European Commission - Health & Consumer Protection Directorate-General

Research Project

Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States

Final Report

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Research Project - Grant Agreement No. SI2.254882 (2000CVF3-407)

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1 Introduction

The involuntary placement and involuntary treatment of mentally ill patients are central issues in mental health care. Their massive impact upon the liberty and freedom of the persons concerned have made them a topic of controversial legal and ethical debates for more than 100 years. These debates evolve from the necessity to apply coercive measures in certain circumstances, a fact which singularly distinguishes psychiatry from most other medical disciplines.
Thus, during the 19th and 20th centuries different approaches to regulating the application of coercive measures were developed across Europe and all over the world that depend on a variety of cultural or legal traditions, as well as on different concepts and structures of mental health care delivery.

The application of coercive measures in mental health care has to balance three different and often controversial interests:

- the basic human rights of the persons concerned,
- public safety, and
- the need for adequate treatment of the person concerned.

Since the 1950s and 1960s, far reaching changes in the delivery of mental health care coupled with the achievements of the human rights movement have shifted the public focus upon a basic criterion for providing mental health care from a paternalistic emphasis upon the need to treat patients who are not able to take care of themselves, to the rights of the mentally ill patients. Alongside this development, the legal frameworks for the involuntary placement and treatment of the mentally ill or the commitment laws have been reformed in many European countries. A basic objective of many of these reforms (Curran 1978) had been to reduce the frequency of compulsory admission to mental health care and of compulsory treatment. In sharp contrast to these intentions, increasing rates of compulsory admission have been reported by many European authors as an outcome (Wall et al. 1999, Darsow-Schütte & Müller 2001). Additionally, it was criticised that over-emphasising the human rights of patients would stress autonomy at the expense of treatment, neglecting the need for appropriate care, so that in extreme cases patients might even "die with their rights on" (Treffert 1973).
A reverse tendency is marked by the objective of the commitment laws of many countries to protect society at large or the patients themselves from harm done by the mentally ill. Emphasising the "dangerousness criterion" as a mandatory prerequisite for compulsory admissions might foster a strong

public perception of the mentally ill as being generally uncontrollable or dangerous persons and thus contribute to their stigmatisation (Angermeyer & Matschinger 1995, Phelan & Link 1998).

Nevertheless, strong tendencies for harmonising the concepts and guidelines for mental health care delivery, the legal frameworks for the involuntary placement or treatment of the mentally ill, or the application of coercive measures still differ widely all over the world. Overviews of national approaches are scarce. Moreover, there is a lack of methodologically sound studies. Statistics on compulsory admission from official sources are rarely published internationally (Riecher-Rössler and Rössler 1993). When such comparisons are available, they usually include only selected nations (Laffont & Priest 1992, Legemaate 1995, Forster 1997, Röttgers & Lepping 1999, Van Lysbetten & Igodt 2000). Consequently, the Assembly of the Council of Europe criticised the lack of comparative European studies in the field (Assembly of the Council of Europe 1994).

Against the background of the rapid European integration process, a standardised description or systematic analysis of commitment laws or other legal instruments for regulating involuntary placements across the European Union Member States seems to be overdue.

This study attempts to bridge this gap. For the first time, the legal frameworks and routine procedures of compulsory admission and involuntary treatment in the European Union Member States are described in a comprehensive, systematic and standardised manner. Furthermore, epidemiological data from official national sources are provided, detailing the compulsory admission rates for most of the Member States for the last decade. Thus, this report contributes basic empirical information, which is essential to any discussion of this issue on a European level.

Criteria for compulsory admission

When determining the basic concept of compulsory admission, a basic conflict between a medical model and a civil liberties approach must be resolved. The medical model emphasises the need for treatment as a sufficient prerequisite for the involuntary treatment of a mentally ill patient. While supporters of the medical model might regret the necessity for admitting a person compulsorily, they consider this to be essential and inevitable to securing treatment for a minority of patients whose mental illness interferes with their capacity to accept treatment on a voluntary basis.

A strict human rights approach accepts forced hospital admission only when a mentally ill person threatens to do harm to others or to him-/herself. This is the only criterion ("dangerousness criterion") justifiying or permitting someone to be placed involuntarily (Chodoff 1984).

Criteria for civil commitment have been substantially revised during the last three decades. Beginning in the United States, the process has been paralleled to some extent by similar reforms in Europe

(Appelbaum 1997). Prior to 1969, most legal frameworks stipulated a given need for treatment as a standard criterion for compulsory admission. At that time, California adopted a new standard stipulating that a person had to be dangerous to her-/himself or to others to be considered for involuntary placement. Since then, most states in the U.S. have passed similar acts (Hodge et al. 1989). Many psychiatrists argued, though, that a large number of the mentally ill in need of treatment would not qualify for commitment under these new standards, thus minimising their chance of receiving adequate care and increasing their chances of referral to the criminal justice system (Abramson 1972). Additionally it was criticised that restrictive commitment criteria might further entrench the chaotic living conditions of many chronically mentally ill and contribute to the widespread homelessness among them (Lamb & Mills 1986).
However, some evidence from empirical research refutes in part concerns about giving preference to the dangerousness criterion for compulsory admission. Some studies show that treatment of the seriously disturbed mentally ill who are not able to seek help on their own might be possible even while applying the dangerousness criterion (Hiday 1988).

Experts nevertheless continue to propose and debate numerous additional or other commitment criteria. One of the most-discussed is the so-called "Stone model", which stipulates several conditions for commitment: a) a reliable diagnosis of a severe mental disorder, b) major distress of the patient, c) availability of an effective treatment, d) patient´s incompetence to decide e) reasonableness of applied treatment, which would be accepted by a competent person (Stone 1975, Hoge et al. 1988). These criteria provided the basis for the American Psychiatric Association's (APA) proposed model for civil commitment laws (APA 1983).

The criteria debate includes studies concluding that in routine care the characteristics of compulsorily admitted populations are rather stable, irrespective of the various commitment criteria which might be in effect (Hoge et al. 1989). This suggests that apart from legally defined conditions, decision-makers all over the world might also be relying on rather similar intuitive criteria for involuntary placement even though a narrow reading of the law might have led them elsewhere (Appelbaum 1997).
In addition to their strong influence on routine, the application of legal commitment criteria seems to be influenced by a variety of known and unknown factors that might seriously affect the procedures and the outcome in terms of compulsory admission rates.

Factors influencing procedures

Besides the influence of mechanisms as described above, commitment procedures are considered to be determined foremost by legal regulations and commitment criteria. Thus, many studies confirm correlations between reforms of legal frameworks and changes in commitment rates. Some studies report a strong increase in commitment rates or a changing mix of involuntarily admitted patients when the commitment criteria are broadened (Pierce et al. 1985, Hasebe & McRae 1987, Webster & Kessel 1987) Emphasising the dangerousness criterion seems to correlate to a predominance of younger males among

compulsorily admitted patients, whereas an emphasis upon the priority of the need for treatment criterion might more frequently select older female patients (Segal 1989).

There might be paradox effects of legal reforms which were explicitly initiated to lower compulsory admission rates, however. The adoption of rather restrictive commitment criteria by Belgium and Austria resulted in an unexpected increase in commitment rates during the first years after the new laws had taken effect (Lecompte 1995, Haberfellner and Rittmansberger 1996).
Moreover, large regional differences in the commitment rates of a country might occur even though the same criteria are used, suggesting an influence of regional administrative routines or differing standards of quality of regional mental health care provision (Crefeld 1997). Engberg (1991), as well as Riecher-Rössler and Rössler (1993), observed lower rates of compulsory admission in areas with good standards of mental health care, e.g. areas served by university psychiatric hospitals or psychiatric departments at general hospitals. These findings might be in line with considerable differences in the commitment rates for urban or rural areas (Miller & Fiddleman 1983, Spengler & Böhme 1989).
Other authors report a positive correlation between rates of compulsory admission and the number of psychiatric beds, whereas areas giving priority to comprehensive outpatient care show fewer frequent involuntary placements (Kokken 1993, Malcolm 1989).

This variety of somewhat controversial research findings suggests that a complex set of still poorly understood legal, political, economical, social, medical and multiple other factors seems to interact in the process of involuntary placement (Faulkner et al.1989). Thus, it would be rather short-sighted to trust in simple mechanisms (e.g. simply changing the criteria) in order to change commitment (Roth 1989).

Activities for safeguarding human rights

Since World War II, there have been numerous, and still ongoing, activities to ensure the protection of the human rights and dignity of people suffering from mental disorder, especially of those placed as involuntary patients.
In 1948, the United Nations detailed items which are now generally accepted as Human Rights (United Nations 1948). Only two years later the European “Convention for the Protection of Human Rights and Fundamental Freedom” was signed (Council of Europe 1950). Although basically safeguarding the “right to liberty and security of the person”, this document also defines exceptions for which basic human rights could be suspended. Thus, detention or involuntary placement might be permitted for persons of unsound mind, alcoholics, drug addicts or even vagrants or for preventing contagious diseases, when detention is processed “in accordance with a procedure defined by law”.

On a European level, the Committee of Ministers of the Council of Europe (1983) adopted guidelines for the legal protection of involuntarily placed persons suffering from mental disorder (Recommendation

R/83/2); the Parliamentary Assembly of the Council of Europe (1994) recommended to the Committee of Ministers to adopt the rules laid down in this document (Recommendation R1235)
The Committee of Minister's Working Party on Psychiatry and Human Rights under the authority of the Steering Committee on Bioethics (CDBI-H) presented a "White Paper" (2000) that draws up guidelines for a new legal instrument of the Council of Europe to ensure the protection of the human rights and dignity of involuntarily placed persons with mental disorder.
These efforts benefited from the experience of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), whose activities also addressed the involuntary placement in psychiatric facilities.

In 1991, the United Nations (1991) provided in its "Principles for the Protection of Persons with Mental Illness" detailed guidelines for safeguarding human rights during daily routine or processes and procedures. The World Health Organisation also published ten basic principles for mental health law (WHO 1996).

Psychiatric cases in which violation of the convention has been alleged can be referred to the European Court of Human Rights or to the Committee of Ministers. The number of cases investigated by the Commission is small, however, compared to the total number of involuntarily placed patients. The number of cases heard by the Court is even lower (Harding 1989).

Despite these numerous efforts at and achievements in safeguarding the human rights of compulsorily admitted or treated mentally ill persons, it was criticised as not being enough. Some critics even raised the accusation that these principles or guidelines justify the coercive use of medical power and undermine patients´ rights (Gendreau 1997, Harding 2000, Wachenfeld 1991).
This assertion might be supported by empirical studies showing that only half of all patients admitted voluntarily and a third of those admitted involuntarily were able to correctly state their legal status or whether they had a right to decide on their discharge (Tuohimäki et al. 2001). Other studies revealed that many compulsorily admitted patients are not adequately informed about their rights and are not aware of appeal procedures. As a consequence, very few patients in routine care appeal against a detention order (Bradley 1995).

Socio-demographic and clinical characteristics of compulsorily admitted patients

Most of the scientific evidence available points to significant differences between voluntarily and compulsorily admitted patients, even though results from empirical studies in the field are usually difficult to compare due to lacking representativeness or to other methodological shortcomings. Nevertheless, compulsorily admitted mentally ill patients are more frequently of lower social status, unemployed or less educated. They are more apt to be male than female. (Gove and Fain 1977, Waller 1982, Mahler & Co 1984, Riecher et al. 1991, Riecher-Rössler & Rössler 1992, Sanguineti et al. 1996a, Sanguineti et al.

1996b, Crisanti & Love 2001). Some authors found a predominance of black patients and other ethnic minorities (Dunn und Fahy 1990, Davies et al. 1996, Singh et al. 1998). Only a few researchers did not confirm any influence of socio-demographic factors (Okin 1986, Tremblay et al. 1994). There are contradictory findings as well: Some studies report that the compulsorily admitted mentally ill are older on average (Tomelleri et al. 1977, Szmulker et al. 1981, Nicholson 1988), while others identify compulsorily placed cohorts as younger than those admitted voluntarily (Bruns 1991).
Compulsorily admitted patients suffer mainly from schizophrenia, mania, depression, or other psychotic disorders. Substance abuse, personality disorder and organic psychoses are usually less frequent (Mahler & Co 1984, Spengler 1986, Riecher et al. 1991).

Epidemiological data

There are considerable differences in commitment rates (annual number of compulsory admissions per 100,000 population) and quotas (percentage of all psychiatric admissions) across Europe.
Comparisons of frequencies, rates or quotas across countries must distinguish between artificial and real differences, which might be due to a reduced reliability of data. Data from official sources is often provided by national health reports, health departments or statistical bureaux, and thus is based on differing definitions of or methods used to calculate involuntary placements.
In the case of empirical field studies, representativeness of study populations sometimes might be doubtful. An additional bias might be caused by the inclusion or exclusion of short term detentions (emergency procedures, by recording changes from voluntary to involuntary status during already ongoing inpatient episodes or to differing concepts for including mentally ill offenders, patients under guardianship or mentally ill children or adolescents.

Reported compulsory admission quotas from the early 1990s differed dramatically across Europe from 1% in Spain to up to 93% in Switzerland, whereas compulsory admission rates varied from 24.4 per 100,000 population in Denmark to 248 in Sweden. (Riecher-Rössler & Rössler 1993).
In Germany, where each of the sixteen Federal States has passed its own mental health act, enormous differences were found even within regions, varying from 9.4 per 100,000 population to up to 108.8 per 100,000 population (Spengler & Böhme 1989). In a more recent study, a nationwide median compulsory admission rate of 28.8 per 100,000 population was reported alongside a rate of 10 preliminary or short-term detentions per 100,000 population (Spengler 1994). Representativeness was doubtful, though. A study of the German Federal State of Lower Saxony alone showed a rate increase from 22 to 45 per 100,000 population from 1988 to 1998, whereas the compulsory admission quota remained unchanged (Darsow-Schütte & Müller 2001).

When analysing official national statistics from England, an increase in the compulsory admission quota from 7% to 12% from 1984 to 1995 was found (Wall et al. 1999). Likewise, Italy reports almost increasing rates from 26 per 100,000 population to 49 over ten years (de Girolamo & Cozza 2000).

In Belgium, a paradox increase in compulsory admissions to up to 30% of all inpatient episodes was detected after restrictive compulsory admission criteria had been adopted (Lecompte 1995). Data are based on the records of only one hospital, however. In contrast to the Belgian experience, after the commitment law in Sweden was reformed, compulsory admissions decreased sharply from 116 per 100,000 in 1979 to 19.7 in 1993 (Kjellin 1997).

Denmark is in the favourable position of being able to rely on reliable information from a national psychiatric case register. Twenty-four-point-two compulsory admissions per 100,000 population are reported for the Danish mainland, whereas for Greenland (whose statutes for involuntary placement are different) 43.5 per 100,000 population were calculated (Engberg 1991).

Considering these heterogeneous findings, conclusions from a comprehensive review article published ten years ago (Riecher-Rössler & Rössler 1993) still apply. The authors complained of a serious shortage of internationally comparable data and profound analyses of the problem area. The situation has failed to improve since then and methodologically sound studies are still missing.

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2 Study

Study aims

This study was funded by the Health and Consumer Protection Directorate-General of the European Commission. It aimed at gathering, describing and analysing information on the differences or similarities of legal frameworks for involuntary placement or treatment of mentally ill patients across the European Union Member States.

Involuntary placement or treatment in this context did *not* include the treatment of mentally ill offenders or any other aspect of forensic psychiatry, which was seen as another topic, requiring a different scientific approach.

Study milestones

According to the Grant Agreement (No SI2.254882 (2000CVF3-407), the study lasted from October 1, 2000 to January 1, 2002). Due to the receipt of the contract by the beneficiary on October 27, 2000, actual work on the study started on November 1, 2000.

All work-packages were completed according to the work plan as outlined in the original application. These included

1. To set up a network of experts and collaborators from each Member State.
2. To develop a questionnaire for gathering structured information about the current situation and practice concerning legislation for compulsory admissions and involuntary treatment of mentally ill patients in each Member State.
3. To develop guidelines for national experts for writing a chapter describing specific characteristics of their Member State (e.g., regional differences, historical changes).
4. To conduct an assessment of the situation regarding involuntary treatment of mentally ill patients in each of the EU Member States (by means of the questionnaire).
5. To analyse and compare the results of the assessment and to compile a synopsis of the current situation in the EU.
6. To organise and conduct a meeting for discussing the national contributions and their consequences with at least one expert or collaborator from each Member State.
7. To summarise the discussions and conclusions from the meeting.
8. Report writing.

Network of Experts

During the first study phase at least one expert from each EU Member State was selected and contacted for collaboration. The experts agreed to collaborate as national partners which included filling in the study questionnaire, writing a chapter about the national situation regarding involuntary placement and treatment of

mentally ill and attending an expert-meeting to discuss preliminary results. These tasks were subcontracted out. The experts were also obliged to inform their responsible ministries of their collaboration on this study. All experts returned the signed subcontracts before April 20, 2002. The national experts included

- Austria Prof. Peter König, Rankwiel
- Belgium Dr. Marc de Hert, Bruxelles
- Denmark Prof. Helle Aggernaes, Kopenhagen
- Finland Prof. Riittakerttu Kaltialla-Heino, Tampere
- France Prof. Viviane Kovess, Paris
- Germany Dr. Hans Joachim Salize, Dr. Harald Dreßing, Mannheim
- Greece Prof. George Christodoulou, Prof.V. Alevizos, Dr A.Douzenis, Athens
- Ireland Dr. Dermot Walsh, Dublin
- Italy Prof. Mauro Carta, Cagliari
- Luxembourg Prof. Charles Pull, Dr. J.M. Cloos, Luxembourg
- The Netherlands Prof. Willem Schudel, Rotterdam
- Portugal Prof. Miguel Xavier, Lisbon
- Spain Prof. Francisco Torres Gonzalez, Granada
- Sweden Dr. Karl-Otto Svard, Karlstadt
- United Kingdom Dr. David V. James, London

Assessment tools and methods

Information on the legislation and practice of involuntary placement and treatment in the EU Member States was gathered by means of a detailed questionnaire, which was the major assessment tool used in this study. The items on the questionnaire were based on a thorough review of the research literature as well on the expertise of the project leaders. Finally, the questionnaire increased in volume up to a total of 80 items, which addressed four main areas: legislation, practice, patients' rights and epidemiology. Among the main aspects covered are the criteria for compulsory admission, the procedures of decision-making, the periods of detention, the rules for compulsory treatment or other coercive measures, quality assurance, the complaint procedure, the total number or rates of compulsory admissions in each Member State etc.

In order to ensure the questionnaire's ability to gather valid information, draft versions were discussed with a core group of experts and adapted according to their proposals and comments. This core group included the following experts:

- Prof. Helle Aggernaes, Kopenhagen
- Prof. Riittakerttu Kaltiala-Heino, Tampere
- Prof. Francisco Torres Gonzalez, Granada.

In particular, these experts were asked to comment on the questionnaire's feasibility and comprehensibility.

In addition to the questionnaire, guidelines for the experts on the preparation of the chapter about the national circumstances were established. These chapters (one for each Member State) were supposed to describe and discuss the national situation in more detail, in completion of the information given in the questionnaire. The guidelines propose the same global structure for the chapter as that used in the questionnaire. The experts were also to report on the history of reforms of national mental health legislation, the limitations or weaknesses of current legislation, as well as on the reliability and validity of epidemiological data.

Final versions of the questionnaire and guidelines for chapter-writing were sent to the experts on May 10, 2001. The deadline for the submission of chapters and filled-in questionnaires was July 31, 2001. With some delay in some cases, the study centre received chapters and questionnaires from all experts during summer and autumn 2001.

