient provided patient will be given necessary care treatment. Becomes final after 3 months. | |
| | Persons who by reason of their dangerous tendencies should be placed under control. | | Court order. | | | | | | | | |
| SEARO: INDIA Punjab and Uttar Pradesh Lunacy Act of 1912. | Allegation of lunacy. | -Application by husband, wife, relative or other person. | Magistrate's reception order. | 2 medical certificates | Personal examination by Magistrate. | Not specified. | Punjab Appeal to Visitors which can be forwarded to the court or the Director of Health Services. Uttar Pradesh Appeal to the Criminal or the Executive Magistrat's Court. | | Order of discharge by board of Visitors. -Upon application by the person who made the petition for admission, by the person in charge of the asylum. -Delivery in care and custody of a friend or relative. | | |
| | Person alleged to be a lunatic found wandering at large or dangerous or not under proper care and control or cruelly treated or neglected. | -Arrest by police officer or report by police officer or informant. | Magistrate's reception order. | 1 medical certificate. | Personal examination by Magistrate. | Not specified. | | | | | |
| | Person alleged to be a lunatic, | -Application by relative or the Advocate- | Court order after inquisition. | Not required. | | Not specified. | | | | | |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SEARO: | | | | | | | | | | | |
| INDIA ./. | of unsound mind and incapable of managing himself or his affairs. | General. | | | | | | | When found on inquisition not to be unsound of mind. | | |
| EURO: | | | | | | | | | | | |
| FRANCE Law of 30 June 1838. | Placement Volontarie: Accessity for treatment and detention. | Written application by husband, wife, relative, friend. | | 1 medical certificate. | -Admission bulletin including medical certificate, to be sent to Police Prefect who in turn will inform the public prosecutor. -Within 2 weeks of admission, new medical certificate. | Not specified. | To the competent court of the region where hospital is located. | | When hospital physicions have signed a certificate of recovery. On request of family or person who requested admission, or of the Prefect. By the court in case of appeal. | | In case mental condition of patient presenting danger for public order of safety of others, the Prefect can change his status into "Placement d'Office". |
| | Placement d'Office: Danger for public order and safety of others. | | Prefect of police. | Not required in the law but often in practice. | Notification to the public prosecutor, to the family of patient. | | To the competent court of the region where hospital is located. | Once every 6 months, report to the Prefect on each individual case, by hospital physician (nature of illness and results of treatment). Prefect will decide for each case either prolongation of detention or discharge. | By the Prefect on medical advice. By the court in case of appeal. | | |
| | In case of emergency (imminent danger). | | Police officer or mayor. | Medical certificate. | 24 hours notification to the Prefect. | | | | | | |

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| EURO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| POLAND<br>Instruction of the Ministry of Health of 10 December, 1952. | Patient found dangerous to himself or to society. | Family member, guardian, physician. | Formal confirmation by head of admitting institution. | | | Determined by medical head of institution. | Introduced by persons authorized to request admission (patient, relative, guardian, physician, legal authority) to the competent administrative authority | | Request by persons who solicited admission. Granted, subject to a certificate of sufficient health. | Temporary leave allowed to visit relatives. Only twice yearly for up to 7 days each, at the discretion of hospital director. | |
| | Persons having committed an offence. | President of the Court, Public Prosecutor. | Court decision. | Medical Certificate confirming need for admission. | Confirmation of admission by head of hospital. | | | | Request by Court of Public Prosecutor, subject to a certificate of sufficient health. By director of hospital. | | |
| ROMANIA<br>Decret 12/965 of 25 Jan. 1965. Penal Code. | Dangerousness - when mental patients -endanger their own life, health or bodily integrity or that of others, and are liable to commit at any time other serious acts covered by penal legislation; or repeatedly and seriously disturbing, because of their behaviour, the normal living or | On information or ex officio, report by the public prosecutor. | Judicial decision by people's court. | Medical examination by a psychiatrist. | Provisional detention pending decision by people's court. During provisional detention examination by medical board. Opinion communicated to public prosecutor within 5 days of admission to hospital.<br>*In case of* deprivation of Civil rights, notification to competent | Until the patient is no longer considered to be dangerous. | Appeal against any decision taken by the people's court, pursuant to provisions of the Code of Civil Procedure | Periodic review every 6 months by the Medical Board. | <u>During provision of detention</u>, discharge on recommendation by Medical Board or by public prosecutor or by court. <u>During detention itself</u>, discharge by order of the court on petition by public prosecutor, patient, his family, the Medical Board. | Provisional discharge is possible pending court's decision on final discharge. | |

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| EURO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ROMANIA ./. | working conditions of other persons. | | | | supervisory body, guardian, or parents of a minor. | | | | | | |
| SWITZERLAND<br>Geneva<br>Law of March 14, 1936. Amended 1 April 1959 | Emergency, obvious danger or neglect. | Patients, friends, legal representative.<br>Police authority.<br>Board of Psychiatric Surveillance. | Authorization of Health Department. | 1 medical certificate (symptoms of illness and reasons for hospitalization). | Notification to the jurisdiction in charge of procedures for guardianship. | Not specified. | Appeal to the Board of Psychiatric Surveillance.<br>Appeal to the competent administrative jurisdiction. | | By medical officer of hospital.<br>By Board of Psychiatric Surveillance (Discharge is always provisional) | Conditional discharge: patient under the responsibility of a qualified person who will take care of him.<br>Trial discharge granted by Director of hospital for 30 days at a time. | |
| Basel<br>Law of 21 December 1961. | Danger to security, order and public moral or themselves. Need of care and supervision. Need of treatment. | | Guardianship Jurisdiction or Penal Court. | 1 medical certificate issued within 14 days of admission. | | Not specified. | Appeal to the psychiatric commission.<br>Appeal to the Government Council.<br>Appeal to the administrative court by patient himself or person who can request hospitalization. | | By superintendent with the advice of the psychiatric commission which has to give its decision within 14 days of request. | | |
| | Ditto. | Legal representative, relative, director of the institution for care or old age. | Private doctor. | | When a patient refuses hospitalization, the consent of a "judicial doctor" is required to hospitalize him without his consent. | | | | | | |

| EURO: | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| UNITED KINGDOM<br><br>Mental Health Act of 1959, England and Wales. | Necessary for own health or safety, or for safety of others. | Nearest relative or mental welfare officer (social worker).<br>Covers patients of any age who are mentally ill or severely subnormal, and persons under 21 years who are suffering from psychopathic disorder or are subnormal (see text for discussion). | Hospital managers. | 2 medical certificates one from someone with special experience in treatment of mental disorder and approved for such purposes by secretary of state. Unless this physician knows the patient, the other should have previous acquaintance with the patient. | | 1 year; renewable at hospital for 1 year; then at 2 year intervals.<br>For psychopaths and subnormal patients, must release before 25 years of age unless finding patient is likely to act in a manner dangerous to self or others. | Petition to Mental Health Review Tribunal within 6 months after initial admission and once during each subsequent renewal period.<br>If psychotic or subnormal patient not released at 25 years, nearest relative can appeal to MHRT within 28 days.<br>If patient reaches 16 years, not released, nearest relative can appeal to MHRT within 6 months. | Medical examination within 2 months of renewal date on hospitalization.<br>Within 2 months of reaching 16 years.<br>Within 2 months of reaching 25 years in case of psychopathic and subnormal patients. | Hospital managers or responsible medical officer (RMO) can discharge at any time. Nearest relative who made application for discharge on 72 hrs. notice. RMO can prevent discharge by certifying to hospital managers that if released, patient would be likely to act in a manner dangerous to self or others. Nearest relative cannot request discharge for another 6 months. | RMO can allow leave of absence at any time specified conditions and for specified period or indefinitely. | If a patient admitted as mentally ill or severely subnormal is reclassified as psychopathic or as only subnormal he cannot be detained in hospital beyond 25 yrs. unless RMO or MHRT determines that if released patient is likely to act in a manner dangerous to self or others. (Amendment Act of 1975) |

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| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| UNITED KINGDOM (cont.) | | | | | | | Where nearest relative applies for discharge of involuntary patient and is refused, can appeal to MHRT within 28 days. Decisions of MHRT final on facts. | | | | |
| DENMARK law of 13 April 1938 order of 9 Sept. 1957 Order of 5 June 1959 | Dangerous to himself or his surroundings, or hospitalization necessary to ensure adequate treatment. | Husband, wife, relative, social commission, police | | Due medical certificate (supported by a certificate of the local medical officer of health where the practitioner certifies that recovery would be improbable if patient were not hospitalized) | In all cases of involuntary stay in hospital, a guardian must be appointed, his duty being to ensure that the patient is not detained longer than necessary. | No person shall be hospitalized for treatment longer than is necessary. | Appeal to the Ministry of Justice. Appeal against decision to court within 5 days. | | By superintendent. | Trial leave for period not exceeding 6 mos. by superintendent. | |

| NORWAY | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of Stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental Health Act of 28 April 1961 | Hospitalization beneficial to patient, necessary for public order may prevent serious danger to life or health of others. | Nearest relative or public authority. | Medical Superintendent. | | Express agreement of nearest relative to admission unless medical superintendent decides that hospitalization is necessary because of the patient's mental condition. Medical superintendent must immediately inform Control Commission. | Not specified. | By patient, relative or authorities to Control Commission, against admission, discharge or complaints relating to treatment. | | Application by patient himself or his nearest relative. Discharge by superintendent at his own discretion. Discharge by superintendent when conditions for hospitalization are not present | | |
| EMRO: | | | | | | | | | | | |
| EGYPT Mental Health Act of 1944 | Dangerous to himself, to others or to public safety. | Written application by relative or guardian. Notification by a medical officer or public prosecutor. | Arrest by police | 2 medical certificates.<br>1 medical certificate. | Notification of detention by director of hospital to Board of Control. Within 30 days the Board must either discharge the patient or confirm his detention. | Confirmation by Board of Control valid for 1 yr Possible prolongation following medical report for:<br>- another year<br>then - 2 years<br>- 3 years<br>- 5 years | Appeal against detention: to director of hospital to Board of Control (also against refusal of discharge) | See "length of stay" Necessity of a medical report supporting decision of prolongation | By Board of Control Automatic discharge if Board does not issue within legal delays a decision to confirm or prolong detention By hospital director on own accord or upon application by patient's relative | Trial discharge for periods limited to part of a day or a day. | Involuntary patients when improved may be accepted on a voluntary basis. |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CYPRUS Mental Patients Law of 29 May 1931 | Person mentally afflicted and a proper subject of confinement<br>Person wandering at large believed to be unsound of mind and dangerous. | Information on oath by any informant.<br>Apprehension by a police officer. | Court order.<br>Court order. | 1 medical certificate. | District court has custody, control & management of property of mental patient and may appoint administrator of such property.<br>Notification of admission by superintendent to director of medical services. | Not specified. | By or on behalf of patient to the Supreme Court. | | By director of medical services, whether patient recovered or not. | Absence on parole for such period as Director of Medical Services thinks fit provided some person will take charge of patient. | |
| SUDAN Public Health Law of 1975 Chapter 13 | Mentally disturbed person felt to be dangerous to himself or others. | | Mental Health Board (Psychiatric Provincial Council) | Recommendation of a psychiatrist | Consent of a specialized court to any legal action taken to safeguard patient's money until he is cured. | Not specified. | Patient can appeal against Board's decision to province court within 1 month of decision. | Monthly report to Board by a psychiatrist | | | |
| SYRIAN ARAB REPUBLIC<br>Decree No. 687 of 12 May 1954 Regulations of 17 Jan. 1965 | Danger to patient himself or to others<br>Persons considered dangerous to general public or who have disturbed the peace | Written application by guardian of patient<br>Written application from judicial or executive authorities<br>Referred to hospital by public security authorities | Director of hospital | 1 medical report | Medical examination in hospital within 1 week of admission to determine whether condition requires confinement or release | Not specified. | | | Upon request by guardian if he takes responsibility of patient<br>Director of hospital can release patients upon recovery or cessation of justification for confinement | Trial discharge to patient's family (temporary or permanent) at request of treating physician | |

| DEMOCRATIC | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| YEMEN Lunacy Ordinance of 20 July 1938 | Allegation of lunacy | Husband, wife or nearest relative or other person | Magistrate's reception order | 2 medical certificates | Personal examination by magistrate | | Possible to Court in cases of Court order after inquisition when unsoundness of mind claimed to have ceased | | By order of 3 visitors<br>Upon application by person who made petition for reception order unless dangerous or unfit to be at large<br>Delivery into care and custody of relative or friend | | |
| | Person believed to be lunatic & found wandering at large, dangerous or not under proper care & control or cruelly treated or neglected | Arrest by police or report by police or informant | Magistrate's reception order | 1 medical certificate | Personal examination by magistrate | | | | | | |
| | Person alleged to be lunatic, of unsound mind & incapable of managing himself or his affairs | Relative, administrator or government pleader | Court order after inquisition | Not required | | | | | When found not to be unsound of mind on inquisition | | |
| IRAN Provisions in different codes | When patient presents danger to himself or others | | Magistrate's reception order | 1 medical certificate | Patient can be admitted on medical certificate & remain 3 wks. before magistrate notified & question of formal committal decided | Not specified. | By patient or relative during 3 wks. to magistrate; Magisterial inquiry to be ordered by Minister of Health; Against refusal of discharge to judge of supreme court; Free access to ombudsman; Direct to Minister | Yes | | | |

| WPRO: AUSTRALIA | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| South Australia Mental Health Act 1935-1974 | Any person believed to be mentally defective & without sufficient means of support or found wandering at large or under circumstances that denote purpose of committing some offence against law | Complaint on oath before 1 justice<br>Initiative of police officer or of justice | Order of justice | 1 medical certificate | Inquiry as to person alleged to be mentally ill | Not specified | To judge against wrongful detention | 6 times a year during first 3 years & subsequently once a year by superintendent or other medical practitioner | Written request by person who signed admission request, who made last payment, family, with consent of Director General<br>By Director General on own authority<br>Upon issue of certificate by official visitor or superintendent that patient is detainee without sufficient cause, order of discharge by Director General<br>Delivery into care & control of relative or friend<br>Upon information by judge if person is wrongfully detained | By superintendent with consent of Director General for such period as he thinks fit - renewable<br>By Director General<br>By Superintendent for period not exceeding 24 hours (absence upon parole) or not exceeding 28 davs (trial leave) | |
| | If person is believed to be mentally defective & not under proper care & control or cruelly treated or neglected by any person having or assuming his care & charge | Complaint on oath by police within 3 days of his knowledge of such case to 1 judge<br>Initiative of 2 justices | Order by 2 justices | 1 medical certificate | Procedures in 2 stages: Visit, examination & inquiry by justice or report by medical practitioner which lead to order to apprehend patient & take him before 2 justices<br>Examination & inquiry by 2 justices | Not specified | | | | | |
| | Person found mentally defective by inquisition or other proceedings in Court | Request signed by Committee appointed by Court<br>Request by some person | Committee appointed by Court | Not required<br>2 medical certificates | Request must be accompanied by copy of order appointing Committee | Not specified | | | | | |