Informing other organisations in the field

Other important organisations in the field were informed about the study and were asked for comments on the general approach as well as on the draft questionnaires. These included

- WHO-Regional Office for Europe, Copenhagen – Dr. Wolfgang Rutz
- Mental Health Europe, Brussels –Josée van Remoortel, Dr. Aart-Jan Vrijland
- European Network of (ex-)Users and Survivors of Psychiatry, European Desk - Clemens Huitink.

All of them replied and expressed their support of and agreement with the general approach of the study. Additionally, the Working Party on Psychiatry and Human Rights (a subordinate body of the Steering Committee on Bio-ethics of the Council of Europe), was contacted for an exchange of information and discussion. This working party of the Steering Committee on Bio-ethics (CDBI) elaborated a white paper outlining principles and guidelines „to ensure protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients" in preparation of a new legal instrument of the Council of Europe. An exchange of information and experience was considered a valuable contribution to this project. Unfortunately, the responsible press office informed us by note that the list of the members of the working party has to be kept confidential.

Communication with the European Commission

During the study period there was close contact to the Directorate-General Health and Consumer Protection of the European Commission, to ensure a continuous sharing of information.

Before starting the study, a meeting was held on October 26, 2000 in Luxembourg (Participants: Harald Dressing, Horst Kloppenburg, Monika Peitz, Hans Joachim Salize) to discuss the details of the study aims, work packages and administrative issues.

A further meeting took place in Luxembourg on February 12, 2001, attended by Harald Dressing, Horst Kloppenburg, Monika Peitz and Hans Joachim Salize. For further communication, mail or e-mail was used. An interim activity report including an interim financial statement summarising the work done so far was sent to the Health and Consumer Protection Directorate General of the European Commission on June 20, 2001.

Assessment and Analysis

All information gathered by means of the questionnaires and the chapters was compiled into a comprehensive set of tables and figures, which is presented as a central part of this report. Similarities and differences in the current legislation and practice of the European Union Member were analysed.

During this stage, the national experts were contacted frequently to clarify queries or provide more detailed information on statutes or procedures. To provide an overview of the current situation in the Member States, most important characteristics and crucial issues were compiled in a synopsis.

Expert Meeting

Preliminary results were presented and discussed at an expert-meeting held in Mannheim, Germany from November 16-17, 2001. Experts from each Member State were invited, experts from eleven Member States were able to attend:

- Helle Aggernaes, Denmark
- Athanassios Douzenis, Greece
- Harald Dressing, Germany
- Maria Hardoy, Italy
- David James, United Kingdom
- Vivianne Kovess, France
- Monika Peitz, Germany (Study Co-ordinator)
- Hans-Joachim Salize, Germany
- Willem J.Schudel, The Netherlands
- Karl-Otto Svard, Sweden
- Francisco Torres-Gonzalez, Spain
- Dermot Walsh, Ireland
- Miguel Xavier, Portugal

All preliminary results, as presented by the project leaders and the project co-ordinator, were discussed thoroughly by the participants. Certain problems were clarified and additional valuable contributions and comments for the analysis were provided.

Report Writing

Besides all information and data gathered by means of the questionnaires and national chapters, the discussion and comments from the meeting contributed to this final report, which was completed during the last months of the study period and forwarded to the European Commission by May 15, 2002.

3 Results

The tables and chapters below summarise information concerning the legislation of involuntary placement or treatment of mentally ill patients across the European Union, as gathered from the experts from each Member State (see chap.2).
All data and information were taken from either the questionnaires which have been filled in by the experts or from the chapters they have written about their respective country. Besides their own expertise, the experts have used various sources of information, e.g. law books, official statistics or scientific research. In case of queries, data were cross-checked or experts were requested to provide additional information.

Since the main objective of this study referred to mental health legislation, all tables – except when otherwise indicated - describe the basic legal frameworks of the Member States, i.e. if or how acts, statutes or regulations pertaining to certain problems are provided.
When Member States are described as having no acts, statutes or rules regarding specific problems or issues, it does not necessarily mean that these problems are not regulated at all. It means only that the respective problem is not considered by or has not been included in the legal mental health framework.

Moreover, regulating certain problems on a legislative basis usually may serve only as a rough indicator for how or how frequently rules and regulations are applied in actual practice or routine care. More detailed information about the application of legal frameworks in routine care or its outcome should be taken from the national chapters (see chapter 4) or from the tables below describing epidemiological or outcome data (e.g. national compulsory admission rates).

The following tables try to cover the most important or crucial issues in this field. To break down rather complicated procedures or stipulations into two or three simple categories, as it has been attempted in these tables, cannot be done without losing specific information. Additionally, specific terms or concepts might be used differently across the Member States, e.g. as it is the case with the concept of compulsory outpatient treatment, which includes as different modalities as discharge from inpatient treatment "on probation", or short-term interruption of an involuntary placement for various reasons (even for vacation) or a completely independent alternative to involuntary placement in a psychiatric facility. In some cases, such a different understanding of terms or concepts might allow other interpretations or classifications of the Member States than those which have been made here.
Thus, wherever topics seem to be simplified, this has been done in favour of providing a global European overview rather than reflecting each procedural detail of national legal frameworks. In a few cases data was not available, so the information provided in some tables might not be complete.

Abbreviations

Throughout the following tables, abbreviations for the Member States are used:

Aus:	Austria	Bel:	Belgium	Den:	Denmark
Fin:	Finland	Fra:	France	Ger:	Germany
Gree:	Greece	Ire:	Ireland	Ita:	Italy
Lux:	Luxembourg	Neth:	The Netherlands	Port:	Portugal
Spa:	Spain	Swe:	Sweden	UK:	United Kingdom,

When referring to the *United Kingdom*, usually results for England and Wales are indicated. Scotland and Northern Ireland hold separate legal frameworks regarding involuntary placement and treatment of mentally ill patients. More details are outlined in the chapter about the United Kingdom.

There are two different procedures for involuntary placements in *France*. The first, known as "Hospitalisation d'office" (HO), is executed by the police for persons suffering from mental health problems and considered an endangerment to public safety. The second, "Hospitalisation à la demande d'un tiers" (HDT), entitles family members or other close persons to apply to have someone placed involuntarily who might be unable to ask for help or care by him- or herself. Where ever regulations for these procedures differ, the divergence has been indicated in the tables below.

Germany has sixteen Federal States, which independently organise and regulate mental health care. Consequently, each Federal State provides a separate legal framework for regulating involuntary placement or treatment of the mentally ill. Statutes and rules are often similar, but can also differ remarkably with regard to crucial procedures. Whenever possible, this has been detailed in the tables. Where this has not been possible, the least common denominator has been used to describe the situation in Germany (e.g. in the case of short-term or emergency detention, the longest possible time-frame from among those of all Federal States has been included in the respective table).

The Faeroe Islands and Greenland provide separate legal frameworks distinct from that of *Denmark*. The tables usually refer to the situation on the Danish Mainland.

Legislation

1.1 Member States with special mental health acts regulating involuntary placement or involuntary treatment of people with mental disorders

	number	*countries*
special mental health acts	12	Aus, Bel, Den, Fin, Fra, Ger, Ire, Lux, Neth, Port, Swe, UK
no special acts	3	Gree, Ita, Spa

Comment: Most Member States regulate compulsory admissions of mentally ill people by means of special mental health laws. Only Greece, Italy and Spain do not. One of the main reasons for not issuing a separate mental health act in these countries is to avoid stigmatic effects when separating rules and regulations for mentally ill patients from those in effect for general health care. Many psychiatric diseases, however, impair an individual's capacity for reasonable judgement, thus making legal regulations necessary. This special situation puts mental health care in a position distinct from that of other medical disciplines. Clear legal regulations for this special problem which adequately consider the civil rights of the compulsorily admitted patients seem to be a good safeguard for the interests of the persons concerned. Thus, there is no evidence that a not separated mental health law in itself constitutes progress.

1.2 Age of statutes, laws, acts or legal instruments regulating involuntary placement or involuntary treatment of people with mental disorders

	number	*countries*
laws taking effect before 1980	2	Ger*, Ital
laws taking effect between 1980-1989	5	Den*, Ger*, Lux*, Spa*, UK*
laws taking effect in or after 1990	14	Aus, Bel, Den*, Fin, Fra, Ger*, Gree, Ire, Lux*, Neth, Port, Spa*, Swe, UK*

* Denmark, Germany, Luxembourg, Spain, United Kingdom: more than one mental health law or act currently in effect

1.3 Major changes in legislation regarding involuntary placement or treatment planned or in preparation

	number	*countries*
changes planned	5	Fin, Fra, Neth, Swe, UK
no changes planned	10	Aus, Bel, Den, Ger, Gree, Ire, Ital, Lux, Port, Spa

Comment: The overview shows that mental health legislation is an important topic on the nations' legal agenda. Almost all Member States have reformed their legislation within the last decade. This indicates a common awareness across the Member States that mental health legislation is subject to continuous legal adaptation. Ongoing plans or preparations for adapting legislation in a variety of countries pose an opportunity to harmonise legal frameworks across the Member States.

1.4 Scope of laws, acts or legal instruments

	number	*countries*
nationwide	12	Aus, Bel, Fin, Fra, Gree, Ire, Ital*, Lux, Neth, Port, Spa, Swe
regional	3	Den*, Ger*, UK*

* Denmark: Faeroe Islands and Greenland provide different acts
Italy: Some regions have specific regulations regarding the application of nation-wide laws
Germany: Sixteen separate laws according to sixteen Federal States in Germany. Only legislation for guardianship is nation-wide
United Kingdom: England and Wales have a common legislation that differs from that for Scotland and Northern Ireland

Comment: Among those countries with regional laws, the situation in Germany is unique across the European Union. Germany's sixteen federal states are autonomous with regard to health care legislation, which results in remarkably different regulations and procedures regarding involuntary placements or treatments.

1.5 Explicit statutory or described overall aims for involuntary placement or treatment (besides the decrease of the detention criteria)

	number	*countries*
statutory/described aims	8	Den, Fra, Ger, Ire, Lux, Neth, Port, Swe
not statutory/described	7	Aus, Bel, Fin, Gree, Ital, Spa, UK

* aims as defined or referred to in the laws:
Denmark: treatment of the disorder
France: re-integration
Germany: different in each Federal State: treatment, improvement of mental health, to prevent deterioration, re-integration, to improve social abilities

Luxembourg:	re-integration of patient into society, to improve physical health, to increase familial and social contacts
The Netherlands:	protection from harm
Portugal:	to prevent deterioration of person concerned
Sweden:	to restore insight of person concerned

Comment: Only eight Member States define overall aims of involuntary placement that are more detailed. Usually these aims describe the improvement of the mental state of the person concerned. There is little scientific evidence, though, whether compulsory admission alone influences the course of a mental illness.

1.6 Priority of less restrictive alternatives to involuntary placement or treatment

	number	*countries*
priority of less restrictive alternatives included in law	13	Aus, Bel, Den, Fin, Ger, Gree, Ire, Ital, Lux, Neth, Port, Swe, UK
not included	2	Fra, Spa

Comment: Inclusion of the priority of less restrictive alternatives in the laws underlines that coercive measures is an “ultima ratio”. Prerequisite hereto is the availability of facilities offering less restrictive alternatives.

1.7 Laws, acts or legal instruments stipulating adequate aftercare following involuntary placement or treatment

	number	*countries*
aftercare stipulated	6	Bel, Ger*, Lux, Port, Swe, UK
not stipulated	9	Aus, Den*, Fin, Fra, Gree, Ire, Ital, Neth, Spa

* Germany:	in some Federal States
Denmark	stipulated in other acts

Comment: Aftercare following an involuntary treatment episode is dependent upon the consent of the patient, otherwise it too would be a compulsory measure.
If laws do not explicitly recommend or stipulate aftercare, that does not mean that there is no such care available or applied. However, it is surprising that such an important modality is mentioned explicitly in the legislation of only six Member States.

1.8 Involuntary placement or treatment of children and/or adolescents

	number	*countries*
regulated in the same manner as for adults	11	Bel, Den, Fra*, Gree, Ire, Ita, Lux, Neth*, Spa, Swe, UK
regulated separately	4	Aus, Ger, Fin, Port

* France: only for the HO-procedure, not for the HDT-procedure
The Netherlands: different procedures for minors below 12 years of age

Comment: Mental health conditions that require involuntary placement or treatment can differ remarkably in minors. When placing or treating minors involuntarily, educational aspects must be considered. The inclusion of parents into the detainment process might be crucial. Detaining minors can require special staff or special types of facilities, e.g. special homes or licensed schools. Taking these aspects into account, it seems remarkable that only few Member States provide separate regulations for placing children or adolescents involuntarily.

1.9 Special regulations apart from the general laws, acts or legal instruments directing involuntary placement for certain groups of patients

	number	*countries*
for people in guardianship	8	Aus, Den, Ger, Gree, Ire, Lux, Port, Spa
for mentally ill offenders	13	Aus, Bel, Den, Fin, Fra, Ger, Gree, Ital, Lux, Neth, Port, Spa, Swe
for persons with addictive behaviour	4	Aus*, Fin, Fra, Swe
for mentally handicapped persons	2	Den, Fin

* Austria: only for addicted offenders

Comment: According to the special requirements for placing and treating these groups of patients, separate regulations seem necessary. This is especially true for mentally ill offenders. Forensic psychiatry has become a specialised discipline, and is thus in need of a special legal framework. In the case of persons with addictive behaviour, evidence is scarce whether involuntary withdrawals are effective or long-lasting. A guardianship law is especially relevant for gerontopsychiatric or demented patients because requirements of the admission procedures for these patients may not be fully covered by the general compulsory admission laws. The table reveals that six Member States do not provide special legal regulations for this group of patients. Thus, the legal safeguards for basic patient rights for patients with dementia seem to be weak across the European Union.

Criteria and Definitions

1.10 Criteria or conditions of person specified by statutes, laws or acts

criteria	*countries*
Mental disorder + danger	Aus, Bel, Fra*, Ger, Lux, Neth
mental disorder + danger ***or*** **mental disorder + need for treatment**	Den, Fin, Gree, Ire, Port, UK
mental disorder + need for treatment	Ita, Spa, Swe

* France: danger criterion (to the person him-/herself) and need for treatment criteria in the HDT-procedure; threat to others or to public safety in the HO-procedure, need for treatment is not mentioned as a criterion in this case.

Comment: To define the conditions of persons who are going to be involuntarily placed or treated is crucial to preventing abuse. Although all Member States stipulate a given and confirmed mental disorder as a major condition for detaining a person, additional criteria are heterogeneous across the European Union. Danger to oneself or to others is not an essential prerequisite everywhere. It is lacking completely as a criterion in Italy, Spain and Sweden. Among those countries that stipulate the need for treatment as a criterion, Finland, Ireland, Portugal, Spain and Sweden additionally emphasise a given lack of insight by the patient.
The danger criterion is not applied in a similar manner across the Member States. Some countries include only public threats into the definition, while others add possible harm to the patient him- or herself. Thus, suicidal behaviour might fulfil both criteria, as in current mental health care it is agreed that it constitutes a strong indicator for treatment.

1.11 Psychiatric diagnoses for involuntary placements specified by statutes, laws or acts

	number	*countries*
diagnoses specified	4	Den*, Ger*, Ire*, UK*
not specified	11	Aus, Bel, Fin, Fra, Gree, Ital, Lux, Neth, Port, Spa, Swe

* Denmark: "psychosis"
Germany: some Federal States specify "psychosis"
Ireland: "mental illness", "severe dementia", "significant intellectual disability"
United Kingdom: "psychopathic disorder"

Comment: Despite the availability of detailed definitions as specified by international classification systems (e.g. the ICD-10 or DSM-IV), legal frameworks rarely define clear, specific diagnostic criteria. If diagnostic categories are mentioned, very global concepts are used.

1.12 Definition of risk level of danger to the person concerned or to others by statutes, laws or acts

	number	*countries*
risk level specified	10	Aus, Bel, Den, Fin, Fra, Ger, Ire, Neth, Port, Swe
risk level not specified	5	Gree, Ital, Lux, Spa, UK

Comment: Some Member States specify the level of danger required for placing a person involuntarily. Defined thresholds are rather vague, though, requiring that the danger to health or safety of the person concerned or the public be "serious, "immediate", "significant" or "substantial". None of the Member States seems to operationalise "danger" in as much detail as does the law of the United States, which specifies suicidal behaviour, harmful attacks etc., and provides clear time-frames for this behaviour.

1.13 Exclusion of conditions *not* sufficient for an involuntary placement by statutes, laws or acts

	number	*countries*
conditions specified	6	Aus, Ger, Gree, Ire, Swe, UK
not specified	9	Bel, Den, Fin, Fra, Ital, Lux, Neth, Port, Spa

Comment: Conditions which do not suffice for the involuntary placement of a person are defined by only six Member States and are heterogeneous as well (e.g. oligophrenia without psychotic symptoms, non-compliance, substance misuse, personal neglect, promiscuity, sexual deviance).

Assessment and Decision Procedures

1.14 Essential expertise for assessing the medical (psychiatric) criteria for involuntary placement

	number	*countries*
trained psychiatrist	7	Aus, Gree, Ire, Neth*, Port, Spa, UK*
any physician	8	Bel, Den, Fin*, Fra*, Ger*, Ita, Lux, Swe

* Finland: preliminary assessment: any physician; hospital assessment: psychiatrist
France: HO-procedure: any physician
Germany: "physician" in some Federal States, "psychiatrist" or "physician experienced in psychiatry" in others
The Netherlands: psychiatrist, any physician only in case of an emergency
United Kingdom: two physicians are required, one must be a psychiatrist

Comment: Seven Member States require that initial psychiatric assessments be made by a psychiatrist. In the remaining eight Members States, however, potentially far-reaching decisions like detaining someone preliminary might be based upon the certificate of physicians not trained in mental health care. However, in all Member States, thorough assessments are performed by psychiatrists as soon as a patient is admitted to a psychiatric facility. This table refers to the initial medical certificate *during the routine procedure*, which may apply for a compulsory admission. Regulations for *emergency procedures* usually differ and might be less strict as to the expertise of initially assessing physicians in most Member States.

1.15 Number of experts involved in the assessment of psychiatric condition

	number	*countries*
one expert	4	Bel, Den, Ger, Neth
two experts	10	Aus, Fra, Gree, Ire, Ital, Lux, Port, Spa, Swe, UK
more than two experts	1	Fin

Comment: Most Member States require the opinion or certificate of more than one expert, which can be seen as a measure of quality assurance.

1.16 Authorities or persons authorised to decide on an involuntary placement

	number	*countries*
medical (psychiatric)	5	Den, Fin, Ire, Lux, Swe
non-medical (judge, prosecutor, mayor)	10	Aus, Bel, Fra, Ger, Gree, Ital, Neth, Port, Spa, UK

Comment: In ten Member States, the decision is made either by a representative of the legal system (judge, prosecutor, mayor), or by other agencies independent from the medical system (e.g. social workers in the UK). In the remaining Member States the decision is left to psychiatrists or other health care professionals.

1.17 Mandatory hearing of persons concerned during the decision process

	number	*countries*
mandatory hearing	12	Aus, Bel, Den, Ger, Ire, Ital, Lux, Neth, Port, Spa, Swe, UK
not mandatory	3	Fin*, Fra, Gree

* Finland The statement of persons concerned must be considered, but can be taken from patient files.