| AUSTRALIA (cont.) | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Involuntary Temporary Commitment: Advisable to remand a patient | Statement by 1 or 2 justices | | 1 medical certificate | Within 30 days, patient brought before 1 justice in the institution & either discharged, further detained in receiving ward or house or transferred to mental hospital | Admission in receiving house or receiving ward for period not exceeding 30 days Prolongation after examination for period not exceeding 6 months | | | | | |
| Victoria Mental Health Act 1959 Section 42-43-45 to 52 | | Request of some person | | Recommendation of medical practitioner within period of 6 months during which patient can be admitted for observation | Report by superintendent to Chief Medical Officer | Not specified | By patient to Chief MO for reconsideration of his case | Examination of every patient at least once a year with report to Chief MO | On request of person requesting admission By order of superintendent By order of Chief MO Upon recommendation of visitors Delivery into care & control of relative or friend By judge | By superintendent for period not exceeding 7 days or for longer period with consent of Chief MO Boarding out of patients not dangerous to themselves or others | |
| | Any person considered mentally ill | Request of some person | | 2 medical certificates | Examination without delay by superintendent Report to Chief MO | | | | | | |
| | Person mentally ill found without sufficient means of support or wandering at large or found in circumstances showing intention of committing a crime not under proper care & control, cruelly treated or neglected | Information by medical officer, by other person, initiative of a justice | 2 justices certificates | 2 medical certificates | Report to Chief MO | | | | | | |

| | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FIJI ISLANDS Mental treatment Ordinance of 28 Feb. 1940 amended extensively in 1964 | If it appears that any person suspected of being unsound of mind is at large or dangerous to himself or others or is not under proper care & control or is cruelly treated or neglected by any relative or other person having care or charge of him | Information on oath Application by any person related to or having care or control of mental patient | Magistrate will order apprehension by police for examination & commit patient to mental hospital | Medical certificate by 1 registered practitioner In case of absence of med.prac., possible detention for period not exceeding 7 days provided required certificate is issued within that period for further detention 2 medical certificates (under special circumstances, possible reception with 1 med. cert. provided second med. cert. furnished within 7 days of admission) | Within 48 hrs notification by superintendent of any admission to chairman of Board of Visitors Visit & examination of every patient by superintendent within 24 hours of admission | Not specified | Upon information on oath or otherwise Supreme Court can order that detained person be brought for examination & order discharge if it appears that such person is sound of mind | | By order of superintendent if he believes patient is fit to be discharged By order of 2 visitors after 2 visits if patient is detained without sufficient cause Upon written request of person who signed application for reception | Trial discharge upon application by person who requested admission by superintendent Permit for absence given by 2 visitors with advice of superintendent with possible limits in time or place | |
| | Person alleged to be unsound of mind & incapable of managing himself or his affairs | Any person related by blood or marriage to person alleged to be unsound of mind Any officer in public service | Supreme court can order inquiry and upon inquiry order detention in mental hospital | | | Not specified | | | By Supreme Court If unsoundness of mind has ceased Court, after inquiry can order discharge | | |
| MALAYSIA Mental Disorders Ordinance of 1952 | Temporary detention Person suspected of being mentally disordered & found wandering at large or suspected of being dangerous Ill treatment of person suspected of mental disorder | Apprehension by police officer Proven by Court OR Report by police officer or informant to magistrate Request of some person | Order by Medical Officer (Form A) | Examination by Medical Officer | | Period not exceeding 3 months | | | Upon application of relative or friend, order of discharge by magistrate after consultation of superintendent & delivery into care & custody of friend or relative | By order of 2 visitors without set limit of time By superintendent for period not exceeding 7 days | |

| MALAYSIA (cont.) | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Allegation of lunacy | Husband, wife or relative to medical superintendent | | 1 medical recommendation signed by 2 registered medical practitioners (valid only for 28 days) | Within 1 month of admission patient shall be examined by 2 visitors | Period not exceeding 6 mths. Renewable for further 3 mths. but not exceeding 6 mths. in all | | | Upon request by patient within 28 days | By order of 2 visitors without set limit of time<br>By superintendent for period not exceeding 7 days | |
| | Indefinite detention<br>Person found to be unsound of mind & incapable of managing himself or his affairs | Application for inquiry by any person related by blood or marriage | Court order | Not required | | Not specified | | | By order of the visitors | | |
| | Same grounds as for temporary detention by order of a medical officer | Application by visitors concerning patients detained for 3 mths or detained for 14 days for observation or voluntary boarders | Magistrate issuing an order of detention | | | Not specified | | | By order of the visitors<br>By order of the magistrate | | |
| JAPAN<br>Law No. 123 of 1 May 1950 Revised between 1951 and 1965 | Compulsory hospitalization<br>Person who is liable to injure himself or others owing to his mental disorder | By any person who has discovered a mentally disordered person<br>Report by police officer<br>Report by Chief of Reformatory (in case of release or discharge of mentally disordered inmate)<br>Report by Adm. of Mental Hospital when patient claims to be discharged | Governor of Prefecture | Medical examination by 2 or more medical examiners of mental health | | Not specified | Compulsory hospitalized patient or person responsible for care can appeal to Governor of Prefecture for inquiry as to his mental condition (whether he is still liable | | By Governor of Prefecture with opinion of Administrator of Hosp.<br>Upon application by Adm. of Hos.<br>Upon application by patient or person responsible for his care to Governor of Prefecture | Temporary discharge by Administrator of Hospital for a period not exceeding 6 mths. with approval of Governor of Prefecture | |

| JAPAN (cont.) | Grounds | Application by | Decision making Authority | Medical Certificate | Other Formalities | Length of stay | Appeal | Periodic Review | Discharge | Trial Discharge | Change of status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Initiative of Governor of Prefecture | | | | | to injure himself or others | | | | |
| | Involuntary hospitalization Committment to hospital deemed necessary for adequate treatment & care of mentally disordered person | Consent of person responsible for his care | Administrator of Hospital | 1 medical examination | Report to Governor of Prefecture within 10 days | | | | By Governor of Prefecture after 2 or more medical examinations by medical examiners of mental health | | |

TABLE 6

INVOLUNTARY HOSPITALIZATION

INFORMAL SYSTEMS

| | Application by | Grounds | Med. Certificate | Decision making Authority | Length of Stay | Discharge |
|---|---|---|---|---|---|---|
| AFRO: | | | | | | |
| BENIN (Partial application of French Law of 1838). | Administrative authorities, police. | Aggressive behaviour dangerous for the public safety. Criminal offences. | | | Not specified. | At the patient's request with medical authorization. |
| SEARO: | | | | | | |
| THAILAND | Relatives, Police officer, Court. | | One medical certificate. | Final decision of admission by Psychiatrist, except when there is a Court order, but with relative's agreement. | Not specified. | |
| EMRO: | | | | | | |
| BAHRAIN | Call for police. Court order. | | | Police. Court. | Not specified. | Discharge after recovery. |
| IRAQ | Application in writing by the patient's family to - magistrate or police authority. | Unwilling or agressive patient. | One psychiatrist's report required. | By Magistrate or Police with approval of - religious Judge or court for non-Muslims. | Not specified. | By the treating physician. By a relative who will take over responsibility for his treatment. By patient himself. |

(contd.)

| EMRO: | Application by | Grounds | Med. Certificate | Decision making Authority | Length of Stay | Discharge |
|---|---|---|---|---|---|---|
| IRAQ<br>Draft Law<br>Arts: 5-11. | Information received from police, or civil authorities or patient's family | | Recommentation from the medical committee. | Court order. | *Not exceeding 4 months.* | *By responsible officer on the* basis of a medical recommendation. Notification to Magistrate or Court.<br>On application by supervisory committee. In case of refusal by responsible officer, final decision by the Council for the Protection of the Mentally Afflicted.<br>On request by Director General of Medical Services in the Ministry of Health for non-violent patients.<br>Upon application by family, discharge into care of family who will supervise treatment, by examining Magistrate. |
| | Report by police officer or other person responsible for public order. | Suspicious or immoral behaviour, danger to health or life, neglect or exposure to personal or material injury. | Examination by a physician or the Medical Committee. | Magistrate issuing an order for non-voluntary treatment. | Not exceeding 6 weeks. Possible extension by examining Magistrate on medical recommendations for period not exceeding 3 months. | |
| JORDAN | Relatives.<br>Police. | | | Police.<br>Court. | Not specified. | By family or by patient himself if not dangerous for himself or the community. |
| KUWAIT | Family or community or the police. | Disturbance to community or public nuisance. | One medical certificate (by a psychiatrist). | Admission to hospital - right to appeal to the Court in case of detention of a dangerous patient against his will. | Not specified. | Discharge when condition has improved, back to the police with a medical report.<br>Discharge upon application by family or patient himself even against medical advice.<br>Trial discharge. |
| QATAR | Family of patient when request for help to the police. [illegible] have to be in writing. | The family of the patient feels it has difficulty in coping with the patient. | Decision of a psychiatrist. | [illegible] patient's or family agreement. | [illegible] | |

| | Application by | Grounds | Med. Certificate | Decision making Authority | Length of Stay | Discharge |
|---|---|---|---|---|---|---|
| EMRO: | | | | | | |
| SAUDI ARABIA | Police. Psychiatric clinic in Provinces. Administrative-source. | | | | Not specified. | Upon a request of his sponsor after permission by the specialist. By family or through mass discharge of recovering patients Upon appeal by the patient him-self to the specialist. |
| Draft Law | Patients family. | Nature of disease is such as to be prejudicial to security or order or to arouse concern for the safety of patient or others. | One medical certificate = | Order of the representative of the Ministry of Health or his deputy. | Not specified. | By order of Director of Hospital - when cure completed or sufficient improvement; upon application by patient's family or guardian. Trial discharge for non-violent patients. |
| | Patient's family | | 2 medical certificates | | | |

The statutory definitions of persons subject to involuntary hospitalization differ from country to country. The majority of the laws require a finding, usually included in the medical certification, that the patient must be likely to be dangerous to self or to others, due to mental illness or disorder, unless he is hospitalized and confined. Some laws also add an alternative criteria that the patient can be involuntarily admitted if he or she does not understand the need for treatment and is unwilling or unable to apply for it voluntarily. Since there is little, if any, effective medical audit of the opinions offered by those persons who are making or accepting such certificates, and very infrequent legal challenge of commitment orders in any country, it matters little what standard the law imposes. The practically important factors are related to the methods and customs of the medical community in making referrals to mental hospitals and the availability of alternatives in the treatment of mental illness, particularly severe disturbances and psychotic episodes.

5. Observational Hospitalization:

In Table 9 will be found the procedures we have classified as observational. The selections are somewhat arbitrary and can be found to overlap, in actual operation, both the previous section and the next following category of emergency care.

TABLE 9

OBSERVATIONAL HOSPITALIZATION

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| AFRO:<br><br>LESOTHO<br><br>Mental Health Law of 1963. | Allegation that the patient is suffering from mental hyper-disorder and that it is expedient in the interests of the patient or for the protection of other persons. | Application by responsible relative to the District Commissioner who with one medical recommendation, will direct admission for observation. | Not exceeding 21 days. Possible further periods of 7 days, with a total not exceeding 6 weeks. | It must appear to the responsible medical practitioner and the district commissioner or the medical officer in charge of the Mental Hospital that no satisfactory alternative method of treating the patient is available. | When procedure for admission to a mental hospital is followed. |
| EURO:<br><br>DENMARK<br><br>Law of 1938. | | Voluntary. | 6 months. | | |
| UNITED KINGDOM<br><br>Mental Health Act of 1959, England and Wales, §25. | Patient is suffering from mental disorder and "ought to be detained" for health or safety of self, or for safety of other persons | By nearest relative, or mental health officer.<br>2 medical certificates. | 28 days.<br>Nearest relative who made application can request discharge on 72 hours notice. | | The medical officer in charge can refuse discharge on certifying that patient would be likely to act in a manner dangerous to other persons or himself if discharged.<br>Nearest relative has 28 days to appeal this refusal to MHRT.<br>Renewal is for up to 6 months. |

| AMRO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| PERU<br>Executive Decree of 14 October 1952, sect. 32. | Any patient entering a public institution. | In a special admission and observation service by superintendent. | Not exceeding 30 days. | | If it is decided that further treatment is necessary, the patient shall be transferred to the appropriate service. |
| EMRO: | | | | | |
| EGYPT<br>Mental Health Act No. 141 of 1944, article 5. | Observation of person alleged to be mentally ill. | If the medical officer cannot give a definite diagnosis within 24 hrs, the patient can be placed in a general hospital. | 8 days. | Daily medical examination | When the medical officer will issue a medical certificate stating that the patient is mentally ill. |
| IRAQ<br>Draft Law, Art. 5 (11). | If the patient's condition requires further study. | By Court, in the light of the medical committee's recommendation. | 2 weeks. | | |
| DEMOCRATIC YEMEN<br>Chapt. 80 of Aden Law. | None | | | | |
| SYRIA<br>Instruction No. 1 of 17 January 1965. | Certain detained or accused persons. | Written application from judiciary or executive authorities. | | | |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| EMRO: | | | | | |
| SAUDI ARABIA<br>Draft Law, Art. 4. | When the physician has been unable to decide definitely whether the patient is suffering from a mental disease. | By order of a physician in a government hospital other than a mental hospital. | 8 days. | Patient must be examined every day. | By physician at the expiration of the 8 days: either release or confinement. |
| WPRO: | | | | | |
| AUSTRALIA<br>South Australia<br>Mental Health Act 1935-1974, Sect. 35 & 36. | | Upon request by patient himself or other person, with 1 medical certificate.<br>By order of the superintendent of a public hospital, with 1 medical certificate.<br>Hospitalization in receiving house or ward. | 2 months, renewable but further period not exceeding 4 months. | Examination by superintendent without delay. | Discharge or transfer into a mental hospital. |
| Sect. 32 &33.<br>(contd.) | When a mentally ill person is without sufficient means of support or is wandering at large or was found under circumstances denoting a purpose | Order of 1 or 2 justices accompanied by 1 medical certificate. | 30 days. Renewable up to 6 months. | Within 30 days the superintendent will cause this person to be brought before a justice in the institution. | Discharge or transfer into a mental hospital. |

| WPRO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| South Australia<br>Sect. 32 & 33<br>(contd.) | of committing some offence against the law, or, not under proper care and control or cruelly treated or neglected. | | | | |
| Victoria<br>Mental Health Act 1959, Sect. 42. | | On the request of some person with the recommendation of a medical practitioner, hospitalization in a psychiatric hospital. | 21 days. Renewable up to 6 months after medical examination. | Examination without delay by superintendent. | Discharge or transfer into a mental hospital. |
| JAPAN<br>Mental Health Law of 1 May 1950, Article 34. | When the administrator of hospital thinks that a longer period of time is necessary for the diagnosis of the patient. | By Administrator of hospital. | 3 weeks. | Consent of guardian, spouse, or person responsible for patient's support.<br>Report within 10 days to Governor of Prefecture. | Discharge or further commitment by Governor of Prefecture. |
| MALAYSIA<br>Mental Disorder Ordinance of 1952. Section 7.<br>(contd.) | Upon application for inquiry whether a person who is alleged to be mentally disordered is or is not of unsound mind. | Court order. | 1 month. | Within that period the superintendent has to produce a certificate as to the state of mind of the patient and present it to the Court. | By Court order. |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| MALAYSIA (contd). Section 37,43. | Person suspected of being mentally disordered and found wandering at large, or dangerous, ill-treated. | Order of detention signed by a medical officer. | 14 days. | | The visitors can make an application to a Magistrate who can issue an order for further detention. |
| Section 41. | Public safety or welfare of a person alleged to be unsound of mind. | Removal by police officer or medical officer. | 3 days. | If medical officer in charge of hospital believes it necessary, possible further detention until next monthly visit of visitors. | The visitors will either discharge the patient or make an application to a Magistrate for further detention. |

The criteria for placement in this section relate primarily to the grounds stated for use of the procedure. The physician who certifies the patient for hospitalization does not generally need to be certain of his diagnosis, he need only be seeking the care and treatment in order to determine the condition of the patient. Some laws seem to require that the physician be fairly convinced that the person is mentally ill, but the severity of the disturbance and methods of treatment may be uncertain and requiring of observation over a period of time.

The procedures included herein are also specifically limited in time. The general mode is 3 to 4 weeks of observational care and treatment at the end of which time a decision must be made to transfer the patient to a regular, indefinite, or extended stay, or to release him. At release, of course, it may be recommended that the patient seek out-patient care, or other professional help in the community.

Nearly all of the procedures are involuntary. Most of them are without prior court approval. In Denmark, however, as in the other Scandinavian countries, there has long been a tradition of voluntary observational hospitalization for a period up to six months. We have listed that procedure in our Table herein.

The Malaysian legal procedures are multiple and complex. We have listed 3 different procedures in this category because the law of Malaysia so classifies them, even though one of them is limited to 3 days. Another Malaysian procedure is listed under emergency hospitalization, even though it is allowed for 7 days hospitalization with a provision for renewal for an additional 7 days.

It is our impression that observational hospitalizations are less frequently utilized at present than in former years. In a formal way,. this is evident from the relatively small number of countries having such a provision in their current law. Such procedures are not included in the quite recent revisions of the law in the Canadian Provinces and the American States surveyed. The reason for this change in practice is quite clear. It is due to the greater availability of out-patient and consultation services in many countries where diagnostic services and early and effective treatment can be given in the community without the need to hospitalize the patient. Only where the large public mental hospital is

the only available facility will there be the continuing need for the 3-4 week observational periods for non-dangerous patients who do not need emergency confinement. General hospital psychiatric services are also absorbing a large percentage of this type of patient in nearly every country surveyed, either in out-patient or short in-patient stays. This practice was reported in the developing countries as well as in the industrial nations.

6. Emergency Hospitalization:

Unlike the previous classification, the emergency hospitalization procedures would seem still to be a significant and frequently used admission method in all countries. The key factor here is time. The patient is in need of immediate professional attention. He usually needs both immediate treatment and immediate restraint, due to a violent outburst, or suicide attempt, or other sudden and bizarre behaviour.

In those countries which require pre-hospitalization review by court, or the certification of the illness by 2 physicians, the use of the emergency procedure dispenses with these requirements. Many countries still require one medical certification, even for acute emergencies. Also in many countries, the application itself is made by a health officer or by a physician who has examined the patient.

In many countries, emergencies are handled by the local police. Therefore, the law usually allows police to detain persons who as suspected of being mentally ill and in need of immediate psychiatric care. The police are authorized to take the person to a mental hospital and it is the responsibility of the hospital to make a determination of whether the person should be admitted. In practice, the local police are often reluctant to take people to a mental hospital even for an evaluation without a physician first examining them and advising the police, or making out emergency commitment papers. This is particularly the practice in any country where the police are at all apprehensive about law suits by such persons against the police for improper confinement or arrest.

In some countries, especially those without formal legislative systems, there may be little opportunity on the part of the hospital doctors to exercise medical discretion about admitting patients escorted

to the hospital by the police authorities. Improved legal systems with more modern procedures would strengthen the role of the admitting doctors to refuse to admit, or to refer elsewhere, when inappropriate cases are brought to the facility by police or other governmental agencies.

Nearly all of the procedures outlined in Table 10 are limited in time to from 1 to 3 days before the patient must be discharged or handled through some formal procedure. In some of the countries, the French system of reports to the prefecture of police, or other special surveillance board, are installed, with the reports usually required in 24 hours. In only a few of the countries are emergency hospitalizations currently allowed for periods of from 7 to 14 days.

Serious doubts have been expressed about the psychiatric advisability of the very short reporting requirements. These doubts will be explored later in the Report.

## 7. The Criminal Law Processes and the Mentally Ill Offender:

The criminal law and mentally ill offenders were not a part of our study. Some of the mental health codes which we examined had provisions on care and treatment of criminal offenders and provisions on observational commitments of persons charged with crime. In other countries, such matters were taken care of in completely separate criminal codes. Many countries have separate institutions for the "criminally insane", usually under the supervision of the state penal authorities.

It was reported that in some countries observational cases sent to the hospitals from the criminal courts take up a considerable number of the beds in the public mental hospitals. These cases often add to overcrowding in many hospitals, since the admitting doctors cannot refuse admission of these patients. Very few jurisdictions provide psychiatric consultation to the criminal courts to screen out inappropriate observational commitments.

Some of the civil law hospitalization procedures which were surveyed overlap with the criminal areas, or provide for alternative methods of disposition of persons who could otherwise have been handled in the criminal law system. This is the case with the mental hospitalization of

alcoholics and drug-dependent persons, reported upon earlier in this Report. It also occurs under laws such as the Mental Health Act of 1959 in England and Wales and laws modelled thereon which include "psychopaths" in the same classification and within the same system as other "mentally disordered" patients. It is very difficult to integrate this type of patient into the more modern psychiatric facilities with their open wards and doors and much liberalized and freer rules of operation. A Report of the World Federation of Mental Health in 1967 questioned the British approach:

> "Among the categories of mental disturbance provided for is "psychopathic disorder"..... This clause has the effect of bringing psychopathic behaviour within the scope of medical treatment and has raised the significant question of a medical type of institution for the treatment of chronic criminality. If moves are made in this direction they will undoubtedly result in the provision once again of some closed psychiatric hospitals for individuals who are there under some form of legal duress"[24].

The doubts expressed were quite prophetic. Among the most serious problems in the British mental health system at present is the handling of psychopathic patients, both in the special hospitals and in the general mental hospitals. Cases involving patients who are or were psychopathic and highly dangerous have given the greatest difficulty to the Mental Health Review Tribunals. A recent Report in the United Kingdom recommends extensive reforms in the handling of mentally ill offenders[25]. There is also considerable interest in this subject in many other regions of the world. The subject is dealt with in a paper on health aspects of avoidable maltreatment of prisoners and detainees prepared by WHO for the Fifth United Nations Congress on the Prevention of Crime and the Treatment

of Offenders held in Toronto in 1975. The difficulties of drawing a clear distinction between criminality and mental disorder are stressed and the growing practice of "arranging" informal admission to psychiatric hospital for offenders who "accept to be received for observation and any necessary treatment" is mentioned. The problems which have arisen as a result of preference of committal to psychiatric hospitals rather than prisons of offenders medically judged to be anormal are discussed in the light of the evolution of the "open door" policy.

## D. Protective Measures for Patients

### 1. Court and Administrative Review:

Throughout history, the independent system of the judiciary -- official justice-- has been the primary recourse of the individual to protect his rights and to redress wrongs against him, and to gain his liberty from unjust or improper imprisonment or detention. These principles have been adopted in international documents on human rights. The first principle appears in the Universal Declaration of Human Rights:

> "Article 10. Everyone is entitled in full equity to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him".

The second principle appears in the International Covenant on Economic, Social, and Cultural Rights:

> "Article 9. (1) Everyone has a right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.
> (4) Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful".

Very similar provisions to the above may be found in the European Convention on Human Rights:

> "Article 5. (4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be speedily decided by a court and his release ordered if the detention is not lawful.
> Article 6. (1) In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law".

The commitment of an individual to a mental hospital is clearly a deprivation of liberty. It is also a personal trauma and a social, political, and legal stigma of great severity. It is often considered more damaging and more lasting in its effects on the future wellbeing of the individual than criminal charges or conviction. Therefore, commitment procedures in most countries are provided for in the official law of the country enacted and promulgated by its law-making assembly. Such is the requirement of Article 9 above of the International Covenant on Economic, Social, and Cultural Rights.

The provisions of the international documents concerning the right to a public hearing are not as clear. They are open to interpretation and to different application, depending on the circumstances of the individual case. The most serious interpretative problem concerns when the hearing, or an opportunity for a hearing must take place. Article 9(4) of the International Covenant on Economic, Social, and Cultural Rights and the European Convention, Article 5(4) deal with the matter of when the court, once the request is filed, must make its decision. In the former, it is to decide "without delay", in the latter it is to be "speedily decided". But the implication of the provisions is that the person has already been deprived of liberty before the request for court action is made.

It seems reasonably clear that these documents were concerned mainly with the very serious problems of arbitrary arrest and imprisonment under sentence without trial. Such persons are in confinement and without

opportunity to protest. Unless the legal system is independent and watchful, such persons could never exercise any right to liberty, short of a personal escape.

Nevertheless, the most effective means of exercising the right of freedom from improper confinement and imprisonment is by public trial or hearing prior to confinement. Under interpretation, the Constitution of the United States has been held to require such a public hearing, including the issue of involuntary commitment to a mental hospital[26]. The older commitment laws of the nineteenth century in Europe which were adopted from about 1850 onward generally followed this principle. There were, of course, exceptions to this requirement in situations of emergency, but the person was afforded the opportunity to appeal his confinement very speedily, or the confinement itself was limited to 24 to 72 hours, within which the hospital was required either to release the patient or to seek court action for a further confinement. The person's opportunity to protest was, of course, to be exercised at this hearing.

The laws of many countries, as indicated in the previous tables, currently adhere to this system. Among the jurisdictions surveyed, 10 provide for non-emergency commitment exclusively under prior court review and judicial order of detention. (Cyprus; Democratic Republic of Yemen; Ghana; India; Iran; Iraq,(under the current law and the draft law); Nigeria; Romania; Sénégal; and the United States of America (both states).) 11 jurisdictions provide for alternative means of commitment: with prior court review and order; and without such review. (Australia (both states); Bahrain; Brazil; Canada (British Columbia); Fiji; Jordan; Malaysia; Mauritius; Peru; Rwanda; Switzerland (Basel).) In the remaining jurisdictions surveyed, prior court review is not required.

As was indicated earlier in this Report, the compulsory hospitalization without prior court review is the most favoured system in nearly all countries. Where it is available, it tends to be much more utilized than any alternative method requiring prior court review. Also, where the only method of indefinite commitment is by prior court order, the tendency is to utilize any available non-judicial, temporary hospitalization procedures such as observational and emergency admissions. At the end of these periods, a court hearing should be required, but in the past, at

least, some jurisdictions have allowed a change of status of the patients to take place, either without court approval, or without providing the patient with prior notice and an opportunity to request a hearing in court or before an administrative tribunal. One of the earlier reform bills in America in Massachusetts in the 1950s was required to correct practices of this type[27]. More recent court cases have uncovered similar practices in other American states.

In countries providing for court review after indefinite commitment, the burden is usually upon the patient to request a hearing before a court or tribunal. The exercise of the opportunity to request a hearing is itself often restricted to once per year, or once during a renewal period of 2 years. Such restrictions on applications to the Mental Health Review Tribunal are quite common in the Mental Health Act of 1959 in England and Wales and in legislation of other countries using that legislation as a model. The purpose of the restrictions is to avoid multiple appeals by severely paranoid patients. However, the severity of the restrictions and their universal application to all patients is open to question.

In our questionnaire we asked about the influence of recent court decisions on the mental health legislation of the countries. There was no significant mention of court decisions in any country except the USA. **Most of our respondents** were psychiatrists, so that the data could be questioned. However, nearly all were functioning very actively in mental health programmes of their countries, in universities, senior clinical positions and as administrators, or in the health ministries. If court decisions were having a major and direct influence on policy and practice, these respondents were not aware of it.

The lack of mention of court decisions is usually indicative of the fact that few patients are seeking court review of their commitments. Of course, there can be appeals to administrative tribunals and lower courts without appeals to upper courts. Changes in law or constitutional-civil rights matters are most apt to require decisions by the highest courts.

It has been reported that in England and Wales, appeals to the special review tribunals are very infrequent (3.5% actual cases heard in 1971 of all first involuntary commitments) and further reviews in the courts are almost never sought[28]. Court review is limited to matters of

law; findings of fact are final before the Mental Health Review Tribunals.

In the United States of America, there have been a large number of appellate court cases in the commitment-law field in the past decade concerning mental illness, mental retardation, alcoholism, drug addiction, sexual psychopathy, and special problems related to these areas, plus numerous decisions concerning mentally ill offenders. The impact of these decisions has been substantial, particularly regarding patient's rights. The cases have also provoked a great deal of new legislation in the field and considerable interest in the entire subject in the law schools of America. It should be noted that this court involvement in the United States is a recent phenomenon, probably more related to civil rights interest generally than to special problems in mental health legislation unique to the USA. A national survey published in 1953 indicated that there had been few appellate court cases in the entire country up to that time[29].