1.18 Change from voluntary to involuntary status

	number	*countries*
same procedure as for initial placement	11	Aus, Bel, Fra, Ger, Gree, Ire, Ital, Lux, Neth, Port, UK
different procedure	2	Fin*, Swe*

* Finland: second expert left out of assessment
Sweden: danger criterion included, judge involved earlier

Comment: The status of an inpatient episode can change from voluntary to involuntary in all Member States, when necessary. This usually requires assessment or decision procedures similar to those described above. Only in Sweden and Finland does this procedure differ.

1.19 Maximum period of time between psychiatric assessment and compulsory admission (begin of placement) – regular procedure

country	*period*
Austria	4 days
Belgium	15 days
Denmark	for danger criterion: 24 hours; for treatment-criteria: 7 days
Finland	3 days
France	HDT-procedure: 15 days; HO-procedure: 24 hours
Germany	different for each Federal State: ranging from 24 hours to 14 days
Greece	10 days
Ireland	24 hours
Italy	2 days
Luxembourg	3 days
The Netherlands	5 days
Portugal	12 days
Sweden	4 days
Spain	not defined
United Kingdom	14 days

Comment: Across the Member States the legally stipulated period of time that may elapse between the psychiatric assessment and the actual start of detention is heterogeneous. No common patterns can be identified, suggesting that the defined periods depend very much on the organisational requirements of the respective co-operation between the assessment-making and the decision-making authorities. In Denmark and France, periods vary in each case according to the admission criteria applied (threatening harm or need for treatment).

1.20 Short-term detention (emergency cases)

	max. duration of short-term detention	*decision-making authorities for short-term detention*
Austria	48 hours	psychiatrist
Belgium	10 days	prosecutor
Denmark	Regular procedure applies to emergency cases also	psychiatrist
Finland	Regular procedure applies to emergency cases also	psychiatrist
France	48 hours	mayor (Paris: police)
Germany	24 hours (15 Federal States) 3 days (1 Federal State)	Municipal public affairs office or psychiatrist
Greece	48 hours	prosecutor
Ireland	Regular procedure applies to emergency cases also	psychiatrist
Italy	48 hours	public health department
Luxembourg	24 hours	police or physician or psychiatrist or guardian or social worker
The Netherlands	24 hours	mayor
Portugal	48 hours	psychiatrist
Spain	24 hours	psychiatrist
Sweden	24 hours	psychiatrist
United Kingdom	72 hours	police or physician plus social worker

Comment: Emergency procedures for short-term placement are usually applied at night, at week-ends or whenever immediate action is deemed necessary. Short-term detention is permitted from 24 up to 72 hours (except in Belgium, where it can take 10 days). In some Member States, the decision-making authorities for short-tem placements differ from those deciding upon the regular detention procedures.

1.21 Statutory maximum duration of involuntary placement / statutory re-approval of decision

	maximum length of initial placement	*re-approval by*
Austria	3 months	3 months
Belgium	40 days for observation, 2 years for regular placement	after 25 days of initial observation, 15 days before end of individually ordered length
Denmark	not defined	3, 10, 20, 30 days, then monthly
Finland	9 months	3 months
France	not defined	HDT-procedure: 15 days, then monthly HO-procedure: 1 month, 3 month, 6 month
Germany	preliminary detention: 6 weeks regular placement 1 year, in obvious cases 2 years	preliminary detention: 6 weeks regular placement: 6 months (defined by Federal State of Saarland only)
Greece	6 months	3 months
Ireland	21 days	21 days, 3 months, 6 months, 12 months
Italy	7 days	7 days
Luxembourg	preliminary detention: 14 days	14 days
The Netherlands	preliminary detention: 3 weeks regular placement: 6 or 12 months	preliminary detention: 3 weeks regular placement: 6 or 12 months
Portugal	not defined	2 months
Spain	not defined	6 months
Sweden	4 weeks	4 weeks, 4 months, 6 months
United Kingdom	assessment order: 28 days treatment order: 6 months	28 days 6 months

Comment: Only Denmark, France, Portugal and Spain do not define a maximum duration of initial involuntary placements. In the remaining Member States, the maximum length of initial placements can vary from seven days to two years, depending mostly on regulations regarding re-approval or re-assessment procedures, which are established in all Member States. Those countries defining a maximum length of initial placements also allow premature termination of placements under certain conditions. For treatment and rehabilitation purposes, some Member States (Bel, Den, Fin, Fra, Ger, Ire, Neth, Spa), allow the interruption of involuntary placements for short periods (from several days up to several weeks).

1.22 Legislative distinction between involuntary placement and involuntary treatment

	number	*countries*
distinct modalities	7	Aus, Den, Ger, Lux, Neth, Swe, UK
modalities not distinct	8	Bel, Fin, Fra, Gree, Ire, Ita, Port, Spa

Comment: Seven Member states define involuntary placement and involuntary treatment as distinct modalities in their legal frameworks, thus acknowledging that admitting a person compulsorily may not necessarily include compulsory treatmtent. This distinction is partly due to achievements of the civil rights movement or to principles of the EU Court of Civil Rights or to UN Declarations emphasising that patients' competence to decide on treatment prevails even though they have been admitted involuntarily. A legal distinction of involuntary placement from involuntary treatment might increase awareness for safeguarding patients' rights when applying coercive interventions. However, regardless of distinguishing these modalities on a legal level, there are Member States where patients must accept treatment whenever being placed involuntarily, as it is the case in Sweden, Denmark or Luxemourg (see table below). When the application of involuntary or coercive treatment measures is not explicitly defined in the laws of the Member States, the civil rights of involuntarily admitted persons are usually safeguarded by other means or procedures (see tables below).

1.23 Involuntary placement without treatment

	number	*countries*
placement without treatment possible	6	Aus, Bel, Ger, Gree, Neth, UK
not possible	9	Den, Fin, Fra, Ire, Ita, Lux, Port, Spa, Swe

Comment: Even if no distinction is made between involuntary placement or treatment as separate modalities, in six Member States involuntary placement is generally possible without involuntary treatment.

1.24 Informed consent for involuntary treatment

	number	*countries*
informed consent required	5	Aus, Ger, Ire, Neth, Swe
not required	10	Bel, Den, Fin, Fra, Gree, Ita, Lux, Port, Spa, UK

Comment: In Member States which do not require informed consent, involuntarily placed patients might be treated without consent in cases of emergency or should they lack the mental capacity to consent.

1.25 Special mental health care interventions

	number	*countries*
application regulated	7	Aus, Den, Ger, Ire, Neth, Port, UK
not regulated in law	8	Bel, Fin, Fra, Gree, Ita, Lux, Spa, Swe

interventions	**explicitly permitted**	**Permitted on defined conditions**	**explicitly prohibited**
pharmaceutical intervention	Den, Ire, Neth		Aus *
Electro-convulsive therapy (ECT)	Den	Ire, Port, UK	Aus
Psychotherapy	Ire	Ger	
Psychosurgery		Den, Ire, Port, UK	Den, Ger
Treatment of somatic comorbidity	Den	Ger	
Forced feeding	Den, Ger, Neth		

* Austria: depot neuroleptics

Comment: Numerous psychiatric treatments or interventions can potentially be applied compulsorily. Across the Member States, coercive application of interventions is regulated by a wide variety of stipulations or statutes. Common patterns could not be identified. If not regulated on a legal level, the application procedures and rules might be directed by codes of practice or court decisions etc. Please note: list of interventions might be incomplete for some Member States.

1.26 Application of other coercive measures

	number	*countries*
other coercive measures regulated by law	5	Aus, Den, Ger, Neth, Swe
not regulated by law	10	Bel, Fin, Fra, Gree, Ire, Ita, Lux, Port, Spa, UK*

* UK: no statutory regulation, but a detailed code of practice

coercive measures	*number*	*countries*
physical restraint	6	Aus, Den, Ger, Neth, Swe, UK
seclusion	5	Aus, Ger, Neth, Swe, UK
pharmaceutical restraint	2	Den, Ger

Comment: During involuntary placement, a variety of coercive measures that are not primarily psychiatric treatments might be used to keep the patient from doing harm to himself or others,. These interventions should be the last resort. From a human rights point of view, adequate regulation of their application is a major concern. Again, on a legal level there is no common approach across the Member States. The lack of statutory regulations in various countries does not mean that coercive measures in their routine care are exempted. Detailed regulations might be substituted by more global guidelines.
Please note: list of measures might be incomplete for some Member States.

1.27 Compulsory outpatient treatment

	number	*countries*
mentioned as an option	4	Bel, Lux, Port, Swe
not considered by law	11	Aus, Den, Fin, Fra, Ger, Gree, Ire, Ita, Neth, Spa, UK

Comments: Involuntary outpatient treatment as a follow-up to an involuntary inpatient episode is considered to enhance the continuity of treatment as well as public safety. Additionally, it is discussed as an alternative to involuntary inpatient treatment. However, the efficacy of coercive outpatient treatment has not yet been confirmed by research, which might contribute to the fact that only four Member States mention the option of this modality in their laws.

Practice

2.1 Major court decisions specifying or modifying legislation

	number	*Countries*
major court decisions	7	Aus, Den, Ger, Ire, Ital, Neth, UK
no court decisions	8	Bel, Fin, Fra, Gree, Lux, Port, Spa, Swe

Comment: Many specific terms or concepts used in the legal frameworks are not defined and are subject to clarification or interpretation. Some Member States have done this by means of court decisions, while others (e.g., the United Kingdom) have incorporated these decisions into a comprehensive code of practice that serves as a guideline for daily routine.

2.2 Inclusion of standardised risk assessment into medical examination

	number	*countries*
Standardised risk assessment included	0	None
not included	15	Aus, Bel, Den, Fin, Fra, Ger, Gree, Ire, Ita, Lux, Neth, Port, Spa, Swe, UK

Comment: No Member State currently stipulates the application of standardised risk assessment procedures as a mandatory part of the psychiatric examination. According to the general trend towards evidence-based or guideline-supported procedures in mental health care, the inclusion of standardised risk assessments could improve the quality of confirming the danger criterion. In forensic psychiatry standardised risk assessments are more common and have been proved feasible in supporting the procedures of decision-making.

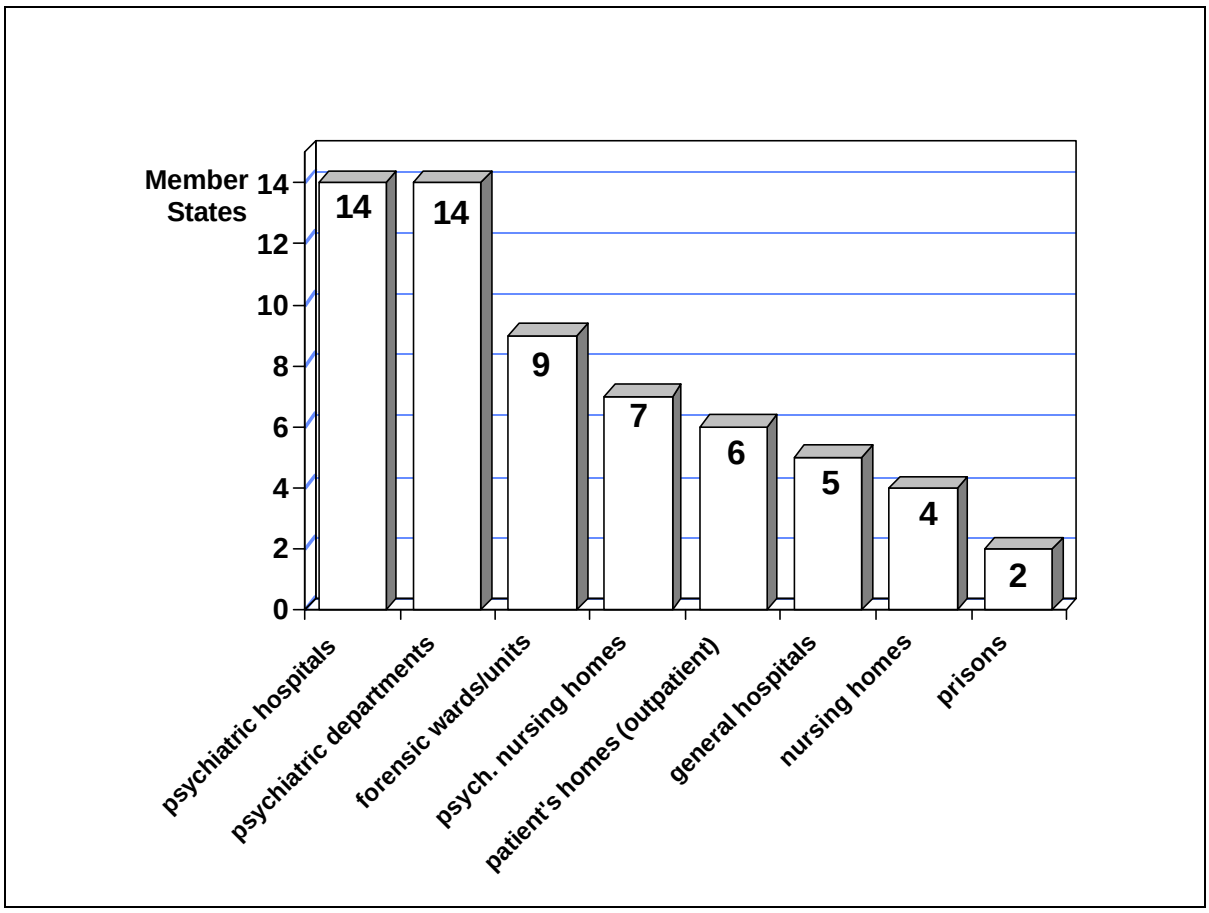
2.3 Separation of involuntary placed and/or treated patients

	number	*Countries*
Always in locked wards	1	Fin
always apart from voluntary admissions	0	None

Comment: Finland is the only Member State to keep involuntarily placed or treated patients always in locked wards. According to the routine in the remaining Member States, safeguarding of involuntarily

admitted patients seem to be possible in open wards as well. No Member States separates involuntarily admitted patients from those who are being treated voluntarily, thus minimizing any additional stigma for involuntarily placed patients.

2.4 Facilities for involuntary placement and/or treatment



* psychiatric hospitals:	all Member States except Italy
psychiatric departments at general hospitals:	all Member States except Luxembourg
forensic wards/units:	Austria, Belgium, Denmark, Finland, France, Germany, The Netherlands, Sweden, United Kingdom
psychiatric nursing homes:	Belgium (only for aftercare), Germany, The Netherlands, Portugal, Spain, Sweden, United Kingdom
person's home (involuntary outpatient treatment):	Belgium (only for aftercare), Germany (civil commitment), The Netherlands (only after initial inpatient episode), Portugal, Sweden
general hospitals:	Belgium, Denmark (for treating somatic co-morbidity), Italy, Spain, Sweden (for treating somatic co-morbidity)
non-psychiatric nursing homes:	Belgium, Germany (civil commitment), Spain, Sweden
prisons:	Belgium, Greece

Comment: According to the national experts involved in this study, these are the facilities to which mentally ill patients in principle are compulsorily admitted. There is no information about preferences for certain types of services or frequencies of admissions. In general, this might depend upon the availability of beds or on other administrative requirements. Likewise, it is not known whether or not Member States not indicated here generally prohibit involuntary placement, or whether these data reflect only current practice in the Member States.
Nine Member States (Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Luxembourg, The Netherlands) require special accreditation for facilities, when treating involuntarily.

2.5 Separate placement of mentally ill offenders

	number	*countries*
always separate	1	Port
in most/some cases	14	Aus, Bel, Den, Fin, Fra, Ger, Gree, Ire, Ita, Neth, Spa, Swe, Lux, UK

Comment: Since the treatment of mentally ill offenders requires special interventions, therapeutic approaches, or programs, along with distinctive security measures, placement separate from compulsory admitted non-offenders is a common standard across the Member States.

2.6 Financing involuntary placements and/or treatments

	number	*countries*
state, government	9	Den, Fin, Gree, Ire, Ita, Port, Spa, Swe, UK
health insurance, patient	6	Aus, Bel, Fra, Ger, Lux, Neth

Comment: Although it is an issue of increased public security and concern, and public responsibility for financing detainment thus seems to be at least debatable, in at least six Member States involuntary placements or treatments are paid for partly or fully by health insurance or the patient himself. Joint payment seems to be a frequent option, however. No Member State seems to apportion cost responsibilities according to the original cause for placement or treatment (whether posing a public threat or merely a threat to oneself).

Patients' rights

3.1 Information or notification of others in the event of compulsory admission

	number	*countries*
notification stipulated	12	Aus, Bel, Den, Fra, Ger, Ire, Lux, Neth, Port, Spa, Swe, UK
not considered	3	Fin, Gree, Ita

3.2 Persons/authorities to be informed

	number	*countries*
legal representative	6	Aus, Bel, Den, Ire, Neth, Port
family members/relatives	9	Fra, Ger, Ire, Lux, Neth, Port, Spa, Swe, UK
guardian	7	Aus, Ger, Lux, Neth, Port, Spa, Swe

Comment: The mandatory notification of relatives or other persons in case of a compulsory admission is a basic civil right, which is regulated by the laws of twelve Member States. In six Member States, the notification, or inclusion of a legal representative of the patient (e.g. advocate counselor, social worker) in the procedure is mandatory, whereas in other Member States acts only stipulate that family members or guardians have to be informed immediately.

3.3 Free legal support for the person concerned

	number	*countries*
free legal support	8	Aus, Bel, Den, Ire, Port, Spa, Swe, UK
no free support	7	Fin, Fra, Ger, Gree, Ita, Lux, Neth

Comment: Including a legal representative of the patient in the procedure is free of cost in eight Member States, regardless of whether or not this inclusion is mandatory.

3.4 Advanced directive / predefined psychiatric will

	number	*countries*
advanced directive possible	3	Aus, Ger, Neth
not considered	12	Bel, Den, Fin, Fra, Gree, Ire, Ita, Lux, Port, Spa, Swe, UK

Comment: Advanced directives are the predefined instructions of a patient about the preference or refusal of certain treatments or interventions in the event of any later incapacity to decide due to their mental state. Advanced directives care is an increasingly frequent topic in mental health care and is increasingly demanded by user organisations. Currently only three Member States discuss the option of advanced directives in their mental health legislation.

3.5 Independent review of the commitment process

	number	*countries*
yes	12	Aus, Den, Fin, Fra, Ger, Ire, Ita, Lux, Neth, Port, Swe, UK
no	3	Bel, Gree, Spa

Comment: Independent reviews of compulsory admission procedures are possible in twelve Member States as an additional measure of quality assurance.

3.6 Right-to-complaint procedure

	number	*countries*
complaint procedure	15	Aus, Bel, Den, Fin, Fra, Ger, Gree, Ire, Ita, Lux, Neth, Port, Spa, Swe, UK

Comment: The right of persons concerned to complain about an involuntary placement or about certain details of the procedure is one of the most basic human rights. All Member States safeguard this in their legislation. Authorities with whom an appeal can be lodged differ across the Member States. They include courts (all Member States), local boards (Denmark, the Netherlands, France, Luxembourg) or mental health tribunals (Ireland, the United Kingdom). Consequences that might result from such appeals are serious. Decisions can lead to discharges, discharges on parole, changes or termination of treatments, interventions or coercive measures etc.