Press and other mass media coverage of mental illness and of commitment or hospitalization is often closely related to court cases and court hearings. Also, the public media gives considerable coverage to actions of the courts and tribunals themselves in releasing dangerous psychopaths who, soon after release, commit bizarre murders, rapes, and other crimes. Nevertheless, our correspondents in most countries, as indicated earlier in this Report, were of the opinion that press and other media understanding of the mental health legislation was generally limited. The general public probably gets a large part of its knowledge of a country's mental health programmes from press and media sources. There was generally a correspondence between levels of understanding of the public and of the press in the questionnaire responses.

All of these factors seem to indicate that court and tribunal matters can have a serious impact on mental health programmes quite beyond the formal application of the decrees or decisions upon the parties to the litigation.

2. Visitation Boards and Reporting Laws:

Among the earliest legal mechanisms adopted to provide public surveillance of the operation of the public mental hospitals were the

"visiting committees", "boards of control", and the "lunacy commissions". These official bodies were generally composed of leading citizens with unquestioned integrity and prestige. They were charged by law to "visit" the institutions, to hear grievances, and to make recommendations to the institutions and to the government concerning improvement of conditions.

At the time of our survey, 15 of the countries provided in their law for a visiting committee or similar independent body to conduct activities such as those related above. /Australia (both states); Democratic Yemen; Egypt; Fiji; Ghana; India; Iraq (draft law); Malaysia; Nigeria; Norway; Peru; Saudi Arabia; Sudan; Switzerland (Geneva); and Uruguay./

Most of the same laws require the institutions to make reports to the control boards or committees regarding their operations and often, with information on each patient. The French and Sénégal laws require reports be made to the prefect of police and the public prosecutors and empower these officials to make visits and inspections.

In some countries, the law contains references to responsibilities in the national ministries of health, or mental health department or council to make inspections and to answer complaints. Nearly all countries require supervision of the public mental hospitals by the central government or the government of the state in a federal nation.

3. Periodic Review and Right to Treatment:

Among the newer devices for supervision of operations in the mental hospitals are laws requiring periodic review of the progress of individual patients and release of the patient when advisable after such review.

In the earlier laws, the hospitals were often required to report on the condition of the patients, sometimes periodically, to the boards of visitors on their attendance at the institutions, or in written documents sent to a central office. During the nineteenth century and well into the current century, these reports were perfunctory and of very little utility to anyone. Most of the patients were handled as chronically ill and little more than custodial care was given. The reports could have varied little upon anything but the death or the escape of a patient. Even as more aggressive treatment methods were adopted, the reporting systems had

little effect.

It has only been in recent years that the legislatures have begun to re-examine the issue of periodic review and how such a method could be made more effective. It would seem clear that the first requirement is that an actual examination of the patient take place specifically for the purpose of the review. (In previous years, the administrators merely wrote notes on patient progress based on available evaluations in the records. As might be expected, the reports on most patients read the same: "No change since last report".)

The next issue was who was to perform the required, specific-purpose examination. At a minimum, one might expect, the examination should be conducted by a physician properly trained in psychiatry, or by a physician or other professional properly trained in mental retardation for the latter field. Within the mental hospitals or the schools for the retarded, this presented a problem during former years and still does in many institutions. There was rarely enough professional staff qualified to conduct such examinations of every patient semiannually or annually. In many institutions in many countries there was only one, or perhaps two, fully qualified and licensed psychiatrist. If there was only one, he or she was likely to be the superintendent or director with little or no time to conduct complete examinations and to make reports on progress of individual patients. If there were two such qualified professionals, one was usually the superintendent, the other the clinical director - both carrying heavy administrative responsibility. The latter was usually closer to the patients, but in large institutions, which most of the hospitals were, he or she was generally limited to supervision and consultation with other staff.

During the time when the matter of periodic review was first raised, it usually got no further than this second question. The asking of the question itself exposed the major clinical weaknesses in the entire large mental "asylum" system: the critical shortage, or the virtual absence, of qualified psychiatric personnel in the institutions capable of taking full clinical responsibility for the management and evaluation of individual patients committed to the care of these institutions.

When legislative bodies or reform groups have sought effective periodic review, the institutional managers have countered by pointing out the cost

of employing professional staff to conduct them. Not only were the funds difficult to procure from the same legislative assemblies, which desired the reviews, but the professional personnel was rarely available in the country to be hired to do the examinations and evaluations.

In later years, however, this situation has changed. Through better treatment and management techniques, the hospital patient census has declined and patient stay has been substantially reduced in many institutions. The mathematics on numbers of required reviews has become much more favourable, but also, ironically, much less necessary as well. The short-stay patients aren't apt to be hospitalized long enough to become subject to an annual review, and quite often not even to a semi-annual process. The numbers of chronic patients has also been declining and even these are being discharged to other institutions in some situations.

Another legal movement began in the 1960s which also focussed on the clinical progress, or lack of it, of individual patients. This was the "right to treatment". Professional journal papers and court cases, particularly in the United States, raised the issue that involuntary patients were hospitalized on the theory that, in a medical-care institution, they were being "treated" for their mental disorder[30]. If they were not being treated, the legal basis for their compulsory detention could be challenged. The first statutory enactment of a right to treatment for involuntary patients occurred in the District of Columbia in the USA in 1964.

The basic problem with the right to treatment is one of enforcement. Logically, the only sanction a court has for failure to treat is to order discharge of the patient. However, if the patient is mentally sick and in need of treatment, this is hardly a remedy, unless community-based services can be assumed to be readily available. Also, if the patient is believed to be dangerous if at large, the court will be reluctant to release, since protective detention is also a separate legal ground for involuntary detention despite the inadequacy of the treatment being given. In the past year, the Supreme Court of the United States reviewed its first right to treatment case and rendered a conservative opinion which endorsed the principle, but did not deal with the issue of whether a dangerous patient must be discharged if not receiving adequate treatment[31,32].

A more effective method of enforcement would, of course, be for the court to order an improved treatment programme be installed in regard to this patient (and others in the same class) and then to receive periodic reports in the court on compliance with the order. Most judges or magistrates are traditionally reluctant to enter such orders. To do so intrudes the judiciary into the day-to-day operations of professionally administered programmes where technical knowledge and skill and matters of judgement are constantly required. Also, the imposition of new standards of care and treatment is essentially a legislative matter, not judicial. Lastly, new budgetary appropriations may be necessary to provide the level of adequacy of treatment which the court feels to be minimally necessary. The arguments against imposing minimum or adequate standards of treatment applicable to individual patients may sound quite similar to the earlier arguments against imposing effective periodic review.

Despite these obstacles, American courts have begun to enter into the professional areas and have issued detailed orders for treatment programmes and for institutional improvements in professional staff, maintenance, and facilities in both mental hospitals[33] and institutions for the retarded[34,35].

The efforts to install periodic review have been stimulated by the action of the United Nations in 1971 in adopting the Declaration on the Rights of Mentally Retarded Persons. The Declaration contains a provision requiring effective, professionally conducted periodic review[36]. The "right to treatment" has also been endorsed for all disabled persons, including the mentally ill and handicapped, in the Declaration of the Rights of Disabled Persons adopted by the United Nations General Assembly on 15 January 1976.

In our comparative legal survey, statutes requiring periodic review as an independent procedure were found in very few jurisdictions. The most common practical application of a periodic review which any appreciable number of countries have adopted is attached to renewals of the commitment orders themselves. Where the original orders are for 3 months, or 6 months, a further clinical examination and report to the court or tribunal is required. After that, a clinical examination and report is required for each periodic renewal, usually at 2 year intervals for chronic-care patients in an involuntary status. The more effective statutes

specifically mention the requirement of a clinical examination by the responsible medical officer rather than merely requiring a request for further commitment by the hospital managers. These provisions will be found outlined in our tables on involuntary procedures.

There are no statutes specifically requiring that the periodic review or renewal-application examination be done by independent, outside psychiatrists not on the hospital staff. However, the recent revision in Alberta, Canada seems close to such a requirement in that it applies the same procedure for a "two-therapist certification" to the 6 months renewal procedure which is applied to initial commitments[37]. The law does not, however, go into detail as to who these "therapists" can be, so that two staff members of the hospital could perform the examination and make the certification. The law does, however, provide for administrative regulations to define who can be "therapists" under the law for certification purposes. The regulations actually deal with authorizing psychologists and social workers to conduct initial commitment certifications rather than with procedures for the in-hospital renewal examinations. (The latter subject will be discussed later in this Report in regard to new alternatives in the use of professional manpower.)

No country, including the USA, have moved very far in its statutory enactments on an enforceable right to treatment. One of the two American jurisdictions surveyed, Indiana, has enacted a special law on mental patients' rights which contains a general statement of policy on treatment, but no enforcement procedures. The statement is as follows:

> "A patient shall be entitled to reasonable living conditions, humane care and treatment, medical and psychiatric care and treatment in accordance with the standards accepted in medical practice"[38].

A specific decision was made not to include such a right or statement in the new Massachusetts law. Instead, the requirement was placed upon the State's Department of Mental Health to enact regulations containing "the highest practicable professional standards for reception, examination, treatment,...... of mentally ill and mentally retarded persons in depart-

mental facilities"[39]. (Emphasis supplied.) It was felt that such a requirement would have more practical effect upon institutional management than a vague statement of policy unattached to action responsibility. Failure to adopt and to enforce such standards could be the basis for a court action (for an order of mandamus) to require the Department to meet its statutory obligation.

The quite recent decision of the Supreme Court of the United States, noted earlier, which recognizes a constitutionally-guaranteed right to treatment is currently having its effects in mental hospitals across the country. The questionnaire response we received from Connecticut is particularly illustrative.

It is reported in the questionnaire that in the public and private mental hospitals of Connecticut all committed patients are being surveyed systematically and are being asked:

1. Do you think you are getting treatment?
2. Do you want to leave this hospital?
3. Do you think that you can live safely in freedom?

It is indicated that for the purposes of this survey, "treatment" of mental patients is being defined as "the implementation and administration of a professionally developed, individual, documented plan of care setting forth objectives, activities and therapies, and directed to the point at which institutional care is no longer necessary". "Professional care" is defined as "that form of treatment in which a patient received planned and documented diagnostic, therapeutic, and rehabilitative services from a multi-disciplinary staff for consecutive 24 hour periods in a psychiatric facility". The respondent also indicated that the hospital staffs are making their own estimate of the "amount of sickness" of each patient and his "dangerousness". All of the above will be no easy task in Connecticut where in 1975 the percentage of involuntary patients in all institutions stood at 59%.

The above definitions of treatment and professional care are quite detailed and impose a relatively high standard of clinical management rarely reached or sought after in large mental institutions in past years.

The requirement of an individualized "plan of treatment" designed specifically to achieve discharge of the patient and not merely an improvement in his mental condition is derived from the recent court cases, particularly the case in Alabama involving the State mental hospitals and retardation institutions of that state[40]. The definitions also wisely require that the institutions be able to document their individualized plans and the clinical progress of the patients under them. The court cases have revealed very inadequate clinical patient record-keeping in the mental institutions.

The cases noted above were limited to a right to treatment for compulsorily admitted patients. At least one case in the Federal Courts, however, has applied the right to so-called "voluntarily admitted" retarded persons, most of whom were admitted under the application of parents. The Indiana law noted earlier is not limited to involuntary patients. One of the arguments favouring the statutory approach taken in Massachusetts was that it applied to all patients and residents, whether voluntary or committed, whether in-patient or not. Most of the recent writing in the field favour extension of the right to all patients.

## 4. Rights of Mental Patients and Mentally Retarded Residents:

Very few of the mental health codes examined in this survey contained extensive provisions about patients' rights. The older laws dating from the nineteenth century generally contain a provision, under the heading "offences", which imposes a criminal penalty against hospital personnel who beat patients or sexually abuse female patients. The laws also often contained a provision requiring female patients to be escorted by a female attendant when transferred to another hospital. The older laws also often contained provisions regulating the use of mechanical restraints on patients and requiring the listing of the taking of such actions in a special register which frequently had to be sent to the Board of Control or other supervisory body.

In some of the newer laws the rights of patients and residents to receive mail, to send mail, and to have pocket money are detailed, usually with restrictions which can be imposed by the hospital under stated

conditions. The right of hospitalized patients and retarded residents to treatment or habilitation was analysed in the previous section; the correlative right to refuse treatment, or at least certain forms of treatment, has also been raised. Apparently, voluntary patients can refuse treatment, but the hospital could threaten to discharge them on refusal to follow a given routine of therapy. Committed patients are, of course, under legal constraint. Where a committed patient is hospitalized on a court order, the order often mentions treatment specifically and authorizes and protects the hospital when it uses coercive measures to treat the patient. Nevertheless, we found it to be common practice in many countries to seek the consent of a relative, and often of the patient also, when shock therapy was to be applied, even for court-committed patients. Usually the seeking of consent was an effort at protection against malpractice suits in the event of severe adverse reaction or fractures of bones during provoked seizures. The issue of refusal of psychiatric treatment has, perhaps, been raised more often in recent years concerning criminal offenders than for hospital patients. These matters have been examined in a number of European countries as well as in North America. Objection has been concentrated upon the use of behavioural control measures and on coercive drug treatment.

Our questionnaire sought information in this area. The most frequently mentioned problem reported by our respondents was the lack of adequate protection against exploitation of patient labour within the institutions. A substantial majority of the respondents felt the laws of their countries inadequate on this matter. We discovered only one jurisdiction with a special law addressed to this subject, Indiana in the USA. Some other countries do provide for payment to patients for work in the hospitals, invariable a very low payment, and subject to special appropriation in the hospital budget. Confusion can be added to this matter when the institution insists that the work, even that of cleaning wards and washing clothes and bed linens, is a part of medically ordered therapy and rehabilitation. The Indiana legislation, a rather complex law, defines the "work activity" for which remuneration is authorized to be paid as:

> "any direct service or work performed in an employee-employer relationship for a hospital by a patient of any hospital"[44].

It is further provided that "when a work assignment develops into an employee-employer relationship, it shall be confined as a work activity" and the patient must be sent to the hospital's personnel office by "his physician" and he then is assigned work and remuneration in accordance with the law.

The same law expressly authorizes "therapeutic work assignments" for each patient to be prescribed by their physicians. These work assignments are not remunerated under the Act.

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## IV. Alternative Approaches to Harmonization of Law and Programmes: Some Guiding Principles for Programme Administrators

### A. Introduction

In order to make this international survey of the most practical value to programme administrators in the mental health field, we have gathered in this part of our Report some suggested approaches to improving legislation in this area. These suggestions contain some alternative approaches, depending upon the conditions the country, its traditions in the administration of justice, and the current stage of development of mental health legislation.