3.7 Restriction of basic human rights during involuntary placement

	number	*countries*
restrictions regulated by law	8	Aus, Bel, Fra, Ger, Gree, Lux, Neth, Swe
restrictions not regulated by law	7	Den, Fin, Ire, Ital, Port, Swe, UK

Comment: Involuntary placements do not necessarily include the restriction of basic human rights. Consequently, none of the Member States permits a permanent restraint of legal capacity or the right to vote as an automatic consequence of an involuntary placement. However, temporary restriction of free communication or the right to receive visits can be inevitable. Some Member States include these regulations in their mental health laws (see table). Others use special codes of practice or other means. Free communication is explicitly regulated on a legal level in Austria, France, Germany, Luxembourg and the Netherlands. Criteria for restricting the right to receive visits are defined in the laws of Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Sweden. Patient searches are explicitly regulated in Austria, Germany, the Netherlands and Sweden. No Member State restrain religious beliefs or practice.
Most regulations safeguard the human rights of patients by emphasising the principle prohibition of restraints and by defining clear criteria and setting clear time limits for their application.

Epidemiology

4.1 Number of psychiatric beds per 1,000 population, mean length of stay of all psychiatric inpatient admissions (voluntary *and* involuntary)

	year	*beds per 1,000 population*	*mean length of stay*
Austria	1999	0.51	17.6 days
Belgium	1999	1.2*	not available
Denmark	2000	0.77*	36 days *
Finland	1999	1.0*	46 days
France	1998	1.14	35.7 days*
Germany	1997	0.70	26.9 days*
Greece		not available	not available
Ireland	1999	1.91	130 days
Italy	1998	0.1	13.4 days*
Luxembourg	2000	1.0	not available
The Netherlands	2000	1.7	not available
Portugal	2000	0.3	not available
Spain	1999	0.43	18 days
Sweden	1998	0.67	28 days
United Kingdom	1999	0.69*	52 days*

* Belgium: rate includes day care and psychogeriatric care
Denmark: rate includes child and adolescent psychiatry
standard deviation of mean length of stay: 97 days
Germany: mean length of stay refers to 1999
Italy mean length of stay refers to region of Sardinia only
Finland: calculation of no. of beds: total inpatient days by 365 days
France: mean length of stay refers to 1997
United Kingdom: figures are for England only

Comment: The number of psychiatric beds per 1,000 population and the mean length of stay for all inpatient admissions to psychiatric facilities in the Member States is background information essential for discussing frequency, rate or mean length of stay for involuntary placements of mentally ill patients. As the table shows, there is enormous variation across the European Union, indicating different principles, structures and standards of mental health care as well as its inclusion in general health care in the various Member States.

4.2 Frequency of involuntary placements / percentage of involuntary placements of all inpatient episodes / involuntary placements per 100,000 population

	year	*number*	*percentage (of all inpatient episodes)*	*involuntary placements per 100,000 population*
Austria	1999	14,122	18	175
Belgium	1998	4,799*	5.8*	47
Denmark	2000	1,792	4.6	34
Finland	2000	11,270	21.6	218
France	1999	61,063	12.5	11
Germany	2000	163,551*	17.7*	175*
Greece		not available	not available	not available
Ireland	1999	2,729	10.9	74
Italy		not available	12.1*	not available
Luxembourg	2000	396	not available	93
The Netherlands	1999	7,000	13.2	44
Portugal	2000	618	3.2	6
Spain		not available	not available	not available
Sweden	1998	10 104	30*	114
United Kingdom	1998 1999	46,300* 23,822*	13.5	93* 48*

* Belgium: only status at admission, number of changes from voluntary to involuntary during the same inpatient episode not considered
Denmark: see Belgium
Germany: legal applications per year (of which approx. 90% result in actual involuntary placements), placements per 100,000 pop. refers to 1998, percentage of all inpatient episodes to 1999
Italy: percentage for region of Lombardy only, year is unknown
Sweden: percentage refers to 1997
The Netherlands: number of court decisions on compulsory admissions
United Kingdom: figures for England only, 1998 includes compulsory admissions as well as patients detained involuntarily after being admitted voluntarily. 1999: compulsory admissions only.

Comment: When discussing compulsory admissions on a national basis, the number of involuntary placements or treatments per year should be compared to the total number of inpatient admissions or episodes in mental health care (voluntary or involuntary). Even then, compulsory admissions per 100,000 population or percentages of all inpatient episodes might be confounded by methods or concepts used to calculate figures (e.g. whether or not emergency cases or changes from voluntary to involuntary status during the same inpatient episode are included).

Because of lacking information about the underlying concepts or methods in some cases, the reliability of the data provided in this table might be reduced. Nevertheless, results indicate a wide range of frequency of annual involuntary placements across the Member States, suggesting that comparisons of and conclusions about mental health policies must be taken very carefully (see fig. 4.2a and fig. 4.2b, please note: different scales are used in tables 4.2a and 4.2b to indicate less or more populous Member States). Time series for rates of involuntary placements are indicated below (fig. 4.3).

Fig. 4.2a Total number of compulsorily admitted patients per year and Member State

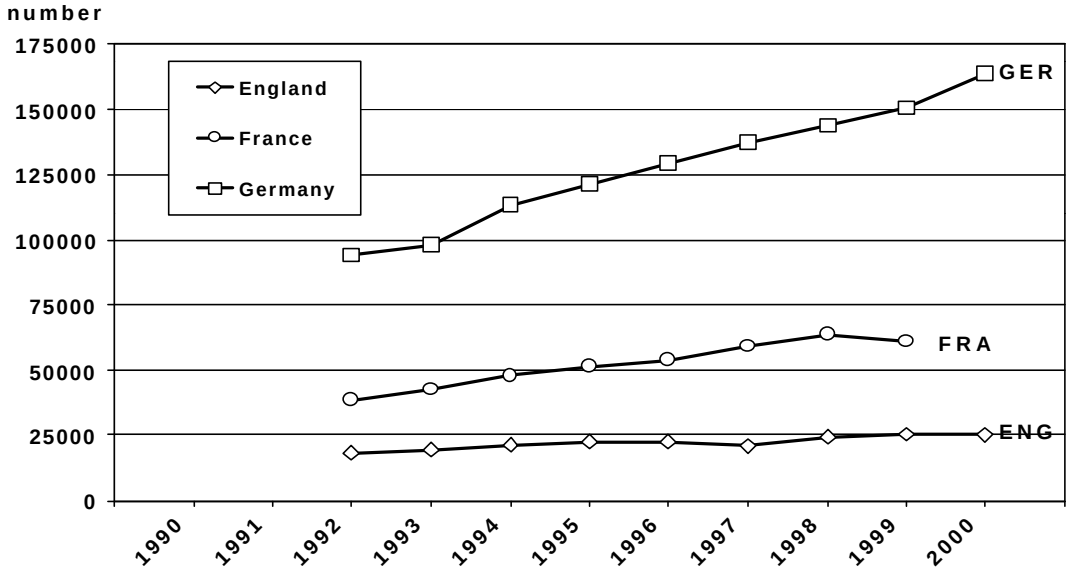
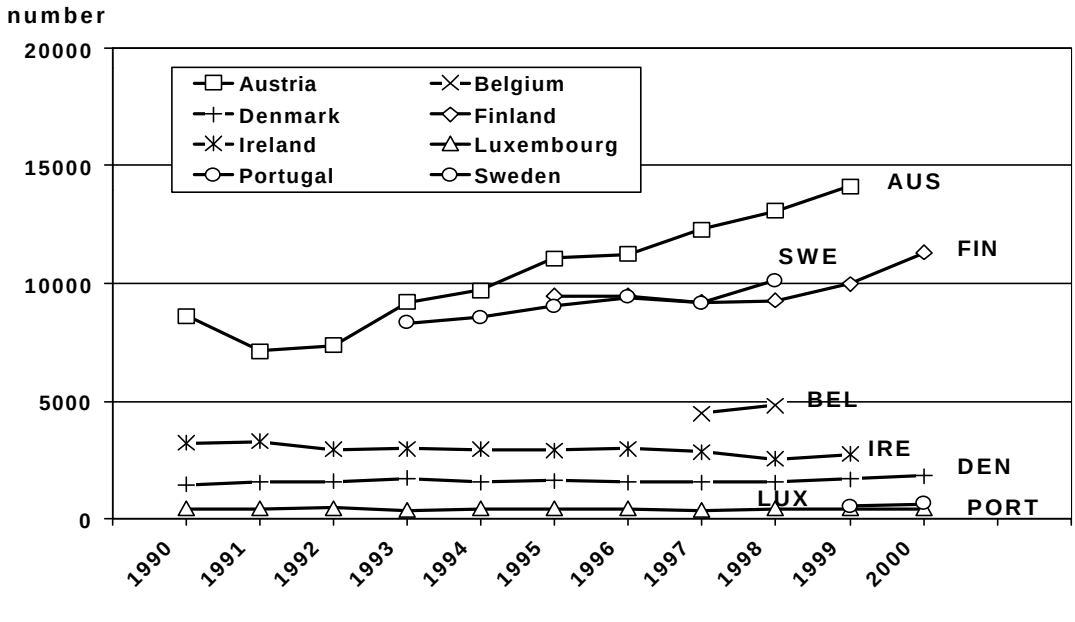


Fig. 4.2b Total number of compulsorily admitted patients per year and Member State



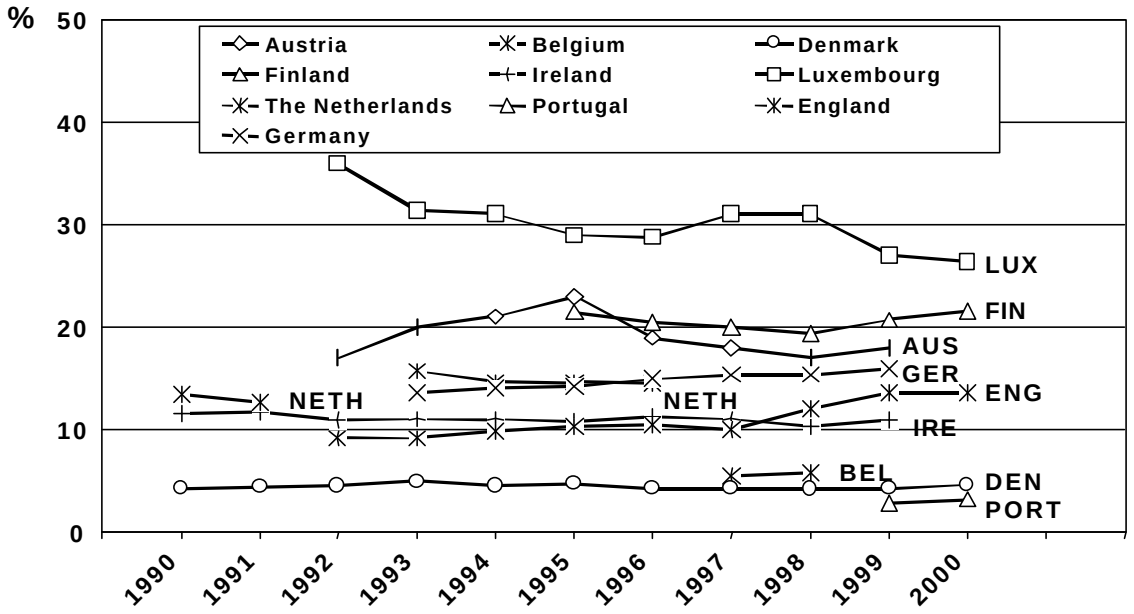
4.3 Availability of time series on involuntary placements

Austria	available 1991-2000
Belgium	not available
Denmark	available 1990-2000
Finland	available 1995-2000
France	available 1992-1999
Germany	available 1992-1999 *
Greece	not available
Ireland	available 1990-1999
Italy	not available
Luxembourg	available 1990 – 2000 *
The Netherlands	percentages available 1990-1999 *
Portugal	available 1999-2000
Spain	not available
Sweden	available 1993-1998
United Kingdom	available 1992-2000

Germany: available are the number of legal applications per year (of which approx. 90% result in actual involuntary placements)
Luxembourg: total number and percentage of all inpatient episodes in Luxembourg's only hospital accredited for involuntary placements
The Netherlands: compulsory admissions to psychiatric hospitals only

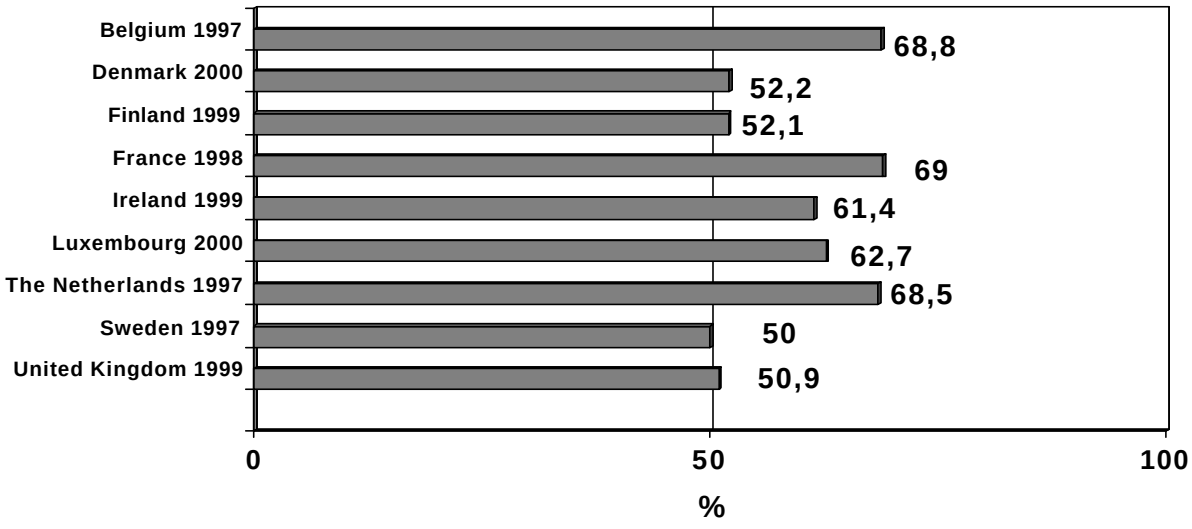
Comment: Some Member States run agencies or statistical bureaux that record or provide data on the involuntary placement or treatment of the mentally ill, whereas others do not. Annually updated rates of involuntary placements (detailed for regular and/or emergency cases as well as for sociodemographic and diagnostic characteristics) are essential for evaluating national policies.
Thus, improved health reporting in the Member States would increase the availability of frequencies, rates or mean lengths of stay of involuntary placements on a European level. On the basis of valid and reliable time series for this data, it is possible to evaluate or conclude the extent to which changes in legislation or practice might influence outcome (in terms of compulsory admission rates, the mean length of stay). Currently, only some Member States provide time series. The reliability and validity of these time series are unknown, however, and require further analysis.
Nevertheless, available data suggest that in most Member States the rates of involuntary placement (or the percentages on total admissions to psychiatric inpatient care) have remained relatively stable during the last decade (see fig. 4.3 below) – in contrast to the increasing total number of involuntary placements (as indicated in tab.4.2 and fig. 4.2a or 4.2b). Thus, a relatively constant increase in compulsory admissions, which is frequently referred to in the literature, could not be confirmed by the data assessed for this report.

Fig. 4.3 Involuntary placements of all psychiatric inpatient episodes (percentages) per year and Member State



* The Netherlands: admissions to psychiatric hospitals only, Germany: applications only
Luxembourg: percentage refers to the country's only hospital treating patients involuntary

Fig. 4.5 Percentage of male patients among all involuntary placements (most recent year availabe)



4.4 Distribution of mental disorders among compulsorily admitted persons

	year		
Belgium	1998	Psychosis Substance abuse Affective disorder Dementia	34.9% 24.5% 12.6% 2.2%
Denmark *	2000	ICD 10 F20 ICD 10 F30-31 ICD 10 F0 ICD 10 F1 others	32.3% 7.1% 14.2% 11.2% 35.2%
Finland	1999	ICD10 F0 ICD10 F1 ICD10 F2 ICD10 F6	6.1% 16.0% 52.7% 2.8%
France*	1997/98	ICD10 F1 ICD10 F2 ICD10 F3 ICD10 F6 ICD10 F7	12.6% 50.0% 12.5% 10.6% 2.9%
Ireland	1999	Schizophrenia Other Psychosis Organic Psychosis Mania Depression Alcoholism Personality Disorder	33.7% 3.7% 3.3% 13.7% 13.0% 12.3% 7.0%
The Netherlands	1997	Schizophrenia Affective Disorder Organic Psychosis Drug related Personality Disorder	29.5% 9.2% 8.7% 5.2% 9.1%
Austria, Belgium, Germany, Greece, Italy, Luxembourg, Portugal, Spain, Sweden, UK		not available	

* France: survey data covering 122 out of 820 catchment areas
Denmark severity of all disorders must be similar to psychosis

Comment: Diagnostic profiles might provide a rough overview of patient groups, giving priority for involuntary placements. Only one third of the Member States were able to provide diagnostic profiles of involuntary placed persons. Despite differences in the usage of diagnostic categories, the largest group being patients admitted involuntarily with severe and chronic mental disorders such as schizophrenia or other psychoses, who account for 30% to 50% of all involuntary placements. The share of other relevant patient groups such as demented patients, and patients with affective disorders or substance abuse, differs remarkably. Additionally, patients suffering from other than the most severe mental disorders are remarkably frequent. Detailed information about the psychopathological state of these remaining patient groups (disorders, severity) was not available.

4.5 Gender distribution for compulsorily admitted patients

	year	*percentage of male patients*
Austria		not available
Belgium	1997	68.8%*
Denmark	2000	52.2%
Finland	1999	52.1%
France	1997/98	69%*
Germany		not available
Greece		not available
Ireland	1999	61.4%
Italy		not available
Luxembourg	2000	62.7%
The Netherlands	1997	68.5%
Portugal		not available
Spain		not available
Sweden		50%
United Kingdom	1999	50.9%

* Belgium: percentages available only for involuntary inpatients
France: survey data covering 122 out of 820 catchment areas, different percentages for HO/HDT-procedures

Comment: Sociodemographic data about involuntarily admitted patient groups is as scarce as psychopathological background information. Even the most basic gender data are available for only nine Member States, five of which have a clear tendency to place male patients more often than females (Belgium, France, Ireland, Luxembourg and The Netherlands) (see fig. 4.5).
Over-representation of male patients might serve as a rough indicator for giving priority to the dangerousness criterion when placing patients involuntarily, since the male mentally ill reportedly show dangerous behaviour more often than do female patients.
However, for a valid comparison, the proportion of compulsorily admitted males would have to be compared to the proportion of all admissions of male patients to psychiatric inpatient care in each Member State, which was not done here because these data were not available.

4 Member States (National Chapters)

In the following chapters, legislation and practice of involuntary placement or treatment or mentally ill patients is described separately for each Member State. The chapters were written by the national experts from the various Member States, who contributed the data summarized in the tables above.
The chapters outline the detention processes in the Member States and provide additional details of legal frameworks or procedures, which had not been included into the tables or might be too complicated to break it down into simple categories.

All national chapters were structured more or less in the same way, thus complementing the overview given in chapter 3.

Austria

Peter König

Up to 1990, when the presently applicable law was passed by Parliament the psychiatric infringement upon personal rights/freedom was regulated by different laws and acts. The basic law was the „Entmündigungsordnung“ (EntmO.) from June 28, 1916 (Law of tutelage). This law was confirmed in 1945 and supplemented in 1948 and in 1958 by additional by-laws. It is to be noted that this body of laws gave definitions of certain psychiatric conditions, assessment, juridical procedures and time frames for compulsory admission, expert hearings etc.