The earlier Report of the Expert Committee on Mental Health (1955) contained recommendations which have been discussed in this Report. Also, in 1973, the Office of Mental Health produced a draft set of Introductory Guidelines to Mental Health Legislation. Essentially these guidelines suggest the text for statutes regarding central administration and hospitalization procedures. They represent modern thinking in law and psychiatry and are very worthy of consideration. The draft document is attached to this Report as Appendix A. At appropriate places in this section, we will discuss some of these introductory guidelines.

It should be noticed, however, that we have tried to make our suggestions in alternatives and without necessarily proposing specific language for the laws. We have offered examples from existing statutes and regulations in various countries. These may or may not be adaptable in other situations. They must be taken only as possible approaches which have at least the practical value of having been enacted and tried out in other jurisdictions. Administrators and legislators, however, must adapt the

suggestions to their own needs and available resources. On the international level, we would reiterate the precautions expressed by Dr. E.E. Krapf in 1959:

> "It would be a serious mistake if the case for an international approach were overstated... Certainly it is frequently possible to use in one part of the world solutions which have proved valuable in others. But precisely the international experience of the last 10 years has shown very clearly that there are limits to the possibility of comparing situations and copying solutions... The risk exists, of course, also in respect of mental health recommendations which are not in accordance with the value systems of the society in question. The simple transfer of solutions from one area to another is therefore often strongly contra-indicated"[1].

Dr. Krapf was not discussing mental health legislation, but his observations, based on his own international experience in the mental health field at WHO, can be applied quite well to the legal field. For example, care must be taken in adapting complex hospitalization procedures and legal controls from industrial countries to the developing world where different patterns of mental health services are being planned and installed. The law, if not enacted and interpreted in accordance with the actual programme plans, could force alterations in the services and create barriers between the programmes and the people who need services. We say this not only in relation to the law concerning the facilities and the admission procedures, but in relation to more strictly legal matters such as "informed consent" of patients to receive care, the methods of judicial review, and the control and regulation of community practice in mental health by traditional healers and auxilliary personnel.

We will try in these sections to follow our own advice.

## B. Legislative Systems

### 1. Desirable Forms and Objectives:

In this study we have been concerned mainly with statutes, the most formal type of legal enactment from the legislative assemblies of the world. There are, of course, other forms of law including national and state constitutions, the decisions and statutory and constitutional interpretation which come from the judiciary, and so-called administrative law or regulations.

Administrators and other personnel usually have their greatest degree of influence upon two forms of law: the statutes and the administrative regulations.

From the point of view of programme formulation, the most important of the two forms is the statutory. It is the point at which the public-law makers, the legislators, are involved most directly. It is also the point at which the governmental budgetary machinery operates to provide the necessary funds for programme operation.

Most of the legal systems in the mental health field have been statutory. This has been the tradition in the field, as pointed out earlier, since about the beginning of the nineteenth century when legislation was utilized to set up the public asylum systems in France, England and other western nations. The content of these statutes was considerably influenced by the mental health authorities who operated the asylums. The commitment laws of later decades, however, as well as the lunacy commissions and visiting committees, were the product of reform movements. They were often enacted over the opposition of mental institutional managers, or at least without their active support. These laws are still the preeminent type of law in the mental health field in many countries. The administrators of mental health programmes have tended to avoid getting involved with the law which has seemed to be designed more to control mental health personnel and programmes than to harmonize the objectives of law and programme policies.

We suggest that programme administrators become more involved with legislative matters and help to formulate more effective mental health

legislation. This should be done, of course, according to the established systems of government and public administration within the country.

The statutory structure of mental health law should include the following objectives:

| | | |
|---|---|---|
| <u>POLICY</u> | (1) | Establishment of broad public policy in mental health; |
| <u>AUTHORITY</u> | (2) | Designation of proper authority for planning and carrying out the public policy and administering mental health programmes (along with other health programmes of a public nature); |
| <u>BUDGET</u> | (3) | Providing the budgetary policy and continuing fiscal support for publicly conducted mental health programmes; |
| <u>OPERATIONS</u> | (4) | Providing adequate structure and detail about the operation of mental health programmes to enable administrators to follow and to implement it, and building in evaluation processes; |
| <u>PROTECTION OF INDIVIDUALS, ACCESS TO SERVICES</u> | (5) | Providing protection of the law and legal-judicial institutions (courts, tribunals, etc.), for the rights, welfare, property, and dignity of mentally disordered or handicapped persons, and providing for equitable, non-discriminatory access to mental health services for such persons; |
| <u>MINIMUM STANDARDS FOR MENTAL HEALTH SERVICES AND PROFESSIONAL PRACTICE</u> | (6) | Establishment of the policy for minimum standards (in such detail as deemed necessary and desirable) for mental health services and professional practice in the mental health field (or delegating such responsibility to professional organizations); |

| | | |
|---|---|---|
| REGULATION OF THERAPEUTIC DRUGS | (7) | Establishment of the policy for regulation of quality, supply, and distribution of therapeutic drugs in the mental health field; |
| DELEGATION OF REGULATORY POWERS | (8) | Delegation of authority, within statutory guidelines, to governmental agencies (such as public health authorities) to adopt administrative regulations, decrees, instruments, or other rules, for further implementation of legislative policy, to apply technical detail to the programme, and to be able to adjust the content of the programme to changes in conditions in the field. |

For those nations functioning under informal, non-statutory systems in mental health, the choice is more fundamental. They can avoid formal legislation, at least for a period of time. Some of these countries have already decided to move toward legislation, or are considering draft provisions[2].

Some countries, however, are determined to keep the informality since they view the law as coercive and punitive and as adding to the stigma of mental illness. This view has historical support, as we have pointed out. However, these are not the inevitable consequences of resort to the law as a formal structure for mental health programmes. Law can be used effectively to assign responsibility for service development and for protection of the handicapped who cannot help themselves. Also, the law can protect the administrators and the providers of mental health services and allow them, for example, to refuse to hospitalize patients in inappropriate circumstances. Decisions concerning the advantages and disadvantages of a legislative structure will be among the most important matters in the entire field of mental health in many developing countries in the immediate future years.

2. Advantages of Regulations:

Once a legislative structure is adopted, there can be substantial advantages in the use of regulations or administrative decrees to implement fairly broad legislative policy in the mental health field. Such regulations have the advantage of greater ease in enactment and in later

change when necessary. They can also be used to vary the application of programmes to different patient groups and in different facilities and services. Examples of the effective use of regulations will be cited later in this section of our Report.

3. Working with Legislatures:

There are also advantages to be gained to mental health programmes by close working relationships with the legislative assemblies. This is often difficult work and time-consuming, but it has clear benefits in greater understanding and cooperation on both sides.

Mental health personnel working with legislatures must be ready to advise the lawmakers on what they, the lawmakers, consider to be their problems and not merely on what the mental health personnel want themselves. It is very important to help the legislators to avoid making ill-advised, bad laws in response to crisis situations -- perhaps even more important than advising them on the content of good legislation. Legislators are often under great pressure from interested groups or the mass media to take definitive action. They need - and are usually glad to get - more calming advice from experienced and expert sources about alternatives of a less drastic nature. Crises involving mental health aspects are not uncommon. Assistance and advice to the legislatures should be a part of a comprehensive mental health programme.

4. The Law as a Rallying Point:

Resistance to change can be very great. At times, legislative bills and enactments can be used effectively to rally public and professional support for a new programme, or for a change in a programme. The more natural inclination of most mental health professions is to avoid going to the legislatures and to seek to accomplish objectives without legal involvement or recognition. Very often -- perhaps most often -- this is the wise choice. However, it can be very habit-forming and can lead to continued acquiescence in the status quo with little fundamental change taking place. It is a fact of life in most countries that the legislatures control the bulk of all budget sources for mental health programmes. The legislatures also control basic policy. The press and the other mass media look to the legislatures as the source of significant change in government pro-

grammes and tend to give only limited coverage to administrative innovations.

Mental health professionals and programme administrators need to be aware of these facts and to be willing to use the law and legislative initiative for improving mental health services. Otherwise, major change tends to be imposed from outside the mental health programmes themselves, forced upon the professionals who may actually have desired the change for years, but haven't moved to effect it through the legislative system.

One of the great advantages in the use of the law as a rallying point is that when the new programme is endorsed by a working majority in the assembly, it greatly helps in obtaining the necessary budget support and the cooperation of other independent government units in carrying out the programme. In the mental health field, this is best seen in new programmes in areas such as alcoholism and drug abuse where changes in public attitudes are vitally important and where the cooperation of other agencies, such as police and road-safety agencies, is needed; and in the development of community mental health services where delegation of authority may be desirable, and where the retention of personal rights and privileges may be advisable for the community-based patients.

5. Public Education through Law:

Closely related to the above point is the significance of law in public education. The utility of law in this respect has been well known since ancient Roman times when the Legal Codes were the chief instrument of general public education.

In the mental health field, we have seen legal changes in recent decades which have been primarily designed to educate the public and to change attitudes toward mental illness. Thus, the legislatives have abandoned terms such as "lunatic" and "insane asylum" and substituted less stigmatized terms. The trouble is, of course, that unless real change in programmes and services and in the rights of the mentally ill and retarded take place, the new terms become stigmatized -- and rightly so -- just as the former titles were.

More effective public education and attitude change is accomplished by

real change in the effects of the law - such as removing criminal penalties for alcoholism or drunkenness, or retaining the civil rights of committed patients. It is, of course, more difficult to convince the legislatures to make these substantive changes than merely to adopt new terminology.

6. Social Psychiatry and the Law:

It is important also to encourage mental health professionals to take a broad interest in law going beyond the specific content of legislation relating to mental health services and practice. This broader interest will be most helpful in preventive programmes, both primary prevention and more remote preventive efforts. Specialists in social psychiatry are taking an interest in legislative activity, as can be seen in the Seventh Report of the WHO Expert Committee on Mental Health[3].

A major area of interest in this field is family law and the law concerned with child custody and protection. Also, in an even broader sense, there will be interest in law related to major social upheaval, transfer of large population groups from rural to urban settings, mass unemployment, etc.

Psychiatrists and other professionals in mental health programmes should be ready to engage in advising on matters of this type which can have very damaging effects on the mental health of their country's peoples. If they do not do so, they will continue to cope with the symptoms of mental disturbance in their nations, but never effectively with the social causes of the disturbance.

An example may be useful here. In a developing country where there was extensive movement of people to the urban area and new housing developments operated by the government, it was the legal policy to take the next applicant in line to move into a housing unit or flat without regard for family arrangements or geographic ties. The inevitable result was that the housing projects were always seen as temporary and without family relationships allowed to develop. Having further children often resulted in a family being forced out of an apartment. As soon as a child married, he or she was also forced to move out and go to the bottom of all housing lists. Extended families could not maintain contact. The social psychiatrist suggested modification of the legal policy aimed at "non-discrimination", usually a worthy legal goal, but here resulting in further social upheaval

and disturbance.

Another example from a legal standpoint concerns the tendency for some types of legal deviancy to be automatically assumed to be mental disturbance. In many situations, the community mental health services become centres for "treatment" of social and legal deviation which may have no psychopathological determinants. As was observed at a WHO Working Group Conference in 1971 in Opatija, Yugoslavia, the result is that "the community may misinterpret the role of the mental health service, thinking of it primarily as an agent for securing conformity with societal norms"[4]. The particular problem discussed was drug dependency. It was pointed out that often mental health professionals failed to express their reservations about the legal control measures being used and the resultant distortion of all other considerations of a preventive, curative, or rehabilitation nature. There is a clear opportunity for social psychiatrists to contribute their views in areas of legal control and not merely to participate as passive agents to "treat" all forms of deviancy as undesirable, unhealthy failures of the individual "to make mature judgements" or "to adjust to social conditions", concepts which continue to appear as diagnostic impressions in many mental health clinics.

7. Methods of Periodic Evaluation in the Law:

**(to be presented separately)**

B. Administrative Structures

1. Integration with other Health Services:

It has long been the policy of WHO to foster general integration of health services thus preventing costly and ineffective fragmentation of the efforts of health personnel working with scarce resources. Most recently this policy was restated in relation to mental health services in developing countries[5].

Within the law, this policy is seen carried out when the central authority for health affairs is concentrated in one ministry or department. It is also seen in the avoidance of placing specific legal powers in

separate divisions or in *ex officio* administrators of separate programmes. Administrative regulations may be used to distribute authority, rather than stating it in the law. Avoiding setting up administrative structures by law within the health department or ministry also enables periodic re-organizations of services or personnel to take place without going back to the legislatures.

Integration with general health services also encourages the development of local community mental health programmes in collaboration with public health clinics and the use of community personnel in mental health services, as will be discussed later in this section.

Separation should also be avoided in areas other than administrative structure. When new methods of evaluation or regulation are developed, such as in peer-review mechanisms for social insurance, they may apply to only one type of medical care. Mental illness is often not included because it is perceived as "specialized" and is often considered inevitably chronic and thus too costly to deal with by means designed for handling other acute illnesses. Administrators of such programmes are often unaware of the radical changes in treatment methods in mental disturbance and the change in mental patient populations to the point where the majority are now on short-term care in most countries. When such separate handling of mental illness cases is allowed to continue, it reinforces the stigma of mental illness and its alienation from other health problems and treatment services.

## 2. Identification and Management of Mental Health Programmes:

The above considerations must, however, be tempered by the realization that there is often a need to identify and provide for the consideration of mental health problems and priorities as such within the operation of general health programmes.

As a matter of public administration and management, this effort at identification generally takes the form of suggesting that the responsibility for mental health programmes be placed in a special division or unit of that name and under the direction of a psychiatrist. Experience has shown that the failure to take such steps often leads to the subordination of legitimate mental health needs and services. This is due to the fact that general

public health professionals and administrators often have little or no background in mental health, through training or experience. Since mental health needs may not be readily apparent to them they tend to assign very low priority to the field.

The Fourth Report (1955) of the WHO Expert Committee on Mental Health advocated establishment of a central authority for mental health in the national health ministries[6]. In their 1960 assessment of accomplishments in mental health work since 1948, Krapf and Moser gave particular importance to the establishment of separate mental health divisions or sections at the national level. (It was the first subject covered in their data.) Among the 34 countries surveyed, information was received on the establishment of mental health divisions in 10 countries[7]. In 7 of the countries, the response was that no such division existed and none was contemplated. Specific countries were not named in the paper for either group .