The present law has the advantage of putting personal rights of liberty at the centre of all legal procedures pertaining to personal rights and very much strengthening the patient's position, not only in theory by law, but also in fact by supporting him with the patient's counsel acting on his behalf in all matters relevant to his condition. Another advantage is the shortened time frame for legal procedures and also for the duration of (compulsory) admission. In addition, the very stringent necessities of documentation and notification of controlling agents (e.g. patient counsel) result in transparent and reflected treatment attitudes and procedures, thus in itself providing an instrument of quality assurance. This is also effected by the mandatory inclusion of external and independent psychiatric specialists as experts for the second stage of judicial decision-making regarding a patient's (duration of) stay or „exceptional treatment“.

An obvious shortcoming of this law is its applicability to a small fraction of psychiatric patients only, thus not providing any standards for psychiatric in-patient conditions of living, treatments, care and hospital expenditure. Another grave omission is the failure of the law to explicitly state the intent to treat or the psychiatric patient's right to adequate psychiatric treatment within the scope of the state of the art.
The present factual practice of the law furthers „revolving-door-psychiatry“ for some of the most vulnerable patients, e.g. certain drug addicts, and schizophrenic and manic patients. For the last diagnostic group the fact that the law does not provide possibilities for treatment in case of (grave) material danger can lead to severe personal or familial consequences. The possible alternative in these cases, namely guardianship, is shunned by patients' families for psychological reasons and also because it may be time-consuming.

The law does not provide any mandatory aftercare, thus contributing to a deficiency in general health care, the revolving-door-effect, and unnecessary costs of re-admissions. Decentralisation of psychiatric

hospitals, i.e. the addition of small psychiatric wards to general hospitals, is not really facilitated by the law necessitating two psychiatric specialists on call for involuntary admissions. The fact that quality assurance in the fields of external psychiatric experts and patients' councillors, each a very relevant factor in the appropriate handling of this law, is not part of its scope may be regarded as a disadvantage.

In general, the new law has become an accepted mechanism of dealing with compulsory admissions and commitment in which the different protagonists can co-operate. It has not been so well received by patients' relatives, who wish for the provision of legal measurements concerning jeopardy of material goods, the possibility of prolongation of inpatient treatment after commitment has been lifted, and a means of compulsory aftercare in certain cases.

Additional information for Austria

Jutta Knoerzer

History and/or frequency of reforming the respective laws and regulations

- 1916 "Anhalterecht" (commitment law)
- 1957 "Krankenanstaltengesetz" (law for the institutionalisation of hospitals)
- 1975 "Maßnahmenvollzug" (special law applied to people who have committed a crime and cannot be convicted because they lack responsibility due to their mental illness)
- 1990 New Commitment law
- 1997 special regulation concerning the protection of data and the dissemination of information by the police when they bring people to a psychiatric ward against their will.

There is a special commitment law in Austria which is related to other laws. The commitment law is not a general law to provide psychiatric treatment as a whole in every aspect. A different law is applied to criminal acts by people who are (probably) mentally ill. The commitment law is a national law and is based on a constitutional law to protect personal freedom ("Gesetz zum Schutz der persönlichen Freiheit").

Major changes in routine through new laws

The roles of psychiatrists and judges in the decision-making process have not changed with the new commitment law of 1990. The possibilities of medical treatment without the patients' consent have been regulated. The commitment law has created a new profession: the patients' advocate (Patientenanwalt), who specialises in assisting patients of psychiatric wards brought there against their will or without their

consent. The proceedings of court begin earlier than before the time when the law was enacted, i.e. within a week from the beginning of the involuntary admission a court review takes place. There are first efforts to regulate a practical routine during non-compulsory admission by providing for standards of information and documentation. Through the possibility to appeal to the court, the position of the committed patients is strengthened.

Generally the patients' legal position has been strengthened due to the facts that court proceedings start earlier, that there is a patients' advocate, and that there are more regulations and standards governing the stay of committed patients.

General philosophy

The commitment law does not regulate "protective" commitment; it solely relates to dangerous persons, but endangerment of oneself is also a reason for commitment. The law strikes a balance between public safety and personal autonomy along with patients' rights.

The principle of application of the least restrictive alternatives is found several times in the commitment law and is considered of paramount importance.

Partly, the regulations to strengthen the patients' position while committed are still too weak, various forms of coercion which cannot be appealed against in court are still practised.

Advantages of current legislation

The legal position of the psychiatric patients has been strengthened; though. There is a legal basis well-known to every professional in the field of psychiatry; there are standards for coercive measures. There is the patients' advocate with an office at the hospital or ward who is obliged to go to the committed patients, to speak with them, to be their advocate in court proceedings and to talk with the professional staff of the ward on behalf of the patients concerning their wishes, interests and concerns.

Problems currently not covered

Many problems which arose in the first years since the new commitment law came into force have been solved through better collaboration between the different professionals and the empowerment of the patients (and their relatives) as their positions in talking and dealing *with* them have improved. This development has not yet come to an end. Particularly the entire health system will change a lot because of the financial austerity in public and social welfare expected in the next few years.– According to the discussion of the first years about a change in the commitment law so as to expand coercion in medical treatment - some psychiatrists and other professionals still want to strengthen the legal basis of coercion measures in outpatient care. To the patients' advocates this seems like taking the last step first instead of starting to build a system of outpatient care which supports patients in their own right.

Current legislation does not take patients with chronic psychiatric disturbances into account to a sufficient extent, in particular, there is a lack of low-threshold options. There are hardly any inpatient crisis intervention centres for mentally handicapped persons who are committed to institutions (albeit temporarily) due to psychiatric symptoms.

There is not so much a lack of legal standards as a lack of possibilities to improve daily routines, especially in documentation and providing information in and out of court proceedings, and there is a lack of time when the different professionals involved should carefully attend to every single patient in an open, democratic manner.
Last but not least, in view of tight public budgets the financial situation in social and health welfare causes a general shift in priority from inpatient care in psychiatric wards to outpatient psychiatric care, which increases the danger of non-care for some of the patients. Instead of an increase in coercion measures in outpatient care, priority should be given to the improvement of social affairs management, which includes the specific necessity of political decisions aiming at greater responsibility for this vulnerable group of citizens.

Collaboration of police, courts, judges and mental health professionals

According to the commitment law there exist standards and control through judicial review in respect to detention, restriction of freedom, and medical treatment.
Co-operation between courts, judges and mental health care experts has improved during the past 10 years, and co-operation with the police has become more intense since the new duty was introduced and the restrictions on the information to be passed on by the police to the psychiatric ward were adopted in 1997 (regulation on data protection).
The community doctors permitted to order compulsory admission are often off duty during the night and on weekends, or it is not easy to get in touch with them in certain difficult situations.

Role of the police

Police can take a person to a psychiatric hospital or ward but they do not decide about the admission of a patient, this decision is made by two psychiatrists.
There are complaints about the stigmatising manner in which the police intervene. There is still a lack of training and further education of the police in this respect, although first steps have been taken.

Aftercare

Together with chronic patients, part of the coercion measures have been transferred out of the hospitals to other institutions like nursing homes, which are less expensive for public welfare. Outpatient care for psychiatric patients still lags far behind inpatient care.

There is little difference between the support and medical treatment in psychiatric wards given to committed and non-committed patients.

Patient-rights

In principle, the commitment law is better than the reputation it had with medical doctors in the beginning. Otherwise, it would not have been possible for the individual professional groups to enforce the law in a responsible manner according to their respective professional duties in the 10 years since the law was enacted in the current version; these years have also been characterised by a growing détente and a calmer relationship between the different professions.

The new provisions of the commitment law not only covered the introduction of the patients' advocacy but also new regulations concerning restrictions and treatment, visits, phone calls and other fundamental rights. In this context patients' rights have improved significantly. However, some grey areas continue to exist, and they should be dealt with as development – including that of related court proceedings - goes on. One example is the removal of personal clothing, which at present would have to be appealed against before an Independent Administrative Board (UVS). It would be more appropriate to formulate a general clause covering any and all other factual coercive measures used in commitment, which could then be dealt with before the court in charge of commitment proceedings.

At times, it is also found that the admission of patients on the basis of the opinions of two specialists cannot always be ensured in smaller, decentralised psychiatric units.

Epidemiology

Due to the work of patients' advocates there are no closed wards for non-compulsorily admitted patients. The number of committed patients has doubled in the wake of the new commitment law of 1990. In public a lot of different reasons for this fact are being discussed: one of them is that the patients' advocacy has led to a more widespread discussion of patients' empowerment and to a greater transparency of medical decisions concerning coercive measures taken by staff members in psychiatric hospitals and wards.

Belgium

Marc De Hert, Maurits Demarsin, Jozef Peuskens

Introduction and history

The oldest laws on compulsory admission date from June 18, 1850 and December 28, 1873. Compulsory admission in those days required a demand from someone concerned, a medical report, and approval from the mayor of the city or village. The main responsibility was in the hands of medical professionals. Compulsory admission was paid for by the authorities. It was not uncommon for people who were incapable of managing their financial affairs or even those who were unable to pay for psychiatric treatment to be compulsorily admitted simply for financial reasons.

Since July 28, 1991 compulsory admission has been regulated by the law of June 26, 1990 (published in Staatsblad of July 27, 1990, page 14806; this law replaced the old laws on 'Insanity' dating from the post-Napoleonic era 1850/1873. The major change is the strong impact of the legal justice system.

The law of 26 June 1990 concerning the protection of a person with mental illness

The law regulates a new administrative procedure in which the Judge of Peace is the central person. The new legal procedure is in agreement with the European Treaty on Human Rights. The central question of the law is : "Who can, and under which conditions, be admitted to a psychiatric institution against his/her will ?". Although there are no specific psychiatric disorders named in the law, the law applies only to people suffering from (severe) mental illness.

The law applies only when there is no other adequate treatment option. In practice this is the equivalent of a patient's refusing voluntary treatment. Article 1 of the law states clearly that limitation of freedom/ incarceration is possible only through the application of the required legal procedure (see below). The last criterion relates to a situation of danger. This covers both personal health and safety as well as the life or integrity of someone else. It must involve a present and real danger. The law is also applicable to minors.

Compulsory admission

The law regulates two types of compulsory admission: a) compulsory admission to a psychiatric institution; b) compulsory admission in a family. There is a general distinction between the first period of "observation" (maximum length: the first 40 days) and the possible prolongation (maximum length of 2 years; "verder verblijf" or "prolongation of stay").

Normal procedure

The Judge of Peace of the locality where a patient is staying is the responsible legal authority in the procedure. A procedure can be started with a written request ('verzoekschrift') to the Judge of Peace. This request can be made by all concerned (the exception being when a demand would be solely motivated by potential financial gains).

Joined to the request must be an "extensive" medical report, based on medical evaluations no older than 15 days. "Extensive" means that it not only contain a psychiatric diagnosis but also a description of the specific problems, e.g. dangerousness of the situation and the lack of other treatment options. This report can be made by any physician who is not a relative of the patient or of the person making the request, or, in the case of a hospitalized patient, who does not work on the psychiatric ward where the patient is staying or is going to stay.

The Judge of Peace will assess whether all conditions of the law apply. Within 24 hours he/she will decide whether the demand for compulsory admission is valid and whether to continue with normal procedure. When the demand has been ruled invalid, the procedure will be stopped. When the demand has been ruled valid, the Judge of Peace will within 24 hours inform the patient or his/her legal representative, a lawyer is appointed either pro deo by the judge or chosen by the patient (see items on patient rights). The judge can appoint an independent psychiatrist to assist him/her in his/her judgement, and the patient can appoint or choose an independent psychiatrist and "a trusted third person".

The judge will also set the date and time when his ruling will take place. On that day he/she will see and hear the patient and all concerned whom the judge has decided can provide relevant information. Within ten days after the procedure has started with the written request, the judge rules after having heard all concerned.

A transcript of the ruling is sent to the patient, the legal representatives of the patient and those who made request, the personal physician of the patient, the appointed trusted person of the patient; and to the prosecutor. If a compulsory admission has been ruled, the judge appoints the psychiatric service where the patient needs to be hospitalised.

Emergency procedure

This procedure does not replace the normal procedure but is used in cases of great emergency, as an introduction to the normal procedure. The prosecutor can order an emergency admission of a patient on his own authority or at the request of someone, with a report from a physician. This report needs to show the urgency of a specific case as well as the other criteria for compulsory admission. The prosecutor can rule for an immediate admission to a hospital, in which case he informs the director of the psychiatric institution. Within 24 hours the prosecutor must start the normal procedure (written demand, medical report) with the Judge of Peace.

Mentally Ill criminal offenders

Each year about 20,000 people are confined to or released from Belgian jails. At each point in time in 1999 about 8,500 people resided in jail. The law of July 1, 1964 applies to mentally ill criminal offenders. A court rules whether someone is not fully responsible for his/her criminal acts due to a psychiatric disorder. This ruling is based on an extensive forensic psychiatric evaluation by an expert psychiatrist. The law of 1964 in currently under review for changes. Each year about 300 persons are granted an insanity plea (1.3% of all convictions). On January 15, 1998 there were 2,953 mentally ill criminal offenders known to the system. Of these, 37% reside in jail or a state-run forensic unit, 17% in a psychiatric facility, 40% were free on parole (with obligatory aftercare), and about 6% could not be traced (Cosyns, 2000).

Law on protection of goods and property

For anyone compulsorily admitted under the old laws of 1850 and 1873 a guardian was automatically appointed to manage financial affairs and goods and property. The automatic link between protection of goods and property and compulsory admission has been abolished. A separate law of July 18, 1991 covers the issues and practice of the protection of goods and property of those partially or fully incapable of managing their goods and property or financial affairs for physical or mental reasons. This law applies to all persons older than 18 years not having a legal tutor. Application upon a demand of someone concerned and a medical report is made to the Judge of Peace.

Practice, Period of observation of maximum 40 days

Upon arrival in hospital all compulsorily admitted patients are entered into a logbook (personal demographic details, date of entry and discharge, each leave from hospital, all procedures of protection (e.g. isolation, use of restraints,…) by the director. This logbook is available to all persons involved with the control of the institution.

Hospitalisation for observation is only possible on accredited hospital wards (psychiatric hospital or psychiatric ward of a general hospital), the responsible psychiatrist of which has passed a specific exam. The period for observation should not exceed 40 days. In this period the patient is ‘guarded’, thoroughly assessed and an appropriate treatment is started. Forced treatment as such is not clearly mentioned in the law, treatment should be provided in agreement with current medical knowledge and guidelines.

Prolongation of stay

A prolongation of stay can start only after the observation period has ended. At least 15 days before the end of the 40-day observation period the medical director has to write an extensive report indicating the

necessity of a prolonged stay. This report is sent to the Judge of Peace, who will decide on an eventual prolongation of stay and its duration. This prolongation of stay is once again a ruling made after the judge has consulted all concerned (e.g. patient, legal representatives, …).

During a prolongation of stay the patient is further 'guarded' and treated. This prolonged stay can last for a maximum of two years. It can be prolonged by a new ruling by the Judge of Peace. During a prolongation of stay the patient can leave the hospital for short periods under the responsibility of the treating psychiatrist; partial hospitalisation is an option.

The psychiatrist can, in concert with the patient, decide upon compulsory aftercare ('nazorg'). This can be compulsory treatment in the community. This can last only for the maximum period of one year, but cannot exceed the duration of the original prolongation of stay. A contract is drawn up between the patient and the treating psychiatrist, signed by the medical director of the hospital, and stipulates the duration of the contract, treatment conditions, place of residence and activities outside the hospital. When a patient fails to observe the conditions of the contract or when the psychiatric conditions requires this, he/she is re-admitted to the hospital.

End of compulsory admission procedures

An emergency procedure by the prosecutor can be ended by the prosecutor before the Judge of Peace has made a ruling. The Judge of Peace can end a procedure for a demand for compulsory admission when he/she has judged that the conditions stipulated in the law have not been fulfilled. During the period of observation the compulsory admission can be terminated by the decision of the judge who ruled for compulsory admission or the psychiatrist head-of-ward, who can conclude that the procedure is no longer needed. If, during the period of observation, no demand is made for prolongation, the procedure ends at day 40. In the prolonged stay the psychiatrist, eventually at the request of the patient, can terminate the prolonged compulsory treatment. The prolonged stay ends at the end date, or after discharge and compulsory aftercare ("nazorg") after a maximum period of one year. The Judge of Peace can at any time review the decision of prolonged stay. The eventual request to do so can be made by the patient with the support of a report by a psychiatrist.

Special case, compulsory admission to a family

The law provides a special chapter for placement in a family. The procedure is similar to the normal procedure and stipulates compulsory placement in a family setting. In practice this a rare procedure.

Patient rights

The law takes into account overall issues related to patient rights. During the procedure the patient is heard and he/she has the right to have the independent legal counsel of a lawyer. The patient can appoint a personal physician and a trusted third person.

The law stipulates some general basic rights during hospitalisation:

- respect of freedom of speech and philosophical and religious convictions
- respect for social and cultural interests and right to have contacts with family
- right of privacy of personal mail
- right to have visits from a lawyer, personal physician and trusted third person. Other visits are dependent on psychiatric conditions and consultation with the treating psychiatrist.

The chosen physician and the lawyer have access to the logbook to consult data on the patient. They can ask the treating psychiatrist for all relevant information needed to assess the patient's condition. The physician chosen by the patient can, in the presence of the treating psychiatrist, consult the patient file.

Appeal against rulings on compulsory admission is regulated within the law. Appeal is possible against the first ruling of the Judge of Peace, questioning whether the demand for the procedure is valid, as well as against all later rulings by the judge (e.g. ordering compulsory admission, prolongation of stay, …). The patient's lawyer is responsible for starting a procedure of appeal before the court of appeal with three judges. The ruling on a higher appeal must be made within a month.

Epidemiology

Data on beds and real occupancy are gathered at both the regional and national levels. Belgian health data are fairly hard to get and are, as a rule, available publicly only after extensive delay (De Hert et al 1997 and 1998). Comparison with data from other countries is complicated further by the diversity of health regulations and definition of services between different countries (e.g. a place in a day hospital is counted as a hospital bed in Belgium).

A survey in the Flemish part of the country (Arteel, 2001) indicates that in the majority of cases (75%), patients are admitted compulsorily according to the emergency procedure. In the larger cities the normal procedure is followed in only 15 % of cases. In one out of three cases, admission to hospital by means of the emergency procedure is not confirmed by the Judge of Peace. In 50% of compulsory admissions the duration of forced treatment is less than six months. A prolongation of stay after a compulsory admission is requested in two out of three cases.

A potential source of information on a national level are the reports of the Minimal Psychiatric Data, an obligatory registry for all residential psychiatric services. At this point in time information for the years 1997 and 1998 is available. The Minimal Psychiatric Data registry was established after the recent laws on compulsory admission were enacted, thus no comparisons before and after the law are possible. Apart from general problems with the accuracy of an obligatory administrative registry, the Minimal

Psychiatric Data has a number of specific biases. Whether or not an admission is compulsory can be registered only at admission.

Table 1. All admissions and legal status of all admissions 1997/1998

1997	**Psychiatric hospital**		**General hospital**		**All services**		
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*All*
All	22741	19099	18655	20686	41396	39785	81181
Voluntary	20239	17838	18241	20380	38478	38225	76700
Legal procedure	2502	1261	414	306	2918	1560	4481
%	11.0	6.6	2.2	1.5	7.0	3.9	5.5
1998	**Psychiatric hospital**		**General hospital**		**All services**		
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*All*
All	23521	19841	18934	21123	42455	40964	83419
Voluntary	20727	18515	18529	20849	39256	39364	78620
Legal procedure	2794	1326	405	274	3199	1600	4799
%	11.9	6.7	2.1	1.3	7.5	3.9	5.8

Table 2. Legal Status of patients on cutoff-date 1997 and 1998 by gender and facility

30/06/1997	**Psychiatric hospital**		**General hospital**		**All services**		
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*All*
All	9229	7817	1068	1393	10297	9210	19507
Voluntary	7254	6871	1025	1371	8279	8243	16522
Legal procedure	1975	946	43	22	2018	967	2985
%	21.4	12.1	4	1.6	19.6	10.5	15.3
30/06/1998	**Psychiatric hospital**		**General hospital**		**All services**		
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*All*
All	9612	7858	1067	1448	10679	9306	19985
Voluntary	7544	6928	1015	1418	8559	8346	16905
Legal procedure	2068	930	52	30	2120	960	3080
%	21.5	11.8	4.9	2.1	19.9	10.3	15.4

The system does not provide for registration of a change from voluntary to compulsory status during the course of an admission. So patients are not registered who have entered the hospital as a voluntary patient but for whom the treating physician has judged that compulsory treatment is needed. In the published data on all admissions during the year we find only the diagnosis at entry.

Table 3. Distribution of mental disorders, all admissions 1998

Psychiatric hospital				
	voluntary	*legal*	*all*	*%*
All	39083	4097	43180	9.5
Psychosis	5786	1501	7287	20.6
Substance abuse	11664	1022	12686	8.1
Mood disorder	8596	481	9077	5.3
Cluster B	2291	224	2515	8.9
Dementia	1375	56	1431	3.9
Children and adolescents	677	86	763	11.3
General Hospital				
	voluntary	*legal*	*all*	*%*
All	39215	678	39893	1.7
Psychosis	3460	166	3626	4.6
Substance abuse	12149	150	12299	1.2
Mood disorder	11567	121	11688	1.0
Cluster B	1303	26	1329	2.0
Dementia	862	51	913	5.6
Children and adolescents	552	29	581	5.0
Psychiatric hospital and general hospital				
	voluntary	*legal*	*all*	*%*
All	78298	4775	83073	5.7
Psychosis	9246	1667	10913	15.3
Substance abuse	23813	1172	24985	4.7
Mood disorder	20163	602	20765	2.9
Cluster B	3594	250	3844	6.5
Dementia	2237	107	2344	4.6
Children and adolescents	1229	115	1344	8.6

Tables 1 (all admissions during the year 1997 and 1998) and 2 (all patients at a specific date) show the latest available data on compulsory admissions in Belgium from 1997 and 1998 according to sex and type of service. Men are admitted compulsorily twice as often as women. The largest proportion of compulsory admissions is done by psychiatric hospitals. In 1998 nearly 6% of patients entered the hospital by means of compulsory admission and on any given day 15% of all patients in hospital have been compulsorily admitted.

Table 4. Distribution of mental disorders on June 30, 1998

Psychiatric hospital			
	all	*legal procedure*	*%*
All	16879	2982	17.7
Psychosis	5323	1469	27.6
Substance abuse	2848	385	13.5
Mood disorder	2709	181	6.7
Cluster B	482	46	9.5
Dementia	1107	103	9.3
Children and adolescents	596	103	17.3
General Hospital			
	All	*Legal procedure*	*%*
All	2421	80	3.3
Psychosis	290	17	5.9
Substance abuse	525	8	1.5
Mood disorder	816	12	1.5
Cluster B	39	1	2.6
Dementia	94	12	12.8
Children and adolescents	93	6	6.5

Tables 3 (all admissions during 1998) and 4 (all patients admitted at a specific date) give an overview of compulsory admissions by diagnosis in both psychiatric hospitals and on psychiatric wards in general hospitals. In both settings psychotic disorders and schizophrenia are the most frequent diagnostic groups for people compulsorily admitted, followed by substance abuse disorders (including alcohol) in an absolute number of patients. Together they constitute nearly 60% of all compulsory admissions over a one-year period. Looking at the percentage per diagnostic group, the second largest diagnostic group hospitalised on the basis of a legal procedure are people younger than 18 years of age. A comparison of data from tables 3 and 4 show that patients with psychosis and schizophrenia remain compulsorily admitted for longer periods, while for people with substance abuse and alcohol problems the procedure is more often terminated.

A recent nation-wide study on psychotic patients hospitalised in psychiatric hospitals shows that at this point in time more than 30% (27.8% compulsory treatment and 2.8% coming from jail after conviction) of all psychotic patients have been compulsorily admitted to hospital (De Hert et al 2000). In this study up to 40% of all psychotic patients have been admitted compulsorily at least once before the current hospitalisation.

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Denmark

Helle Aggernaes

Legislation

The Danish Psychiatric Care act is covered separate from the general health legislation in a special mental health care act.

History

The first Danish psychiatric care act took effect in April 1938. In those days only four psychiatric departments existed as integral parts of general hospitals. These departments were situated in Copenhagen and worked in co-operation with a mental hospital outside Copenhagen. The hospital facilities for psychiatric patients outside Copenhagen were state mental hospitals. A circular existed which regulated the admission to the mental hospitals. No voluntary admission was possible. The 1938 law regulated psychotic patients' residence in mental hospitals. In 1954 the law was revised, and it was decided that the patients could claim decision by a court, if they were detained against their will. Compulsory treatment and other compulsory acts were not described in the law. The current law is from 1989 with revision 1998 (implemented 1st of January 1999).

Law in function 2001

The primary aim sought to be fulfilled by changing the law in 1989 was to secure human rights, by creating possibilities for the patient to complain, not only about the deprivation of liberty, but also about other compulsory acts, e.g. treatment. Thus compulsory treatment and other kinds of compulsion, as well as the criteria for these other kinds of compulsion were described along with procedures for filing complaints. A system of registration was introduced with four protocols for the four types of compulsion: 1. deprivation of liberty (commitment and detention of voluntarily admitted patients), 2. compulsory treatment, 3. other compulsory acts (fixation, grasping, acute medication to restless patients) and 4. protective immobilisation.
Every compulsory act is registered in each patient's special protocol (part of patient's file). Copies of the protocol will be submitted quarter-annually to the local health authorities and to the National Board of Health, which annually provides offical public statistics on the compulsion in each psychiatric department. Until the revision of the law in 1998, the copies of the protocols were anonymised before their submission to the National Board of Health, thus making it impossible to produce statistics concerning the amount of compulsion applied to individuals. Following the revision of the law, these statistics can now be produced,

and the first nation-wide specified statistics about compulsion in all psychiatric departments were published in 2001 (concerning year 1999).

The further aim of the 1989 law was to open psychiatry to the public, and to this end a system of patient counsellors was created. In the protocols 1- and 2- compulsion "...the patient immediately shall have a patient counsellor". In the protocols 3- and 4- compulsion "...the patient shall have a patient counsellor on request".

Also included was the general legislated principle and obligation by which the least thorough means should always be applied, and the psychiatrist should at any moment try to persuade the patient and to have the patient's consent to being an inpatient and to being treated. Thus it was a hope that the number of compulsory acts in psychiatry would diminish. Investigations performed in the years after implementation of the 1989 law showed that the amount of compulsion in some instances remained unchanged, while in others it increased. The current Danish law reflects the eternal discussion between the patients' autonomy (i.e. right to decide against treatment) and the consideration of public safety, and the patients' right to be treated.

The length of the current legislation is seven A5-pages for the actual act No. 849 of the 2nd of December 1998 and attached to it there are 24 pages of circulars and departmental orders.

The major limitation caused by creating a psychiatric care act is the problem arising from the fact that the act was written by people thinking in terms of "common sense", but that it is to be applied to patients who at the moment have no common sense because of their psychosis. Very often the psychiatrist has to use his own judgement and knowledge and make the decision for an ambivalent patient who says "yes" one moment and "no" the next to consenting to a treatment plan. The psychiatrist also has to decide when a patient on an acute visit to the emergency room verbally says "no" to a proposal of admission but then walks into a ward, goes to a bed and goes to sleep. The Danish Law paragraph 1 stipulates that consent is not an absolute requirement for placement and treatment. The relevant criterion is opposition to the proposed measures. Hence a placement is deemed voluntary if the patient neither verbally nor in his behaviour protests the suggested detention (e.g. by not reacting to/acting upon the measures taken). Paragraph 1 also states that the law only takes into consideration compulsory admission, detention and other compulsory acts taking place in psychiatric hospitals and departments. Involuntary placement in nursing homes is not within the scope this law.

A problem in the Danish law is that it allows any medical doctor to make the actual examination and after that fill out the certificate for commitment. Although most medical doctors in Denmark have done an internship as registrars in psychiatric departments, some only have only had a four week undergraduate course in psychiatry. This level of psychiatric education does not seem sufficient to allow completion of a certificate for commitment. On the other hand, the consultant psychiatrist in the hospital also has to decide whether the criteria in paragraph 5 have been fulfilled before the patient can be admitted.

It is a bad thing about the Danish system that although the protocol registration system gives good indicators for monitoring quality standards, the protocol system at the same time creates a large

bureaucracy, which costs both time and money, without sufficient resources having been allocated for such registration. Thus the time consumed is deducted from the treatment of the patients.
Paragraph 2 of the law states that to diminish the amount of compulsion the owners of the hospitals should offer good conditions concerning the number of beds, the number of and education of staff, and possibilities for activity and education of the patients. Unfortunately this very nice paragraph is only a recommendation, not a must. In Denmark many resources have been allocated to rebuilding and modernising psychiatric departments. The aim – single bedrooms – had been fulfilled for 50 per cent of the inpatients in 2000. But for the time being, the number of and education of the staff is not at a sufficient level everywhere, and on top of that, vacancies exist, especially for psychiatric nurses and doctors.

There are several advantages to the current legislation: There is a clear distinction between the legislation concerning civil and that concerning criminal matters. Now we know that it is very unhealthy to stay psychotic for days, weeks, and months, and early treatment is essential, if a person has a chronic disease. It enable very fast and smooth work and co-operation among the different people involved in the care of the psychiatric patient that an involuntary stay at a psychiatric establishment can take place, either by commitment or by persuasion to acquiesce to voluntary detainment. A patient can voluntarily enter a psychiatric department and then later be detained compulsorily if deemed necessary, and if legal according to the criteria for detainment in a psychiatric ward. Another advantage is the very specific definition of the kind a psychiatric illness which has to be present to justify a commitment. It has to be psychosis or a condition quite equivalent to that of psychosis. It is also very good that the same criteria (paragraph 5) have to be fulfilled for involuntary treatment as for deprivation of liberty. It would seem somewhat illogical to place a person in a psychiatric ward against their will without any possibility of treating the patient. The same paragraph states that – besides being psychotic – the patient has to be either dangerous to self/others *or* the prospect for recovery will diminish substantially if detention in a psychiatric ward will not take place. If the criteria are fulfilled, the doctor shall commit the patient – unless of course he can persuade the patient to agree to voluntary admission. If there is a danger criterion the patient shall go to hospital within 24 hours, in the event of the other criteria, within seven days. In reality, the majority of patients committed are admittted immediately. Thus there is no distinction in emergency and regular commitments. The criteria in paragraph 5 also claim that it shall be unjustifiable not to detain the person for the purpose of treatment. Thus, the involuntary admission of a patient to a Danish psychiatric ward will always be for a therapeutic reason; the placement of incurably mentally disordered people without medical aims is illegal.
The Danish legislation uses the act on guardianship for placement in nursing homes of incurably mentally disordered people, but this act is used very seldom for chronically psychotic people, primarily for the demented. The current Danish law is a good law for the majority of the chronically psychotic patients and other psychotics. But there is a group of patients with schizophrenia with almost treatment-resistant hallucinations and delusions, who also might have addiction problems or criminal behaviour. These patients very often become revolving patients, and perhaps the legislation should be interpreted differently. But when

the scope of the lawmakers and the complaint boards is the autonomy of the patient, some of these patients have secured the human right to treatment for their severe psychosis. It would be the hope that the allocation of sufficient financial resources to the outpatient community psychiatric services would give rise to better treatment for this last group. Mandatory (compulsory) out-patient treatment might be the solution for this group of patients, but it is illegal, and not described in the law.

Practise

On an ordinary Danish psychiatric ward the psychiatric care act is an integral part of daily routines. Mostly there will be a good collaboration between general doctors, the department, the police, the courts and the local psychiatric patients' boards, who process the complaints. When the act of 1989 was implemented, lots of changes took place, and in the first years following implementation there was a heavy burden to establish routines for good co-operation between the local police and the local psychiatric department. In the same period community psychiatric centres were established, and in some places it is a problem that the responsibility for the treatment after discharge is in hands of a consultant psychiatrist other than the one who was in charge of the inpatient treatment. But in most counties there will be a single medical head of the same psychiatric department which includes both in-patient wards and one or more community psychiatric centers. This should guarantee the same treatment plan for in- and out patients. There is a risk that the change from in-patient to out-patient will cause the not motivated psychiatric patient to disappear from treatment, followed by a psychotic relapse, and then often by a new commitment shortly thereafter. According to the law, a treatment plan shall be drawn up for all patients admitted to a psychiatric ward. It is also a proposal from the National Board of Health that this treatment-plan should be the same as thatwhich follows the patient in the outpatient setting in community psychiatry. The quality and quantity of supply with services for both inpatient and outpatient treatment could be better, but as mentioned in the first chapter, for the time being resources are being allocated to psychiatry in Denmark.

Patient rights

The patient, who is an inpatient and is submitted to compulsory acts is guaranteed a patient counsellor who will advise in all matters related to the hospital stay and the treatment in the hospital. The counsellor will also help the patient with any complaints. Alas, investigations about patients' satisfaction shows that the patients are not that satisfied, because the counsellors very seldom help them to be released the hospitals or to avoid treatment, since only a small percentage of the complaints boards give the right to the patients. As the system is now, this must reflect that the consultant psychiatrist, in by far the most cases, has decided correctly, when he decides that the criteria for the compulsion exist. In each county there exist a local psychiatric patients board that will meet within a week upon receipt of a complaint from a patient. The complaint shall deal with compulsion as described in the protocols. The board will decide whether or not the

criteria for the compulsion have been fulfilled. The board is chaired by the county prefect, and the two other members will be a medical doctor and a representative of the Danish disabled patients organisations.

Epidemiology

The delivery of psychiatric care in Denmark, as elsewhere, has changed substantially since 1988, when 3.6 percentages of all Danish admissions were commitments. In 1988 Denmark had 8000 beds for psychiatric treatment.

Ten years later Denmark had only 4000 psychiatric beds, and the rate of commitments out of the total number of admissions in Denmark was the same (4.1%). 5 – 10% of voluntarily admitted patients were detained compulsorily for a period. In the same period outpatient-settings were created. Thus, patients could be treated in the community, while they continued to live in their own home. Unfortunately several did not have a home. The building of housing facilities for mentally ill didn't follow at the same speed with which the hospital beds were closed. For this reason, many of the closed wards in Denmark were overcrowded in the nineties with a dramatic increase in bed occupancy; this might explain an increase in compulsion which was seen in the same period. Of course there will be a lot of revolving-door patients, when the same patient is primarily treated as an outpatient, but admitted, when necessary, because of an acute psychotic relapse.

The reliability and validity of the national epidemiological data is superb in Denmark, where not only the inpatients but also all the outpatient visits to the community psychiatric centres have been registered (since 1994) in The Psychiatric Central Register at the department of psychiatric demography, the Psychiatric University Hospital in Risskov, Aarhus.

In addition, the registration of the protocols of all incidences of compulsion in psychiatry in Denmark changed with the 1998 revision of the law. Before that date the registrations in the protocols were anonymous, and thus it was not possible to find out how many individuals were actually admitted compulsorily, it was only possible to find out how many compulsory admissions there were. Of course several scientific papers have discussed and investigated this, but never on a national basis, as iis possible now. The new data reveal that compulsion takes place especially in the five psychiatric departments in the Copenhagen area, that 10 per cent of all the admissions in this area are commitments, and that 25 to 39 per cent of all the individuals who were inpatients in the year 1999 had been submitted to at least one kind of compulsion during one or more admissions. We know that the majority of the patients in these departments are severely psychotic, suffering primarily from schizophrenia. And we also know that more than one quarter of all the patients with schizophrenia registered in Denmark as either in- of outpatients will be living in the catchment area of these five Copenhagen departments. In the year 2000 there were in Denmark 1792 commitments (936 males and 856 females) out of a total number of 38,669 admissions (19,031 males and 19,638 females). In 578 (32.3%) of the commitments the diagnosis was schizophrenia (F20). More specific data will emerge in the coming years, when annual statistics from the National Board of Health will be published.

Finland

Riittakerttu Kaltiala-Heino

Procedure of involuntary admission

In Finland, the procedure of involuntary admission to a mental hospital (=commitment) is regulated by the Mental Health Act (1116/1990) passed in 1991. The process is initiated by writing a referral for observation (M I) (this equals the application for involuntary placement in this EU-project's glossary). The referral for observation (M I) can be written by any physician employed by the public health services (primary, secondary or tertiary care) or any licenced physician working in private practice. The physician must personally carry out the medical examination of the patient concerned. After this examination the physician must consider the fulfilment of commitment criteria likely, and she/he must explicitly write down on the structured referral form how the patient's condition suggests that the criteria are likely to be fulfilled. The MI-referral can be based on a medical examination completed not more than 3 days before.

In the hospital, a psychiatrist or a resident examines the patient again and decides whether or not the to place the patient under observation to find out if the criteria for involuntary treatment are fulfilled. It is possible that a patient arriving with a referral for observation (MI) will be admitted on voluntary basis or not be admitted at all; this could happen if the psychiatrist or the resident on duty in the hospital found the referral clearly invalid (clearly could not see any likely fulfilment of the commitment criteria).

The observation period lasts for a maximum of 4 days. At the end of the observation period, the psychiatrist (or the resident) responsible for the patient's ward gives her/his statement of whether the criteria for involuntary treatment are fulfilled. The statement is given on a structured form (M II).

The psychiatrist in charge of the hospital (or the unit) then decides whether or not the patient is detained in involuntary treatment. The psychiatrist in charge decides on the basis of theinformation in the patient's case history and in the M I and M II forms. The patient's opinion of her/his need for treatment is obtained before the decision is made, and it is documented in patient files. The psychiatrist in charge is not obliged to personally interview the patient before making the decision; the responsibility for interviewing the patientlies with the psychiatrist (resident) who produces the M II statement.

Thus, the final decision to admit a patient to involuntary treatment necessitates that 3 independent physicians consider it justified to place the patient into hospital / keep her/him there (the psychiatrist/resident who first examines the patient in the hospital can be the same one who is responsible for the observation, but the referring physician must be independent of the hospital, and the deciding psychiatrist must not be involved with either of the previous phases of the procedure).

The decision on involuntary treatment is valid for three months. If it is considered likely that involuntary treatment will need to be extended beyond that time, a new observation period is ordered, a new M II

statement is produced, and a new decision is made. This second decision is immediately subjected for confirmation by the administrative district court. The second decision is valid for six months. If there is still reason to think that the patient needs further involuntary treatment, the process has to be initiated again from a new referral for observation. If during involuntary treatment it is observed that the criteria for involuntary treatment are no longer fulfilled, involuntary care must be terminated immediately. The patient must be discharged upon request or can remain in voluntary care.

In question 1.12 you ask about short-term involuntary placement without confirmation from authority indicated in 1.10h. In a way, the observation period described above might correspond to such a short-term period. However, the observation period is in no way illegal or an unnecessary delay, so my opinion is that such an unconfirmed involuntary placement/treatment period does not exist in the Finnish system.