Our current survey did not gather specific information on the establishment of divisions of mental health, or separate agencies for mental health. The legislation reviewed concerned mainly hospitalization and often the central authority of the health ministry was not mentioned, nor was any division of mental health. In some countries, however, the Visiting Committees or Boards of Control, which were mentioned earlier in our review, have been integrated into Ministries of Health and function as part of those agencies. This was found to be the case in Egypt, Malaysia, and Victoria, Australia. In others, these visiting and inspecting functions, along with handling patient complaints, are legally assigned to the Division of Mental Health (as in Brazil), or to a special Mental Health Council or Board (as in Iran, Lesotho, Peru, Saudi Arabia, and Sudan). Overall supervision of the mental health facilities and services is performed nationally in Poland by the Psychoneurological Institute. In some other countries, standards for the mental hospitals are established by the national health ministry or the national health service, depending upon the extent to which the agency operates the facilities, provides fiscal grants for their operation, or provides health insurance payments or reimbursements for care in the institutions. The more remote from actual operation the Ministry is, the more it is apt to impose standards by administrative regulations.

We suggest that consideration be given to the need to provide effective management policy and quality-control standards for all psychiatric facilities, regardless of whether the institutions are publicly or privately operated.

The Introductory Guidelines produced in 1973 contain a suggested provision on a central administrative body for mental health programmes. (Section 4). The functions listed for the central body begin with organization and coordination of facilities and with securing and training of staff. Budgetting and planning are mentioned next along with the establishment of priorities. Following these, stress is placed upon research, manpower development studies, and consultation. There is no mention of policy development as such, or of setting quality standards by formal regulation. Furthermore, some of the functions which are named, such as training, manpower development, and research, tend to be based effectively in other governmental units such as the universities and medical and scientific research councils, academies, and institutes. These functions are rarely placed in the same unit which has management and regulatory responsibility for mental health or other health services.

There is a great deal of room for legal choices to be made about identification and management of mental health programmes and delegation of authority for decisions in specific clinical cases. Traditions will differ in the various countries. However, it is important that specific consideration be given to these matters in revisions of the law and in regulations. Otherwise, important areas will be left vague and uncertain.

3. Decentralization and Community Services:

In the hospitalization laws surveyed, it was found without exception that the legal authority for admission of patients and, in nearly all situations, the discharge of patients was placed in the administrator or superintendent of the facility. In a few laws, the authority was shared with, or placed in, the patient's attending physician, or "responsible medical officer". This is a clear legal placement of power and authority which cannot, formally at least, be interferred with by the Division of Mental Health or the central Ministry, except by its power to remove the administrator.

Under some of the nineteenth century laws creating the Boards of Control and Visiting Committees with extensive powers, these groups were given power to discharge patients whom they determined to be improperly held. However, this authority was rarely exercised.

It is our impression that the more modern legislation which keeps these admission-discharge powers in the hospital administrators have merely re-stated or followed the practice in the earlier laws dating back to the asylum era when these institutions functioned independently and often were not attached to any central Ministry or other authority. The laws creating Boards of Control and Visitors for each institution did not change this situation. These agencies exercised no regular management authority. Even after the mental institutions were attached to central Ministries the traditional concentration of management authority at the institutional level under the law was continued.

The decentralized system was justified by the great size and unwieldy nature of the mental institutions in many countries, which grew and grew throughout the last century and during most of the current century. These huge facilities were virtually the only sites of mental health care in these countries. The heads of the institutions had well-earned professional prestige, considerably above that of the few central office personnel. If there was no psychiatrist in the central mental health office or division, (which was often the case until recent decades), no significant programme policies or decisions were expected to emunate from anything but the hospitals. The mental health legislation reflected this state of affairs, and it still does in most countries.

Recent changes in the methods of treatment for mental illness, particularly drug therapy, have enabled disturbed patients to be cared for in the community by community-based personnel. At the beginning of this new era, nearly all of the new psychiatric programmes were extensions of the large mental hospitals into the community through out-patient services located on the grounds of the hospitals. Later, clinics were established in the communities at a distance, but still as units under the supervision of the hospital. For this reason, the legal structure was not changed and one could discover no reference to community services in the law. Also, since most of the patients receiving out-patient care were not committed, they were not identified or processed

through legal procedures. This lack of official recognition has had its effects in other aspects of programme review. As late as the end of the 1960s and into the 1970s, the European Office of WHO, for example, was reporting that although the countries of the Region were quite universally collecting statistics on in-patient care, there was no reliable patient-care data for community-based or out-patient services[8]. Another Working Group Report from the European Region, commenting on the same lack of data, called it a "hangover" from the days of custodial care in institutions[9]. Most significantly, it was said in this Report that:

> "The consequences of this dearth of data are considerable. Far from assuming any new responsibilities, the mental health services of most countries are unaware of the extent of their present commitments, and even then data usually relate to in-patients, who represent only a small portion of the total load of a modern community-based mental health service"[10].

Both the law and the mental health programme structures have as yet failed in many countries to recognize or to cope with the new system of delivery of mental health care. It is not an "either-or" choice between the hospitals and community care. Both will continue to be needed. Efforts in a few industial countries to move in revolutionary fashion to community services and to close most of the large hospitals are now being re-examined in the face of unfortunate incidents when numbers of patients were thrust into the communities without adequate services or facilities being available for them. Nevertheless, the shift to community care is very great; the centre of gravity of services is now in the community in many industrialized countries. The developing countries are trying, with some clear successes, to avoid overconcentration on large-hospital programmes as the core of their mental health services.

Nevertheless, the law of most countries of the world, as indicated earlier in our survey, does not reflect the change to community-based mental health care. In the drafting of new mental health legislative codes,

we would expect this change to be considered. It has two different types of concern: (1) impact upon management and planning of mental health services; and (2) impact upon the selection of treatment methods for individual patients. Both of these matters have legal implications.

In regard to the first, there is a need to consider where policy-making authority should rest for programme development and management. In regard to the second, there is need to consider installing legal requirements to place priority upon the least restrictive types of psychiatric care which are community based.

Nations can make a variety of choices concerning these issues. The important thing is that they be considered in a formal manner. Otherwise, the new codes will be continuations of the past concentration on in-patient care, reflecting new concepts of the rights of in-patients, perhaps, but not realizing that the best way to protect all patients is to afford them a variety of treatment methods suitable to their needs and conditions and to plan and coordinate these services effectively on behalf of the patients.

The enactment of specific, formal programmes of community-based services can provide the rallying points and public educational efforts described earlier in this section. Public interest is aroused when the programme is itself based upon identifiable communities of particular size to which the services are especially geared, as under the "sectorization plan" in France and the community mental health "centres programme" in the United States of America. In the latter, the adoption of special legislation for such programmes in the various states inevitably brought with it a very substantial infusion of new funds from the legislatures, often with matching contributions from local governments and voluntary agencies. In the major period of growth of these programmes, from 1956 to 1971, the state budgets grew from $832,131,622 to $3,244,020,184 - an increase of 375%[11]. This growth was significantly beyond inflationary pressures and was reflected in large increases in numbers of patients handled. In California, the nation's largest state, the number of patients in the large public mental hospitals declined somewhat from 1964 to 1971 (59,386 down to 52,981), but the number of patients handled in the community programmes nearly quadrupled in the same period (from 55,431 up to 214,884)[12].

## C. Access to Treatment

### 1. The Principle of Voluntariness:

There is no doubt but that the major trend in mental health care throughout the world is toward voluntary care. This is most evident in community-based programmes, but it is also becoming predominant in in-patient care as well.

Voluntary care can be encouraged by three means: (1) making the mental health services effective and attractive to patients; (2) making methods of admission to voluntary care easily accessible and without economic barriers not applicable to involuntary care; and (3) making involuntary admissions more difficult to obtain, or requiring that they be justified as necessary.

The first named is certainly the most effective of the methods and it has been proved so in country after country. The second is also important, however. In most jurisdictions, the effort has been to make access to psychiatric care as similar as possible to any other type of health care. This is the case for community out-patient care and, in most instances, for in-patient care in the psychiatric wards of general hospitals. For in-patient care in the public mental hospitals, the transition has not been so simple. The primary effort legally to achieve easy access similar to general hospital care has been in the English legislation of 1959 and its "informal admission". As noted earlier, however, the English continued the restriction on the discharge of such patients allowing the hospital to refuse it and to change it to involuntary. Some countries have not included this restriction. In the United States of America, the idea of "informal admission" was first greeted with great favour, but an unrestricted admission procedure has not gained ground in the past 10 years. In 1961, six states had laws requiring immediate release on request of the patient. In 1971, there were only two more states added to this list among the 50 states in the Union. The other states imposed a restriction allowing the hospital to retain the patient and requiring the patient to give from 48 to 72 hours notice of intent to leave. Many of the states, like the 1959 Act of England and Wales, allowed the hospital to change the status of the patient, to involuntary without waiting for a request for discharge from the patient. Because of this situation, voluntary admission in the United States has been branded as "an unacknowledged practice of medical fraud" by the psychiatrist,

Thomas Szasz[13]. The conditional release system has been defended by two other leading authorities in American psychiatry as a "highly desirable alternative to involuntary commitment"[14].

The particular change which was made in the English practice by the 1959 law was to remove the requirement that the patient make a positive request for admission and understand the consequences of the request for care and treatment. These requirements were considered a barrier to easy admission. It might well be said that the English-Welsh law installed a system of "non-protesting" admission which it has described as "informal", but which would be considered involuntary in some legal interpretations[15]. In a new reform proposal in New South Wales, Australia, the recommended change would result in the opposite position to that adopted in England and Wales. The Report suggests that the law be clarified to make it clear that the patient "is <u>in fact</u> a volunteer in the legal sense, capable of comprehending what he is doing and what the incidents of the admission are"[16]. The specific statutory language proposed is as follows:

> Such person "(i) understands the purpose of being admitted for care and treatment as a voluntary patient; and
>
> (ii) understands that upon admission he will not legally be able to leave the admission centre, mental hospital or authorized hospital of his own volition except by written application on notice as provided in this section, and that the superintendent may, if the condition of a voluntary patient so requires cause such action to be taken as may be necessary to have the status of voluntary patient altered to that of temporary patient; and
>
> (iii) has been given written notice of the principal provisions of the Act affecting voluntary patients; and
>
> (iv) is likely to be benefited by his being so admitted for care and treatment as a voluntary patient"[17].

The last of the three methods of encouraging an increase in voluntary admission is more indirect. It would make involuntary admissions more difficult to achieve. Such a system will be discussed later, particularly with regard to requiring the application of "least restrictive methods of treatment". Also, however, the law can impose the requirement that the opportunity be offered to any patient brought to the hospital on an emergency basis, or other involuntary basis, to elect to enter voluntarily. Such a method has been adopted in the new law in Massachusetts, USA. However, this latter provision could be criticized as forcing upon the patient the selection of voluntary status when he or she actually wants no treatment at all, or at least a wider choice including outpatient care. Essentially, this is the dilemma of voluntariness. A very strict interpretation will cut down the use of practically any voluntary method of inpatient care. Searching the motives of patients for seeking any kind of psychiatric treatment can be difficult, and unrewarding, in terms of free and unencumbered choice. Is a man who seeks psychiatric help acting freely if he says his wife has threatened to leave him if he does not go and seek help? Is a patient voluntary if her employer very strongly suggested she go into treatment? Is a patient seeking help voluntarily when he knows he is facing criminal charges for his behaviour? Is the care of a minor voluntary when it is arranged, applied for, and even paid for by his parents?

The 1973 Introductory Guidelines have a provision for non-protesting access to treatment for "some persons, whether enfeebled, aged, demented, mentally infirm or retarded", and it is urged that this method be classified as voluntary, except that some "responsible person" should be consulted "as if he were guardian" particularly concerning continuation of treatment or release of the patient. The implication seems to be that adult psychotic patients would not be included in this group, even though not protesting to their admission. (See the section on voluntary access which requires that the person request treatment and understand the nature of the request.)

## 2. Evaluation of Treatment: Periodic Review:

The theme of accountability has been strongly presented in this report. To provide accountability in clinical care, there must be a system of evaluation of the results achieved by treatment. Where the patients are handled in

short-term care, the problem of evaluating does not come up in a legal sense. The patient is discharged from care as in any other medical situation. Post-audits and patient-record reviews may be done by the programme in order to evaluate their performance, as in other medical systems. For longer-term psychiatric care, however, periodic evaluation takes on a legal character. First, the review itself is established by law or regulation. Second, the evaluation may include determinations of legal issues, such as the competency of the individual, especially if he or she has been under guardianship, or has lost civil rights by the hospitalization, or estimates of the "dangerousness" of the patient if released.

As indicated earlier, the various jurisdictions have taken two approaches in installing periodic reviews. One form requires the hospital to conduct an examination and make a report on patients at periodic intervals in their stay. The more recent statutes require that these evaluations be afforded to voluntary patients as well as involuntary. Such a system is most applicable when the hospitalizations are mainly or predominantly indefinite. The other method, which was found in more countries, attaches periodic review to specific and limited periods of commitment. The renewal of the commitment order is dependent upon the evaluation. After the evaluation, the patient is often given the choice of remaining voluntarily rather than being placed under a renewed commitment order. This latter system is quite effective and in accordance with modern psychiatric practice when the commitment periods are geared to expected psychiatric stays. The institution is, in effect, being required to justify a departure from normal practice or expected therapeutic result. This sytem is quite similar to the "peer review" systems now being developed for all areas of medicine where normal hospital stays and methods and costs of treatment are calculated and where the attending physicians must provide explanation for deviations, or not receive insurance reimbursement for the care.

If the installation of either of the above systems is accompanied by the preparation of individual treatment plans for each patient, then the idea of a "right to treatment" is effectively installed without recourse to more formal identification of this legal doctrine.

3. Involuntary Care:

A discussion of involuntary care must depend on the decisions made and the policies adopted in regard to the matters already raised in this section of the report. A reduction in the use of involuntary admissions seems to be the objective of most countries. The "opening" of the hospitals and the increased use of voluntary care and community care necessarily aids this objective.

The most salutary innovation in the involuntary procedures in these past 20 years would seem to be the greater application of limited-stay provisions requiring the hospitals themselves to seek and to justify extensions of the period. At their longest, two-year renewals for more chronic patients are provided, thus installing a periodic review every two years. The initial hospitalization periods were found to run from 30 to 90 days.

If other jurisdictions are considering this sytem, we suggest that it be installed only after a thorough and comprehensive analysis of average-stay figures for all types of patients, review of manpower demands, examination of community-based alternative plans for treatment, and development of future clinical-care objectives for each type of facility where involuntary patients are to be handled.