Other notes on the questionnaire:

1.22 b and d: Who is allowed to order involuntary treatments and coercive measures:

These activities are ordered by the psychiatrist / resident in charge of the ward the patient is treated in. Sometimes, a resident bears a responsibilityfor the ward (with a possibility to consult a more senior psychiatrist), sometimes a psychiatrist is responsible for the ward and works there as the only medical doctor, and sometimes a ward has both a psychiatrist and a resident. The physician who is responsible for the ward orders all treatments and also all coercive measures. Out of office hours, the psychiatrist or the resident on call can order involuntary treatments and coercive measures for any patient in the hospital. In practice, this refers to involuntary medication and to seclusion and restraint. Psychosurgery is not used. ECT would not be given compulsorily if a patient was able to disagree. Informed consent would be obtained for ECT with the exception that in an emergency a catatonic patient might be treated even she/he is unable to consent/disagree. However, in the Mental Health Act, involuntary treatments and coercive measures are only vaguely regulated (see the chapter about legislation and practice).

Driving licence

Receiving a driving licence in Finland necessitates a medical certificate that the applicant's health is good enough not to endanger traffic and safety. Mental disorders (especially substance abuse disorders) might sometimes be of such severity that driving ability is compromised. It could happen that this is detected during an involuntary psychiatric treatment period. Not being allowed to drive would never be due to having been in involuntary treatment but due to the medical condition that compromised driving ability. Thus, I don't think a cancelled driving licence can be considered a long-term consequence of the involuntary treatment. It is very rare that a valid driving licence is cancelled.

Psychiatric bed rate

Beds are no longer counted as such. The bed rate is calculated from the number of inpatient days:

- The number of inpatient days in psychiatric treatment divided by 365 constitutes the approximation of number of psychiatric beds (100% use is assumed)

- Divided by the number of population, this yields the bed rate, 1.0/1000 in 1999

The latest figure for counted beds in the specialty dates from 1995, 1.3/1000. Beds have been closed since then, but the present figure is calculated according to a different procedure.

Statistics

The statistics are available only from the year 1995 to the present, because due to changes in registration practices, earlier statistics are not comparable on the level that scientific research necessitates, and furthermore, due to changes in coding instructions, there are serious errors in the statistics for 1992-1994.
As you willl notice, in recent years the number of involuntary admissions has slightly increased, while the length of stay has decreased. This represents the general trend detected in psychiatric treatment in Finland. The number of all admissions has also increased and LOS in all admissions has decreased in a manner similar to that observed for involuntary admissions.

Legislation

In Finland, involuntary psychiatric treatment is regulated by the Mental Health Act (1116/1990) passed in 1991. The Mental Health Act defines the parties responsible for organising mental health work and regulates involuntary psychiatric treatment as well as the assessment and treatment of mentally ill offenders. Thus, mental health work and psychiatric treatment are governed by a special separate law, while the Public Health Act and Act on Specialist Level Health Services regulate health services in general. The Mental Health Act comprises 5 pages in the law code, but it has to be mentioned that the Public Health Act and the Act on Specialist Level Health Services also are relevant for psychiatric services (as to aspects of funding and organisation of health services). The Mental Health Act largely concentrates on involuntary treatment and on the treatment of mentally ill offenders. The Act places the responsibility for organising mental health services on municipalities but does not define how the municipalities have to carry out this task.
The Mental Health Act was passed in 1991. Previous legislation was from 1952 (revised in 1978). In the law passed in 1991 the criteria for involuntary treatment were otherwise kept the same as in the law revised in 1978, with the addition of the criterion that involuntary treatment can only be initiated if other mental health services are not suitable or not adequate. The observation period was shortened from 5 to 4 days.
The 1991 law did not bring about any major changes to involuntary treatment routines. The shortening of the observation period necessitated some minor reorganisation of resources as assessments now more frequently have to be completed during special holidays such as Christmas or Easter-time. The demand that other mental health services must prove to be unsuitable or inadequate before involuntary treatment can be ordered did not make a major impact on routines: no significant decrease was seen in involuntary

admission figures. Since the late 1970's the proportion of involuntary admissions had been decreasing steadily before the law change.

All health care legislation in Finland is nation-wide. In addition to legislation, health services receive national instructions and recommendations from the Ministry of Health and Social Welfare to harmonise those aspects of their activities that are not carefully regulated by the laws. For involuntary psychiatric treatment, such recommendations are relevant, for example, as to the use of coercive measures (see below, practice).

The Mental Health Act does not largely discuss patients' rights and aspects of autonomy and self-determination. In Finland, the Patients' Rights Act (passed in 1993) guarantees the right to treatment, self-determination and information for all patients. The Patients' Rights Act refers to special situations when a patient's self-determination can be overridden, one of these being mental illness, the involuntary treatment of which is governed in turn by the Mental Health Act. Other patient groups who can, in certain situations, be treated involuntarily are the mentally retarded, intoxicated abusers and patients with certain communicable diseases. Specific laws cover the regulation of involuntary treatment in these situations.

The Finnish mental health legislation reflects more concern for the "right to receive treatment" than for civil liberties. "A person can be taken into involuntary psychiatric treatment (exact translation: treatment independently of the patient's will) only if

- she/ he is mentally ill (this is understood as referring to psychotic conditions), and
- due to her/his mental illness in need of treatment because failure to treat would result in deterioration of the mental illness or would seriously endanger her/his health or safety or other people's health or safety, and
- no other mental health services are suitable or adequate."

Thus, involuntary treatment is allowed both due to "need for treatment" and "dangerousness". The dangerousness criterion is not strict: what can be considered to endanger the patient's or others' health and safety is not defined. The expected outcome of involuntary treatment is not explicitly defined by the law. It is left to clinical judgement to decide when the need for treatment or the harmfulness are serious enough to justify coercion. The incompetence of the patient concerned is not required as a prerequisite for overriding her/his will. Other treatment modalities need not be tried before involuntary treatment is initiated, they must only be considered unsuitable or inadequate. On the other hand, the basic criterion that involuntary treatment can only apply to mentally ill patients (psychotic conditions) is stricter and clearer than in most other European countries.

That involuntary psychiatric treatment is considered an issue of receiving treatment rather than as being deprived of civil liberties is also reflected in the fact that it is decided upon by the medical profession. Only if involuntary treatment is extended beyond 3 months is juridical control involved. However, to place a patient under observation (see above, Procedure), the opinion of 2 independent physicians is needed, and to detain a patient in involuntary treatment beyond the limits of the observation period (beyond 4 days) necessitates the agreement of 3 (or 4) independent physicians. Patients are known to prefer

medical to juridical decision-making (Kaltiala-Heino 1995, 1996). Although Finnish legislation does not distinguish between involuntary placement and treatment, being compulsorily admitted to a psychiatric hospital can only be done in order for the person admitted to receive treatment.

Advantages of the Finnish regulation of involuntary treatment are firstly, the clear basic definition of to whom (the mentally ill) involuntary treatment can pertain. It is also an advantage that this question of receiving medical treatment is decided by medical experts. Social services or police authorities would not have be competent to assess a patient's psychiatric condition, and for relatives such a decision would be a burden that might damage the patient's social network, not to mention that relatives might have interests conflicting with those of the patient. Relatives, social services and police are of course able to inform the health professionals about a situation where a patient may need involuntary treatment and should be assessed. Thirdly, an advantage is that the process does not contain any "grey" periods when a patient's legal status would be unclear or unconfirmed. I also find it most relevant that deprivation of liberty can only occur in order to receive treatment. Involuntary placement that would continue without treatment would only serve as a measure of social control.

A disadvantage of the Finnish Mental Health Act is that use of coercive measures during involuntary treatment is only vaguely regulated. It is stated only that the patient's self-determination can be restricted and that coercive measures can be applied upon her/him to the extent it is necessary for treatment or because of safety demands. In the legislation concerning the involuntary treatment of intoxicated abusers the use of coercive measures is more carefully regulated (Kaltiala-Heino and Välimäki 2001). This problem will, however, be dealt with in the future. The Mental Health Act is going to be revised as to the regulation of using coercion during involuntary treatment.

The Mental Health Act does not discriminate or neglect any population groups. Involuntary treatment of minors is regulated separately by the same law but description of that is beyond the scope of the present project.

Practice

The legislation well supports the daily routine of caring for the patients concerned. Some people are of the opinion that the mental health act should be more permissive so that involuntary treatment would not be limited to the mentally ill but could be extended to people with "severe mental disorders" or some other broader definition. When psychotic patients are concerned, the law is already very permissive: in practice, a psychotic patient could always be committed by referring to a "need for treatment" or "harm" that needs not be only the (threat of) violence but can also be of a more abstract nature. Because the law is actually rather permissive and can be interpreted in different ways, figures for involuntary treatment vary greatly between different health care districts (see below, epidemiology). Anyway, there need hardly be concern that a mentally ill person's need for treatment might be neglected or someone might be "rotting with rights on" due to a strict legislation for involuntary treatment.

According to the Mental Health Act, medical doctors decide upon applying for and taking a patient into involuntary treatment. In case the patient potentially ill in the way defined by the Act is unwilling to

present at physician's practice for assessment, it is the responsibility of the primary care services to organise the assessment either by fetching the patient to a health centre or by making a home visit. Upon request, the police authorities have to assist in organising the assessment and in escorting the patient to the mental hospital. The police also have to assist in bringing a patient back to the mental hospital in case a patient in involuntary treatment escapes from the hospital. The legislation is clear about the role of the police and in my opinion, if there are local co-operation problems, these are due to problematic personal relationships only.

Court hearings are not involved in the process of involuntary psychiatric treatment in Finland (see above, Procedure). If an involuntary treatment period extends beyond 3 months, the decision is subjected to confirmation by administrative district court. The administrative court confirms the decision based on written documents. Patients can also appeal the treatment decision in administrative district court. An appeal is also dealt with primarily based on written documents. No significant problems have been discussed in the co-operation between mental health experts and the juridical control of the treatment decisions.

The Mental Health Act does not specifically refer to aftercare of patients discharged from involuntary care. The Act states that municipalities are responsible for organising mental health services that meet the needs of the population. This should cover the needs of the population never admitted to mental hospitals as well as those of the population discharged from hospitals either from voluntary or from involuntary treatment. Involuntary outpatient treatment does not exist either as an independent treatment modality or as compulsory aftercare. Compulsory aftercare has been discussed as a treatment modality for discharged forensic psychiatric patients, but so far this has remained an academic discussion that has not ledi to any political activity.

Involuntary treatment is provided by the same hospitals and wards that also provide for voluntary inpatient treatment. Involuntary and voluntary patients are treated in the same settings. With the rapid decrease of the psychiatric bed rate, most of the inpatient services offer treatment mainly on locked wards. Free walk out of the wards is denied only to involuntary patients, however, (and usually after a while they also can be given the freedom to leave the ward during the treatment). It has never been considered a problem in Finland that voluntary and involuntary patients are treated on the same wards, and I don't see any problem here, either, since the patients on locked wards are all suffering from similar problems. Earlier, open wards were frequently available for neurotic patients and rehabilitation, but as mentioned earlier, the decrease of the bed rate and the policy of de-institutionalisation have resulted in emphasis upon community care for non-psychotic patients (and for psychotic patients as well, whenever possible), and the number of open wards in mental hospitals has decreased. Thus, supply for services is similar for both involuntary and voluntary inpatient treatment, and the treatment during an inpatient period is not selected according to the patient's legal status but according to her/his disorder and symptoms. As to whether inpatient services at large are effective in Finland, I assume that the situation is similar elsewhere in the Western world: It is well known that a lot of activities in psychiatric treatment have not been evaluated with up-to-date research methodology but the belief in their effectiveness comes from good clinical experience.

The Mental Health Act necessitates that involuntary treatment can not be initiated unless other treatment modalities (community care, voluntary inpatient care) are unsuitable or inadequate to help the patient. The law does not state that other treatment modalities must be tried first. In practice, there are differences from centre to centre as to what other treatment modalities are available and as to how far physicians and mental health personnel are willing to consider and attempt them before committing the patient. This is undoubtedly a source of inequality. There are districts with active, innovative approaches to community care and districts with minimal community care resources, as well as districts with less enthusiastic attitudes and less concern for patient autonomy and integration into normal society. Throughout the 1990's, however, the attempts to increase the effectiveness of the community care in order to avoid hospitalisations has steadily increased, resulting in the formation of new treatment options, especially for psychotic patients throughout the country.

During the inpatient treatment, there is great regional variation in the use of coercive measures (seclusion, restraint, involuntary medication). These differences can not be shown to relate to differences in patient populations (Tuori 1999).

The definitions of the commitment criteria have a certain margin or "elbow room". The basic criterion (that the patient has to suffer from mental illness) is rather clear-cut. However, as the referring physician must consider the commitment criteria likely to be fulfilled (not sure), and whether they really are fulfilled is found out only later during the observation, some patients with mainly personality disorders and non-psychotic affective disorders are committed and have the status of an involuntary patient for the observation period. That a non-psychotic patient would also be detained beyond the limits of the observation period is extremely rare (Isohanni et al1991, Tuohimäki et al 2001, under review). The former, being put under observation, is in accordance with the law, as only then can the fulfillment of the commitment criteria really be assessed. The latter case, a non-psychotic person being detained for actual involuntary treatment, ought not to occur.

More flexibility can be found in the specifications of the situations in which a mentally ill person can be taken into involuntary treatment. "… and due to her/his mental illness in need of treatment because failure to treat would result in deterioration of the mental illness" is a broad definition and could include any worsening of the symptoms of the patient. The following "or would seriously endanger her/his health or safety or other people's health or safety" can be first of all understood as suicidality or as the threat of violence towards others, but also as a variety of behaviours that may cause harm to the patient in the future, such as uncontrolled selling and buying of property or uninhibited professional activities that might destroy the patient's career, or behaviours that threaten to ruin the patient's social network. The harmfulness to others – this criterion is, in practice, a secondary position in Finland. Most of the commitment referrals and the treatment decisions refer to the need for treatment and harmfulness to self, while harmfulness to others is usually only used as an additional criterion, if at all (Tuohimaki et al 2001, manuscript in preparation). The flexibility in the criterion that other treatment modalities be unsuitable or inadequate was discussed above.

Patients' rights

In general, the patients' rights are discussed in Finland in the Patients' Rights Act. Rights guaranteed by this act are basically guaranteed to involuntary psychiatric patients as well, except that they can not refuse treatment. The Patients' Rights Act discusses the right to good medical care, the access to treatment, the right to be informed, the right to self-determination, emergency treatment, the possibility to appeal and to contact the patient ombudsman. Of these, of course, self-determination is restricted in involuntary treatment. On the legislative level it has to be mentioned that the other three laws allowing involuntary treatment in health care (of intoxicated abusers, of the mentally retarded and of people with certain communicable diseases) in some cases guarantee the involuntary patients more rights than the Mental Health Act does. In the other three laws mentioned, there are paragraphs about more detailed control of coercive measures, support for children in the custody of the patient, support for the family of the patient, about aftercare and rehabilitation, and about a patient's right to participate in treatment planning etc (Kaltiala-Heino and Välimäki 2001).

Epidemiology

In Finland, no unexpected or paradox consequences of changes in mental health legislation have been seen. Figures for involuntary treatment did not even essentially change in the expected direction following the change to the law in 1991. The rapid de-institutionalisation from the 1980's to the 1990's has resulted in an increase of short hospitalisations, while the lengthy hospitalisations have decreased. Firstly, the total number of inpatient days has decreased, as was aimed at by the de-institutionalisation policy, but later, the total number of inpatient days increased again, only in the form of shorter inpatient periods and as the increased treatment of mental disorders in primary care inpatient settings rather than in specialist-level psychiatric settings (Kaltiala-Heino et al 2001). I emphasise that it is not known whether numerous short hospitalisations is any worse or better than one or two long-term inpatient treatments. Nevertheless, this shift is not due to changes in commitment criteria but it is due to an active and rapid de-institutionalisation policy. Also the fact that the number of open wards in psychiatric hospitals is decreasing and that, regardless of the patient's legal status, most of the inpatient treatment takes place on locked wards is a consequence of the de-institutionalisation policy and not of the legislation concerning involuntary treatment. I emphasise that Finland has not attempted to treat voluntary patients exclusively on open wards since it is not the legal status of the patient but her/his illness that defines the treatment and its setting.

There are no problems with the reliability and validity of national statistics due to unclear definitions (such as an involuntary admission's only being counted as such after a confirmation that might be delayed), because the statistics register separately the admissions with a referral for observation and the number of days spent in involuntary treatment (= number of observation days + number of days spent in involuntary status after the observation period). Thus, any event of deprivation of liberty should be reported in the

statistics. Of course, it is in the responsibility of the hospitals to see that the reports are adequate. The hospitals are obliged to complete a structured information form (computerised) of all inpatient episodes in all specialities at discharge, and the psychiatric wards also complete a special additional sheet dealing with involuntary treatment. Annually, the National Development and Research Centre for Health and Welfare produces statistics that serve as feedback for the hospitals, which can then compare themselves with others. It is assumed that if a hospital seems to be differing from others to the extent that it awakens suspicions of data quality, they will react by controlling their registration practices. A comparative study of information in patient files and in national statistics is ongoing but has not been completed (Paternalism and Autonomy: A Nordic Study on Coercion in Psychiatric Treatment; I myself am the leader of the Finnish branch of this project). Thus, a bias might be caused by the careless work of the hospitals in reporting the data, but there is no specific reason to believe that there is such a problem.

Conclusion

I conclude that in Finland, the right to receive treatment is emphasised more than civil liberties are. This is in harmony with the general welfare society policy. The Mental Health Act has not been influenced by civil rights movements or the like (such movements are not outstanding in Finland) but emphasises a concern that all who are ill but unable to seek treatment will be treated. The process of involuntary treatment, in harmony with this ideology, is organised as a primarily medical decision-making process. If there is public discussion about whether the regulation of involuntary treatment is optimal, it is in the direction that different parties (doctors, relatives or politicians) are worried that some groups that can not be committed to involuntary psychiatric care under the current legislation (for example, alcoholics, substance users, and patients with eating disorders or personality disorders have been mentioned). The discussion has been sporadic and not very active. The discussion about compulsory community care mainly concerns forensic psychiatric patients, but some voices have been raised in favour of compulsory community care in psychiatry at large. In my opinion this would soon vastly increase the number of involuntary treatments, since surely a number of patients would be placed under such an order to increase compliance to community care, while those committed to involuntary psychiatric care would mainly remain there. In my opinion (and based on my research) it is already a fact that involuntary and voluntary psychotic patients are similar to each other not only with regard to their symptomatology but even with regard to their attitudes to treatment (Kaltiala-Heino 1995), and a considerable share of patients now treated involuntarily could be treated on voluntary basis. What currently prevents this seems mainly to be a tradition of treatment and the attitudes of the mental health care professionals, and in part also the differences in resources from district to district.

The patients and their relatives also seem satisfied with the legislation's being rather permissive regarding involuntary treatment. They are more concerned about the right to treatment than about the right to physical freedom, and most of the patients are satisfied with their own involuntary treatment even during the treatment and especially afterwards (Kaltiala-Heino 1995, 1996). The lack of an aggressive civil rights

movement in psychiatry and the lack of lawsuits due to involuntary treatment also suggest that the parties concerned are satisfied.

The legislation is good in defining clearly a patient's legal status in all situations. No grey periods of unconfirmed involuntary stay exist that afterwards could not enter the statistics as voluntary periods. It is also good in not separating involuntary placement from treatment since placement into health care system without treatment is, in my opinion, difficult to justify. However, compared to legislation in other Nordic countries, for example, the law could be more precise about emphasising patient participation in treatment planning and in explicitly giving the patient in involuntary treatment a choice between treatment options if there are medically relevant options. The legislation has a drawback in that it does not regulate explicitly coercive measures during the inpatient period. It is weaker than other laws allowing involuntary health care in that it does not define the purpose of the involuntary care and the rights of the involuntary patient to participate in treatment planning, and does not discuss rehabilitation and aftercare nor the position of children under the patient's custody. The issues of public safety and dangerousness have received only minor attention, but I can not state a preference as to whether or not they should be emphasised more. In forensic psychiatry these issues are, of course, of outmost importance (beyond the scope of this project).