4. The Declining Use of the Courts

Our comparative survey of the statutes on involuntary hospitalization indicated that the trend away from prior court review of non-emergency, involuntary commitment continued very strongly during the past 20 years. if the "non-protesting" admissions classified in some countries as voluntary were also included, the trend is even greater.

In those countries still requiring prior court review, neither the referring physicians nor the patients and their families seem to want to go through the courts. Therefore, various avoidance mechanisms have been developed, such as over-utilizing the "emergency" procedures, or observational commitments.

The country country where there seemed to be a renewed interest in court commitments was the United States. Each of the state-level revisions of mental health legislation in the past 5 years or so has added restrictions and increased court surveillance in a hospitalization system which, on the whole, was already the strictest in the world. In perhaps the most conservative move of all, recent court cases have required not only prior court review of all non-emergency commitments, but a finding that the patient is mentally ill beyond a reasonable doubt. It seems that the mental health legislation of the USA has returned full circle to its earlier reliance on criminal-law models for protection against improper commitments.

The salutary effect of the stricter requirements for involuntary hospitalization in the United States and elsewhere should be to accelerate the trend to the use of less restrictive alternatives.

5. Emergency Care Procedures:

The major siutation in which involuntary procedures must continue to be applied, despite efforts to encourage voluntary admissions and restrict regular commitments, is emergencies. Hopefully, many more of the acute cases will be handled in community facilities, both by outpatient treatment and by use of day or night centres. Mental health personnel should be able to work with patients and their families to discourage commitments, emergency or otherwise. Nevertheless, emergencies will arise and the police will need to be able to escort a patient to a facility for evaluation. Otherwise, the police will have no other recourse but to place the person in jail, often under a criminal charge.

The more modern emergency laws allow the hospital, or the examining doctor, to reject admission of patients where the referral is inappropriate. The hospital should also be allowed to suggest other alternative care, or to admit the patient voluntarily. Statutes should also protect the hospital staff members from legal liability for the clinical judgement they exercise not to admit a patient. Otherwise, the hospital will tend to admit all emergency referrals to protect itself from future lawsuits.

Many of the newer revisions of the hospitalization laws have shortened the emergency hospitalization period to 24 or 48 hours. Serious doubts have been expressed about the psychiatric advisability of these statutes. They

have been advocated by civil rights groups as efforts to keep the confinement period down to the barest minimum. Experience has shown, however, that the statutes can have the opposite effect. The reporting time is very often too abbreviated to allow for any new evaluation of the patient, particularly if he was medicated either before or after admission. Also, the patient will still tend to be in the midst of the crisis of admission during 24 hours or so and will not be able to evaluate his own situation and decide on further care, a voluntary admission, etc. The result is that the hospital is most likely to adopt a practice of automatically reporting and asking for a further commitment order on all such patients. If the next renewal period is an extended one, usually 3 to 6 months, or even indefinite, the patient certainly has not gained by this procedure.

We would suggest reconsideration of these very short emergency commitment periods to allow for a new evaluation to be made in the interest of patients. Periods of from 7 to 10 days have been adopted in some countries and seem to serve the purpose quite well.

6. Release and Aftercare Problems:

The legal provisions for release of patients are generally quite straightforward. The hospital authorities are given discretion under most laws to release at any time any patient except those under criminal sentence or specific court order requiring judicial action. Some statutes require report of release to the court, but the court is not required to do anything other than to enter the discharge into the judicial records. Some of the older laws give release powers to Boards of Control and Visiting Committees, and a few to central departments acting in similar capacities. These powers were rarely used and the provisions are disappearing from the statute books. It seems obvious that the clinical decision on discharge should rest with the hospital and the physicians caring for the patients. Leaving powers in the courts to discharge patients independently has caused serious problems, due to the failure of the court to carry out the action by notifying the hospital. Thus, patients have been detained in hospitals under criminal "observation" after the criminal case has been dismissed and the observational order revoked.

Recent efforts in a few countries to reduce substantially the numbers of patients in the large mental hospitals has led to great pressure on attending physicians to discharge patients. Problems occur when there is no place in the community for the patients. The most difficult issues arise when the released patients commit violent acts which result in outcries in the press and other mass media against the improper discharge of "dangerous maniacs" into the community. There is currently something of a "backlash" against the aggressive policies of discharge. It would seem that the greatest need is to develop adequate follow-up and aftercare and residence facilities in the community for patients who could suitably be discharged. Where the "non-dangerousness" of psychopathic patients or mentally disordered offenders must be certified, it would seem advisable to protect the certifying physicians against later lawsuits if the patient does commit acts of violence. The physician should be protected if he used his clinical judgement in good faith under the circumstances at the time of the release and he should be liable only if it is proved he acted recklessly and in disregard of indications (usually from other contrary staff evaluations) that the patient was then imminently dangerous.

## 7. Therapeutic Psychiatric Drugs: Legal Controls:

The development of improved mental health services in the community and the more widespread use of auxiliary personnel from general public health programmes in mental health work depends a great deal on the availability of therapeutic psychiatric drugs and the legal authorization of personnel (after proper training) to prescribe and/or to dispense the drugs on the scene in local clinics. The subject of legal control of therapeutic drugs was not a part of this comparative legal survey. The laws in this field are very complex and are currently undergoing considerable change. We suggest that further study be given to this matter. It is our understanding that work is going on in this field in the Office of Mental Health and that a legal survey will be a part of this effort.

## 8. Mental Health Manpower: Legal Controls:

Closely associated with the above subject is the matter of training and certification of mental health professional personnel and auxiliary manpower. Psychiatrists with full qualifications clearly cannot provide all of the

services needed in mental health programmes. The integration of mental health programmes into general health programmes will demand an expansion of training to a much wider group than the current "psychiatric teams" of highly trained psychiatrists, clinical psychologists, and psychiatric nurses and social workers, all acting the supervision of the psychiatrist. The legal issues in this field are of two kinds: (i) those related to the certification of the personnel to deal with psychiatric patients; and (ii) the legal authorization to prescribe therapeutic psychiatric drugs.

The laws in a number of the countries surveyed grant special certification to psychiatrists. Some also certify clinical psychologists. The laws of all but one of the jurisdictions studied limit hospitalization-certification authority to physicians. The 1972 law in Alberta, Canada provides for such certification by what is called a "therapist" who is specially licensed to do so by a newly created board.[18] The law does not restrict what groups can be licensed, but it is expected that physicians, psychologists, and psychiatrically trained social workers will be included in the licensees. Under the hospitalization law, each involuntary admission (and some discharges) must be certified by two "therapists", on of whom must be a physician. The law does not give any other pwoers to the licensees except these hospitalization and discharge activities. It has been pointed out also that for social workers to make an application for an involuntary application is not new with this law; it has been provided in the Mental Health Act of England and Wales since 1959. However, the Alberta law provides that the "therapist" (which is a term implying treatment capacity) does the clinical examination himself and gives an opinion on the diagnosis of the patient in accordance with the legal requirements for admission under the particular provision in question. This is a considerable extension beyond the English-Welsh practice.

## D. Human Rights in Mental Health

### 1. Forms and Labels: Rights of Various Groups:

In the past is has been considered a sign of progress in the mental health legislation of a country when the terms describing mental disorder were changed in keeping with more modern psychiatric usage. Much attention was given to these changes in the 1955 WHO comparative legal survey. It was, in fact, the first matter covered in the report at that time. It is important to note, however, that changes in the actual definition of the terms were not dealt with. It seemed to be assumed that a change of title meant automatically a change in programme and operation.

A concentration on terminology continued to influence legal reforms in later years, most conspicuously in the British Royal Commission Report published in 1957. A large portion of the early stages of the Report (from page 44 to 65) were taken up with a review of the nomenclature for the various mental conditions. Rather obscure differences in terms received considerable attention in text and footnotes. Yet, the Commission eventually recommended one single term, "mentally disordered", to apply to all types of conditions legally intended to be included under the administration of the Act. We have noted earlier criticism of the decision to place "psychopaths" under the same term and the same system as other mentally ill persons. We have also noted the changes of professional attitude and practice about placing the mentally retarded in the same category with the mentally ill. The 1959 law provided definitions for each of the new sub-categories except one: the broadest term of all, "mental illness", was left undefined.

In legal philosophy, the above matters are called "formalism", or a concentration on form to the exclusion of substance. The dialecticism of formalism is also shown in its opposite - the attention to lack of form. This is also displayed in the 1959 English-Welsh law where the voluntary admission law, with its substantive requirements, was abolished and an "informal" admission procedure was substituted. However, the very important substantive to retain the patient and to change his status to involuntary was retained in a later provision of the law.

Mere changes in terminology and even in definitions, especially when the definitions are quite vague, accomplish very little. If the conditions of the programme do not change, the new terms soon become as stigmatized as the old.

There is a tendency in mental health programmes to feel that all mental health terms carry stigma by their very association with the field. An interesting example is the reform legislation referred to earlier in Alberta, Canada. It was determined to discard any reference to either voluntary or informal admission and to cover only involuntary care. The Director of Mental Health Services for the Province described this move as follows: "The category of "voluntary patient" has been dropeed with the intention of removing an unintentional stigma".[19] The classification of voluntary patient was referred to as "this unfortunate label", but without indication of why the term had become so objectionable. Later it was said that th goal of the bill was to place mental health legislation in its "rightful place within overall health and welfare laws" and to avoid the current "legislative schism" which, it was said, "may be the result of the ongoing stigma attached not only to the mentally ill but also to those professionals who administer to them".[20]

In a discussion of terminology for the mentally retarded, the WHO Expert Committee on Mental Health indicated that there were four methods of classification: (i) legal and administrative; (ii) etiological; (iii) psychological; and (iv) clinico-psychological. The only type of classification criticized was the first which it was said was most likely to lead automatically to a decision as to what action, if any, should be taken.[21]

The Expert Committee at that time cautioned against the temptation to "favour" certain special groups, like the retarded, by the enactment of special laws. It was pointed out that special laws could lead to over-protection and discrimination. Therefore, it was suggested that whatever services and facilities were open to other citizens should be open to the retarded on the same basis. The placement of retarded persons under guardianship, with consequent loss of legal competency, should be avoided where possible.

There has been a great deal of objection to "labelling" individuals as retarded, or delinquent, or genetically predetermined to be more likely to become criminal. These classifications have been attacked as self-fulfilling prophesies which can greatly damage the individual and which are very difficult to remove at a later time. Yet, these objections seems at times to scientists and clinicians to be efforts at avoiding any unpleasant diagnosis or classification, however careful the usage and limited its application.

## 2. Least Restrictive Alternatives:

Comprehensive mental health and retardation programmes have reached the point in many countries such that a policy of "the least restrictive alternative" can be applied to the selection of treatment, rehabilitation and habilitation programmes for individuals. Essentially, the policy requires that the person always be offered first the type of programme which will least restrict the freedom of the individual and least affect his status and privileges in the community to continue to work, move about, and deal with his affairs.

Such a policy can be applied by law, as it has been in some law suits in the United States of America. It can also be placed in mental health legislation in appropriate provisions, as it has in a few jurisdictions. However, merely adding it to the law does not help a great deal; the concept is not self-executing. Professional personnel working with patients and clients will need to be very well trained and their data on community and hospital resources will have to be kept constantly up to date in order to make the policy work. Knowledge of the full range of options available to the individual, as well as a clear picture of what is best for the patient-client under his present condition, is essential. Even when the policy is added by law to the periodic review at the hospital, its application will require that community personnel, especially social workers, participate in the review and suggest available community placements. The administrators of the programmes will need to build in consultation and supervision of referring personnel and an evaluation of their work to be assured that genuine efforts are being made to apply the policy.

3. The Right To Treatment:

Both the legal and the psychiatric literature of recent years have given substantial attention to the idea of a right to treatment. The right has, in fact, been incorporated into a number of international declarations and statements concerning the rights of handicapped persons, the retarded, and the mentally ill. New codes of mental health in many countries can be expected to endorse the right in their provisions.

In a broad sense, the right is applied as a part of the overall obligation of governments to provide for the protection of the health of their peoples. As it is put in the often-quoted Preamble to the Constitution of WHO: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

As most specifically applied in the mental health field, however, the right to treatment means that the patient cannot be confined without being given a course of treatment which is designed to help him to regain his health and his freedom. On this basis, any restriction of the patient is unjustified without treatment, except possibly when the patient would be dangerous to other people if left at large. Even in the latter situation, the strictest application of the concept might require that the individual have committed acts of violence toward others and probably be under criminal placement (in confinement or on probation or other conditional release in order to receive treatment and rehabilitation).

The difficulty with enforcing by law the right to treatment as described above is that, like the previous discussion on alternatives in treatment, it is not self-executing. It requires individual evaluation of the "adequacy" of the treatment and the treatment plan for the particular patient. Also, the logical sanction against non-compliance, as pointed out earlier, is discharge of the patient, a legal "remedy" which has the opposite clinical effect for the patient who wants and needs treatment.

It would seem that the best approach to installing an effective right to treatment is to move toward the overall improvement of both inpatient and outpatient services, in hospital and in the larger community. As

suggested earlier, the periodic review attached to discharge provisions at specific intervals is the most effective means of evaluation and accountability for hospital personnel in charge of clinical management of patients.

4. The Right to Refuse Treatment:

The other side of the coin to the above discussion is the right to refuse treatment. This matter was dealt with earlier, and it was covered in the questionnaire survey, to the extent of its application to the requirement of obtaining patient consent (and that of patient's representatives, parents, and guardians) for certain therapeutic procedures. It is also a part of the concept of voluntariness discussed earlier.

There is some dilemma here for clinical personnel. On the one hand, they favour the handling of all patients as voluntary, similar to other hospital medical patients. On the other hand, they prefer to have their clinical recommendations carried out for the benefit of the patients. Where the patient makes what seems an "unreasonable" objection, or where the patient does not seem to understand his condition and the need for the procedure, the clinician may seek to impose the treatment against the wishes of the patient at that time. If the treatment has beneficial results, the patient and his family usually thank the doctor for taking the action. However, in certain countries, a concern for human rights, combined with public distrust of some procedures, particularly those resulting in permanent change such as psychosurgery, requires a more formalized approach to legal requirements for justifying treatment to which patients do not given their informal consent. When special situations are presented, the permission of legal or other review bodies can be sought. If justification is presented, the action, or some revision of the actions agreed to in the process, may be permitted and the clinical personnel can usually be protected from lawsuits and from ethical criticism.

5. Civil Rights, Mental Illness and the General Law:

As indicated in the survey, the trend of the law in most countries is toward preserving the rights of the mentally ill and mentally retarded, and other categories of disorder, such as alcoholic and drug-dependent persons.

This movement is supported in law and in the legislative halls mainly as a part of the civil rights movement. Under this philosophy, any deprivation of rights must be fully and individually justified. The presumption must always be applied that the individual is legally competent and entitled to the rights and privileges - and obligations - of all other citizens.

In mental health programmes, the concept has practical importance to a greater extent now than in the past because the bulk of the patients handled in the system will be living in the community and functioningin society. It is best for their own welfare and for their success in treatment and rehabilitation-habilitation that they retain their legal competency. This retention applies not only to the more classical areas of civil rights such as voting, but to other competencies and privileges under the general law such as the handling of property, automobile driving licenses, professional and occupational licenses and certifications, marriage, divorce, and child custody. This is not to say that restrictions cannot be placed on mentally disturbed persons, or on persons who have been proved unable to handle some of these matters. It merely means that each restriction must be proved on its merits and limits in scope and time be placed on the restrictions.

Most of these areas are not covered in the mental health codes; they are dealt with in other parts of the law of the various nations. Nevertheless, mental health personnel should take an interest in these matters and should cooperate with patients and with the legal system in preserving patient's rights.

6. The Use of Advocates or Patient's Representatives:

The protection of patients' rights requires more than legal enactment, as has been pointed frequently in this report. One of the newer innovations in this respect is the placement of "advocates" or patient's representatives in mental health programmes to advise patients of their rights and to represent their interests in certain situations. These advocates can be lawyers, but they need not be. Lawyers can join the matter at the necessary state of legal involvement with tribunals and courts, but other types of personnel, such as specially trained social workers, nurses, or community people, can function very effectively in this role.

Special advocacy projects have been adopted in only a few jurisdictions. The first programme, called a mental health information service, was begun in New York State in the mid-1960s. In one part of the state, lawyers were used in the programme; in another part, social workers were employed. In general hospitals in the USA, on the other hand, the "patient representatives" tend mainly to have had a nursing background. In the United Kingdom, as noted earlier, such a programme has been suggested by the National Association for Mental Health which recently opened its first "information and advice centre" for patients at Middlewood Hospital, Sheffield, England.[22] Such an advocacy programme has also been examined by the Health Commission in New South Wales. The Commission proposed specifically that an experimental pilot scheme be developed and evaluated over a 12-month period.[23]

Many nations may not feel it appropriate at the present time to adopt this service. It does require further manpower which may be not be available. Other needs in direct mental health services may take priority. The patient advocates or representatives can function best in fairly comprehensive, complex systems where they can help to develop other options for patients and help them with legal problems and personal complaints which may not be receiving proper attention.

## 7. The Search for Knowledge: Experimental Approaches and the Rights of Subjects:

Treatment methods are far from wholly satisfactory in the mental health field. There is a need to continue to search for new methods of care and treatment. The new methods will have to be tested and evaluated.

The rights of subjects in psychiatric clinical studies need to be protected. The entire subject of the ethical and legal aspects of medical experimentation has received considerable attention in recent years. The most well known set of standards in the field is the Declaration of Helsinki of the World Medical Association, recently amended at the World Medical Assembly in Tokyo in October 1975. in addition to clarifying certain substantive provisions, especially in regard to elements of informed consent, the WMA adopted a requirement that all research proposals be reviewed by an independent ethical panel to assure protection of the rights and welfare of subjects and to assure that the standards of the Declaration were followed.

Serious consideration should be given to these matters in the mental health field. It is an area of health care and practice with very thorny legal and ethical problems of application to mentally ill and mentally retarded patients. How does one obtain the "informed consent" of a mental patient? How does an investigator conduct a research project in the atmosphere of a mental institution with a large population of involuntarily committed patients? These are matters beyond this current study, but they are of great importance for all mental health programmes.

## 8. Violence and Mental Illness: Dangerousness and Involuntary Confinement:

Within communities, even in the most sophisticated of societies with high levels of public education, there is a lingering fear of the mentally ill as dangerous, or potentially dangerous to others. There has been an increase in the incidence of violence in some parts of the world. Mental health personnel are expected to treat the mentally disturbed and at the same time to protect the community against the actions of the mentally ill. At times, this double obligation is difficult to fulfill, especially with the imperfect predictive tools of psychiatry.

The trend of the law in the countries surveyed was seen to be toward the requirement of a finding of potential danger to self or others in order legally to justify involuntary commitment (see Table 10). There was also an effort in some countries to encourage the release of patients who have formerly committed violent acts, but now seem to be significantly improved in their mental health. In order to provide encouragement to personnel to recommend release of such patients, however, immunity statutes have been enacted as protection against later lawsuits. These laws help, of course, but no clinician wants later to find that the patients he or she recommended for release have brutally killed innocent people, or committed other violence, or acted violently against themselves. The press and other media will criticize the action despite the legal immunity. The situation is inherent in mental health treatment; it cannot be avoided without retreat to the days of the remote asylums. No one wants to step back. Yet, the public's fears must be dealt with, just as their support must be sought for positive progress in the treatment of mental illness. More studies of violence and the means of treatment and rehabilitation are needed in all

TABLE 10

EMERGENCY HOSPITALIZATION

| AFRO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| GHANA<br>Old Ordinance, 1888.Sect.18. | Expedient either for the welfare of a person suspected by a medical officer to be a lunatic, or for the public safety. | Certificate of urgency signed by a medical officer. | Not exceeding 14 days. Possible extension to 28 days. | Report of the matter to a Magistrate. | The Matistrate, on receipt of the report can proceed to issue an order of detention following adequate procedure. |
| New Ordinance, 1971. Sect.10. | Expedient either for the welfare of a person suspected by a medical officer to be suffering from mental illness, or for the public safety. | Certificate of urgency signed by a medical officer. | Period not exceeding 14 days. | Information to a Magistrate (if not given, release at expiration of 14 days). | The Magistrate, on information, can proceed, following the adequate procedure, to order temporary or prolonged treatment in hospital. |
| NIGERIA<br>Lunacy Law of 1916.<br>Lagos and Western Nigeria. Section 10. | When a medical officer has cause to suspect that a person is a lunatic and considers it expedient that such person should be placed under observation in an asylum. | Certificate of emergency signed by a medical officer. | Not exceeding 7 days. | | A Magistrate can then issue an order of committal. |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| AFRO: | | | | | |
| SENEGAL<br>Law of 9 July 1975.<br>Art. 6 §2. | In case of extreme agitation or serious depression and when the patient refuses medical treatment. | The parents or people living with the patient or even the police can get hold of him and take him to the closest hospital. | No longer than time necessary for treatment or periodic consultation. | | |
| LESOTHO<br>Mental Health Law of 1963.<br>Sect.12(3)(4). | Urgency, when responsible relative is not available. | Any adult may bring a patient to the District Commissioner. If absent recommendation of a medical practitioner. | 48 hours. | | |
| AMRO: | | | | | |
| BRAZIL<br>Decree No. 24,559 of 3 July 1934.<br>Article 14. | Interest of the patient and public security. | On one medical certificate and a certificate of identity. | | | |
| URUGUAY<br>Law of August 8, 1936.<br>Article 17,20. | Insanity being a dangerous condition for public security or for patient himself. | Admission by superintendent. | One day. | Within 24 hours, the medical superintendent must report the admission to the General Inspector of Psychiatry, accompanied by a medical certificate. | Possible, following adequate procedure. |

| AMRO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| PERU<br><br>Executive Decree of 14 October 1952, Sect. 30. | Emergency or when delay in completing the admission formalities may be prejudicial to the patient or dangerous for those living with him. | Admission by superintendent. | No longer than 10 days. | Within 10 days the necessary formalities have to be complied with. | When necessary formalities have been complied with. |
| USA<br>Indiana<br><br>Indiana Code, Ch.9 §7. Public Law 154 of 1974. | Mentally ill and dangerous and in need of immediate treatment. | Written application by health officer, police officer, or other individual. | 72 hours. | At least one medical certification; report to Court within 72 hour period, Court must act on report within 24 hours. If hearing, must occur within 10 days. | |
| Massachusetts<br><br>Mass. General Laws, Ch.123, §12.<br><br>(contd.) | Likelihood of serious harm. | Application by physician; if not available, by a police officer. The physician shall examine and make necessary determination, unless, because of emergency and refusal of person to submit to examination, physician may make application based on facts known at time. | 10 days. | If application is made by physician who is designated by Department of Mental Health for such purposes, hospital must admit immediately. If not hospital must conduct examination prior to admission, examination by qualified, designated physician. | Person cannot be admitted under this provision unless first given opportunity to apply for voluntary admission. |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| AMRO: | | | | | |
| USA | | | | | |
| Massachusetts (contd.) | Likelihood of serious harm. | -Any person may apply to a district Court for 10 day commitment of a person on same basis. At hearing, Court may order the person apprehended on a warrant and brought to Court; order medical examination. | 10 days. | | |
| CANADA Alberta | None. | | | | |
| British Columbia<br><br>Mental Health Act, 1964, Part III, §27. | Acting in a manner likely to endanger own safety or that of others and apparently suffering from mental disorder. | -Police officer or constable satisfied of grounds on own observation, can take person into custody and take him forthwith to physician for examination. If physician certifies, can be taken to provincial hospital, psychiatric unit, or observational unit. | 72 hours. | | |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| AMRO: | | | | | |
| CANADA<br>British Columbia<br>(contd.) | Where use of regular procedures would involve dangerous delays. | -On application of anyone, a magistrate or justice can order admission. | 72 hours. | | |
| EURO: | | | | | |
| FRANCE<br>Law of 30 June 1838. | Imminent danger. | Based on a medical certificate or public notoriety, order of detention by police officer or mayor. | | Notification to the Prefect within 24 hours. | Following the usual procedure after notification to the Prefect. |
| ROMANIA<br>Decree No.12 of 25 Jan. 1965. Section 27. | Urgent cases. | By Health Authorities on the advice of a psychiatrist. | Provisional detention. | Within 24 hours of admission, the chief public prosecutor shall be informed; within 5 days of admission, communication to public prosecutor of opinion of medical board. | The usual procedure is then followed by the chief public prosecutor. |
| SWITZERLAND<br>Geneva<br>Law of 14 March 1936. Amended in 1959. Art.21(3) & (9). | In case of emergency, when only delay can cause prejudice to the patient or when there is an obvious danger for public security. | By director of Mental Hospital on presentation of a medical certificate. | | The director of Hospital must obtain authorization of the Health Department within 24 hours. | Following the Health Department's authorization. |
| | In case of emergency, obvious danger or neglect. | Authorization by the Health Department on presentation of medical certificate. | | | |

| EURO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| SWITZERLAND<br>Basel<br>Law of 1961, Art. 10. | Urgent, acute cases, immediate danger for the patient and his surroundings. | By hospital superintendent. | 48 hours. | Within 48 hours the legal conditions for hospitalization have to be fulfilled. | When these conditions have been fulfilled. |
| UNITED KINGDOM<br>Mental Health Act of 1959, England and Wales, §§ 29, 135, 136. | Urgent necessity (§ 29). | By any relative, or mental health welfare officer, based upon one medical certificate. | 72 hours. | Within the 72 hours, the patient must be examined by another physician. | If second physician certifies patient, the hospitalization is converted into an observational commitment under §25 for 28 days. |
| | Person who is mentally disordered is being ill-treated, or neglected, or is living alone. (§ 135) | Justice of the Peace can issue a warrant based on information given by mental health welfare officer. | 72 hours. | Same as above. | Same as above. |
| | Appears to be mentally disordered in a public place and in need of immediate care and control, in interest of that person, or for protection of others. | By a police officer, can detain and take to a place of safety, or to mental hospital. | 72 hours. | A place of safety, to be examined by a medical practitioner and to be interviewed by a mental welfare officer, to make proper arrangements also, in hospital, same as above. | Same as above. |

| EURO: | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| DENMARK<br>Law of 1938. | | –Consent of super-intendent.<br>–Order of police and emergency medical certificate. | | Appointment of supervisory guardian. | |
| NORWAY<br>Mental Health Act of 1961. | Emergency. | Communication of medical information together with in-formation on the person who has re-quested hospital-ization to physician in charge of hos-pital by telephone. | | Written information and request for hospitalization must be in the hands of the hospital at the latest when patient is admitted. | |
| EMRO: | | | | | |
| CYPRUS<br>Mental Patients Law of 1931. Section 11. | Necessary for the public safety or the welfare of a person alleged to be of unsound mind. | By medical officer or police officer. | 3 days. | | |
| IRAN<br>Mental Health Act of 31 March 1970. | | On one medical certificate. | 72 hours. | | |

| | Grounds | Application | Period | Other formalities | Change of Status |
|---|---|---|---|---|---|
| EMRO: | | | | | |
| IRAQ<br>Draft Law. | Acute or urgent cases. | Application by physician in charge of treatment or general practitioner with written agreement of patient's family. | 3 days. | | After 3 days the patient becomes a "voluntary" patient unless there is an application to the examining magistrate for an order for non-voluntary treatment. |
| WPRO: | | | | | |
| FIJI<br>Mental Treatment Ordinance of 1940. | Expedient either for the welfare of a person alleged or supposed to be of unsound mind or for public safety. | Urgency order made by a magistrate on application of husband, wife or relative, or police officer. | 7 days. Renewable for another period of 7 days. | Examination within that period by registered medical practitioner. | Following usual procedure. |
| Section 13<br>Section 20 | Emergency. | By superintendent. | 24 hours. | Reported to chairman of board of visitors. | |
| JAPAN<br>Mental Health Law of 1 May 1950. Art.29-2. | Mentally disordered person liable to injure himself or others. | Commitment by Governor of Prefecture. | 48 hours. | Examination by Mental Examiner. | By order of the Governor of Prefecture following usual procedure. |
| MALAYSIA<br>Mental Disorder Ordinance of 1952. Section 45. | Expedient for the welfare of a person alleged to be mentally disordered or for the public safety. | Application by husband, wife, relative or police officer. Urgency order signed by a Magistrate. | 7 days. Renewable for a further 7 days. | Examination by a medical practitioner. | The medical practitioner may issue an order for added 3 months detention. |

societies. Failures in this area can lead to legally imposed restrictions and the use of restraint and involuntary treatment methods which all personnel in the mental health field would not want to see. It is in the interest of the entire field of mental health to deal more effectively with the problems of violence in our communities and to encourage communities and community leaders to cope with the problem with humane and well thought out methods.

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