France

C. Jonas, A. Machu, V. Kovess

France's first law on the treatment of the "insane" (or *"aliénés"* as they were known) was enacted on 30 June 1838. This Law was adopted at the time psychiatry was just becoming organised as a medical discipline in France and was aimed at the treatment of persons suffering from mental illness by way of "therapeutic isolation" or "internment in an asylum" and also included a mix of rules related to public law and order and the protection of civil liberties and property.

Since then, the Law dated 3 January 1968 on the legal system applicable to incapacitated adults had more strictly separated the medical treatment of mentally ill persons per se, from the protection of their personal interests (protection of property).

Then, on 27 June 1990, French Law No. 90-527 on the rights and the protection of persons hospitalised due to mental illness and conditions applicable to their hospitalisation replaced the 1838 Law, while maintaining a specific method for treating the mentally ill. Although admittedly, the 1990 Law continued to maintain some of the earlier principles applicable back in 1838, it did lead to voluntary hospitalisation becoming the rule and involuntary hospitalisation the exception.

The 1990 Law also upheld civil liberties, the most important of which was the freedom of movement of every citizen, and laid down certain safeguards of these rights during involuntary hospitalisation. Involuntary hospitalisation is currently the only form of involuntary "treatment" of persons suffering from mental illness in France.

French legislation

Two methods of involuntary hospitalisation:

Ever since 1838, one of the specific features of French legislation has been that our system is based on two methods of involuntary hospitalisation.

These two methods for involuntary hospitalisation of the mentally ill were written directly into the Law of 27 June 1990 and are based on different sets conditions and circumstances:

Hospitalisation at the request of a third party (*"HDT"* - *Hospitalisation à la Demande d'un Tiers*), based on the principle that a person may cause danger to himself, as the conditions are:

- the person must be in a state that requires immediate care and constant supervision in a hospital setting,
- the person is suffering from a mental disorder making his consent impossible.

The 1990 Law provided additional protection of rights in the case of this type of hospitalisation. Two medical certificates describing the mental disorder are required and whether involuntary hospitalisation is necessary is based on the request of a third party. Such a third party may be a member of the family or a person acting in the interest of the person to be hospitalised. Health care professionals where the person will be hospitalised cannot act as this third party. A strict legal framework thus governs this method of involuntary hospitalisation, so as to avoid abusive placement by family members.

Compulsory hospitalisation (*"HO" - Hospitalisation d'Office*) is based on the principle that a person may cause danger to others and applies to persons whose mental disorders jeopardise law and order or public safety. Compulsory hospitalisation is carried out via a police order issued by the local Prefect to commit the person.

Subsequent legal remedies

Members of the French Parliament held a lengthy debate in 1990 over whether a civil court judge should have the authority to order compulsory hospitalisation of the mentally ill. It was nevertheless decided that the administrative, rather than the judicial authorities would continue to decide on placement, but that a court judge would provide an essential safeguard of personal rights and freedoms.

Although in the case of compulsory hospitalisation ("HO") the original placement and continued placement are ordered by the Prefect of Police and admission is decided by the director of the psychiatric hospital in the case of hospitalisation at the request of a third party ("HDT"), the French judiciary plays an essential role subsequent to these decisions.

A person hospitalised involuntarily, a member of his family, or any person acting on his behalf may at any time petition the Presiding Judge of the *Tribunal de Grande Instance* in civil proceedings to order the immediate release of a person hospitalised without his consent.

A civil judge is also represented in the review procedures during involuntary hospitalisation that have been established by law (through the *Commission Départementale des Hospitalisations Psychiatriques* - see below - which receives the names of all persons hospitalised under both the HDT and HO procedures).

Since 24 April 1996, a "conciliation commission" has been set up in all French hospitals "to assist and direct persons who feel they are victims of the hospital system and to inform them of their right to engage in conciliation and their remedies".

Other safeguards provided for in the 1990 Law

Periodic review of decisions: The 1990 Law provides for the periodic review of decisions ordering involuntary hospitalisation. For involuntary hospitalisation at the request of a third party under the HDT

procedure, failure to draw up the legally required certificate on a monthly basis will void the procedure. The same is true for compulsory hospitalisation under the HO procedure, if the Prefect fails to issue a decision to maintain compulsory hospitalisation within the statutory time limits.

The Commission Départementale des Hospitalisations Psychiatriques ("CDHP"): The 1990 Law also required that a Commission be set up in each county (French "*département*" or administrative division). This Commission is in charge of examining the situation of persons hospitalised and ensuring their civil liberties and dignity. The local CDHP receives the medical certificates periodically drawn up during involuntary hospitalisations. The CDHP has the right to petition the civil judge or the Prefect to release a person hospitalised involuntarily under the HDT or HO procedure and under certain conditions, has the capacity to order the direct release of persons hospitalised involuntarily at the request of a third party.

Involuntary hospitalisation versus involuntary treatment

The 1990 Law makes no distinction between involuntary hospitalisation and involuntary treatment of persons hospitalised without their consent under the two procedures described above. Hospitalisation itself is designated as a method of treatment.

Emergency measures

The 1990 Law provides for a short-track procedure in emergency situations when immediate intervention is necessary that is available for both the HDT and HO involuntary hospitalisation procedures.

For persons hospitalised at the request of a third party (HDT), the director of the hospital may exceptionally admit a person on the basis of a single medical certificate (instead of two) if there is "imminent danger" and this single certificate may be drawn up by a psychiatrist working where the patient will be hospitalised.

For compulsory hospitalisation under the HO procedure, if there is imminent danger, the Mayor is vested with police authority to take temporary measures to hospitalise a person involuntarily. However, the local Police Prefect must issue a decision within 48 hours if involuntary hospitalisation is to be continued in this case.

Civil liberties

The 1990 Law stipulates that when a mentally ill person is hospitalised involuntarily, "restrictions of his civil liberties must be limited to those required due to his state of health and implementation of his treatment." Once admitted to the hospital, the Law requires that the person be informed of his legal status and rights. The freedoms listed in the Law must be safeguarded: religious and philosophical freedom, the right to vote, the right to send and receive mail, the right to consult the doctor or attorney of his choice as soon as he is admitted to the hospital, to petition the CDHP, etc.

According to the 1990 Law, persons hospitalised involuntarily must be visited on a regular basis by several authorities (local Prefect, Judges, Mayors or their representatives). During these visits, they may hear complaints from patients and carry out all useful measures to verify that the hospitalisation procedure was carried out in compliance with the 1990 Law.

Practice

Application of the Law does not demonstrate that breaches of civil liberties are being committed

The CDHPs in the various French counties consider that civil liberties and rights of mentally ill patients hospitalised involuntarily are indeed respected and that they do have the real possibility of challenging placement measures (complaints, court petition, etc.).

In addition, over the last few years, there has been a movement to empower patients hospitalised, regardless of their pathology, and to encourage the involvement of organisations representing health care users in decisions on hospital operations and quality care. The progressive implementation of an accreditation system applicable to all French hospitals will require that quality control measures be implemented and patients' rights are generally considered an important aspect when it comes to quality control.

However, the increase in the number of involuntary hospitalisations, the conditions under which they are being ordered, as well as the results of the survey carried out between 1995 - 1997 have led France to consider a reform of the 1990 Law.

Statistical Data

In 1999, the percentage of involuntary hospitalisations out of all patients hospitalised in psychiatric wards amounted to 12.5% of the total. In absolute values, these figures translate into 55,740 hospitalisations via the HDT procedure and 8,508 via the HO procedure nation-wide (95% response rate of the CDHPs), compared to 55,097 HDT placements and 8,807 HO placements in 1998. Note that these figures do not represent the actual number of persons placed through these systems, but the number of involuntary placements in hospital ordered, among which may be several instances for a single individual.

Between 1988 and 1998, the number of involuntary hospitalisations increased by 57%. The number of hospitalisations under the HDT procedure rose from 31,057 in 1992 to 55,033 in 1998 (100% response rate from the CDHPs), i.e., a 77% increase. Hospitalisations using the HO procedure went from 6,631 in 1992 to 8,817 in 1998, representing an increase of 33%. In 1999, the average hospital stays of persons hospitalised involuntarily under the HO procedure were longer than those for personsadmitted under the HDT procedure. HDT placements for a duration of over 3 months involved 16% of those hospitalised at the request of a third party (response rate of 86 French counties out of 99), whereas the number of HO placements for a duration of over 4 months represented 32% of all HO placements (response rate of 86 French counties out of 99). The length of hospital stays under the HDT procedure is apparently

decreasing, since in 1996, 20% of hospitalisations at the request of a third party lasted over 3 months. Since 1992, hospitalisations under the HO procedure for a duration of over 4 months represent approximately 30% of all compulsory or HO hospitalisations.

In addition, between 1992 and 1996, the number of involuntary hospitalisations under the emergency procedure also increased. The figures have remained stable since 1997, while the number of emergency HO procedures actually deceased between 1998 and 1999. In 1999, 66.6% of HO placements were carried out pursuant to a temporary placement order issued by the local mayor on the grounds of imminent danger and 34.3% of HDT placements were implemented on an emergency basis (response rate, respectively, of 92 and 89 counties providing this information). More and more often, persons hospitalised through these emergency procedures have been found to be experiencing behavioural problems due to alcohol and substance abuse.

There are major disparities between the different French counties, however, when it comes to application of the 1990 Law. In 1997, the number of HDT procedures per inhabitant aged 20 years or older showed a difference ranging from 1 to 5 depending on the county, whereas the number of HO placements showed a difference of 1 to 13. Questions regarding this difference between the number of HO and HDT placements depending on the county and questions as to the profile of patients involuntarily placed are pending, particularly when the borderline between psychiatry and social assistance may be unclear (alcoholism, delinquency).

Survey on the application of the 1990 Law

A survey was conducted between 1995 and 1997 on the application of the 1990 Law under the responsibility of Mrs. Strohl, *Inspectrice Générale des Affaires Sociales* ("IGAS"). The report issued by the national evaluation group in 1997 highlighted the following developments:

- The constant increase of involuntary hospitalisations since 1992 should be analysed
- There has been an increase in the number of involuntary hospitalisations using emergency procedures, which may jeopardise civil liberties; in particular, there has been an increase in the number of involuntary hospitalisations at the request of a third party carried out on an emergency basis using the short-track procedure and more involvement of hospital emergency room staff in the procedure
- The HO procedure appears to be more often based on public safety objectives as part of public policy and it has become more and more difficult to obtain the release of persons hospitalised involuntarily under this system
- A "trial release" system provided for in the 1990 Law for persons hospitalised involuntarily under the HO and HDT procedures is being used quite heavily. This does constitute a change in the conditions under which these persons are being treated, as the person is allowed to return to his domicile, while retaining the status of a patient involuntarily hospitalised. In certain cases, these trial release periods have been quite long and can thus constitute a circumvention of the 1990 Law by creating a *de facto* obligation of home care

- There is a disparity between the way CDHPs operate in different counties, due to the fact that they do not benefit from a permanent office and staff

Moreover, certain important aspects are not covered under the 1990 Law:

- Particularly frequent problems on the practical level are not resolved, such as the method of transportation used by the patient to reach the hospital (family car, private ambulance, fire or police vehicle, public emergency services, etc.)
- nor does the Law take into account or require that the patient's opinion be given during involuntary hospitalisation

Future Prospects

A bill on the "modernisation of the health care system " in general is scheduled to be examined by the French Parliament in Autumn 2001. If passed, this bill would amend the 1990 Law by providing a new framework for compulsory hospitalisation (HO) encompassing the requirement of a "serious" disturbance of law and order, by giving a court judge the authority to place minors suffering from mental illness and by boosting the CDHPs through the addition of two new members (6 members instead of 4), which may be a patient's advocate and a general practitioner. This bill also includes noteworthy advances when it comes to acknowledging the rights of users of the French health care system.

In addition, following an evaluation of the 1990 Law by a special committee appointed by the Government, the following other recommendations are currently being studied:

- setting up a short-term initial observation and orientation period (72 hours is the period being contemplated), prior to any decision to hospitalise a person on an involuntary basis
- merging the two involuntary hospitalisation systems (HO and HDT) and eliminating the reference to public law and order currently used as a basis for involuntary hospitalisation, while retaining the notion of potential danger to others,- providing the option of compulsory out-patient care,constituting an alternative to involuntary hospitalisation
- reinforcing verification procedures during involuntary hospitalisation

Epidemiology

There is little epidemiological data on these two methods of involuntary hospitalisation in France. The CDHPs in each county submit an annual statement to the Minister of Health, who produces national statistics. Even if virtually all of the CDHPs do send in these statements (94% response rate in 1999), they contain diverse information and the majority of socio-demographic and clinical data are provided by only a few of the county commissions. According to the CDHP report for 1999: there were 61 063 compulsory episodes, 13.2% of which were under HO and 86.8% under HDT. Moreover, during this year,

14.6% of HDT admissions lasted more than 3 months, while 27.8% of the admissions under HO lasted more than 4 months.

All the information concerns "episode" and it is therefore difficult to describe from this source the population concerned. Currently, the only data in our possession are based on a survey carried out in 1997/1998 of 122 public psychiatric units spread throughout France (i.e., 122 out of the 820 "sectors") that volunteered to provide answers during two 2-week periods. This survey was designed to study the feasibility of collecting data for management purposes, which when put into effect (2002), would make it possible to deliver precise statistics on various features of persons hospitalised, including in particular, those hospitalised involuntarily.

Based on the data from the 1997/1998 survey, rough figures can be given which provide a general picture of the situation:

This figure involves an important gender difference, as 64% of male subjects were admitted through the HDT process and 37% via the HO process, whereas 91% of females were hospitalised under the HDT procedure and only 8% under the HO procedure. Fifty percent of the persons hospitalised involuntarily suffered from ICD 10 Category F2 ("schizophrenia and delirium"), followed by F1 "substance-related disorders" (12.6%), F3 "mood disorders" (12.5%) and "personality and behavioural disorders" (10.5%); mental retardation represented only 3% of involuntary hospitalisations, and physical disorders, 2.4%.

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Germany

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Legal Framework

In Germany, the involuntary placement or treatment of mentally ill patients is regulated on the level of the Federal States. Thus, sixteen different commitment laws (or public laws) are in effect after the entry of the so-called five "new" Federal States of the former German Democratic Republic (Brandenburg, Mecklenburg-Western Pomerania, Saxony, Saxony-Anhalt, Thuringia). In addition to the public Federal legislation, a nationwide guardianship law (or civil law) also regulates the detention of mentally ill persons under certain circumstances. This puts Germany in a rather unique position among the European Union Member States and causes some problems in describing regulations for involuntary placement or treatment of mentally ill at a national level.

Compulsory admission under State commitment law may be invoked in the case of a public or personal threat that has to be directly caused by a mental disorder of a person. Procedures or criteria are stipulated by the Statel mental health acts, which vary remarkably in minor or major details.
The nationwide guardianship tries to guarantee the appropriate medical care of persons whose handicap or illness exempts them from caring for themselves. Thus, regarding the involuntary placement of mentally ill persons, statutes of the guardianship law are applied mainly in the case of self-destructive behaviour of a mentally ill person.

According to their narrow detention criteria (dangerous or self-destructive behaviour), State laws are seen as emphasising the patients' rights more than the National guardianship law. Focussing not so much on the personal or public threat by mentally ill persons, the guardianship law, on the other hand, is considered as less stigmatising. The frequency of compulsory admission under State commitment laws or national guardianship law is more or less the same. However, in daily routine, even among experts there is no common opinion as to which law to favour for application. Cases might even start under the scope of the State commitment law and change to national guardianship law when ongoing and vice versa.

History

Any restriction of freedom is governed most basically by the German Constitution, issuing in article 2: "...the liberty or freedom of a person is inviolable" as well as in article 104 :"...a person's liberty can only be restricted by formal statute. Appropriateness and duration of restriction can only be decided by a

judge.“ Of course, these constitutional rights apply also to mentally ill patients. Hence in 1949, when the Federal Republic of Germany was founded, the State legal frameworks for regulating procedures and responsibilities for involuntary placement or treatment of mentally ill were passed alongside the German Constitution.

The statutes of the first generation of State acts kept many features of the Prussian police legislation of the 18th and 19th centuries, as they considered protecting the public from harm caused by mentally ill people to be a primary objective for detaining a person.
A second generation of State mental health laws, which have taken effect from 1969 onwards, placed much more emphasis upon the needs and rights of patients for adequate treatment or care.
After the re-unification of Germany, an improved nationwide guardianship law was passed in 1992, which inspired or shaped the third generation of State commitment laws in effect today. By adopting the basic philosophy of the national guardianship law, the Federal States adjusted their legal frameworks by placing a much stronger emphasis on the constitutional and basic human rights or safeguards of mentally ill patients as well as on the principles of community-based mental health care. Procedures also were harmonised, though they still differing in many and sometimes crucial details. Below, the third generation of State commitment laws is detailed.

Basic philosophy

Federal commitment laws usually have a broader scope than merely regulating detention procedures. Their basic philosophy emphasises human rights aspects as well as the self-determination of mentally ill patients and demands appropriate mental health care delivery in the least restrictive setting possible. Thus, community mental health care as provided by multi-disciplinary teams or social psychiatric services are most recommended for preventing involuntary placements or reducing their length of stay. Nevertheless, despite all emphasis on need or right for treatment, the threaten of harm to or by a mentally ill person marks clearly the crucial condition for placing him or her involuntarily.

All State commitment laws underline the right of involuntarily placed persons to adequate treatment. But the Acts tend to distinguish involuntary treatment from involuntary placement as two distinct modalities. While assuming that a mentally ill patient’s capacity to decide about his freedom might be fundamentally affected, federal laws basically require the consent of an involuntary placed patient to treat his underlying mental disorder. This sublime contradictory stipulation is supported by a decision of the National Constitutional Court of Germany, confirming an overall “right to be ill” and exempting society at large from being responsible for improving the condition of citizens by infringing upon their personal freedom. This has generated a variety of regulations or statutes across the Federal States, in an attempt to clarify or detail procedures for treating the mentally ill against their will.
Some State Acts permit coercive treatments in life-threatening cases of emergency; others restrict this only to cases in which the life of another person might be in acute danger. Still others require the

immediate notification of a lawyer or a court in the event of application of any coercive intervention. There are controversial positions even within Federal States, as is the case with Baden-Wuerttemberg, where according to the State commitment law any compulsorily admitted patient has to tolerate psychiatric treatment interventions, although the Higher Regional Court of the City of Stuttgart (the Capital of Baden-Wuerttemberg) has decided that treatment interventions may not be forced against the will of a person concerned.

Although any application of potentially life- or health-threatening treatments has to be approved by means of a court decision, there is an ongoing controversial debate, as to which interventions (e.g. electro-convulsive treatment, psycho-pharmaceutical treatment) have to be considered as life- or health-threatening and therefore specified at a legal level.
Other non-treatment related coercive measures during involuntary placements, such as mechanical restraint or separation of persons, are usually regulated in detail by State acts, including the responsibility for decision-making or reporting duties.

Application, assessment and decision

In Germany, the involuntary placement of a person must be always the object of an order by a court or a judge. The State commitment laws clearly define that only local authorities are allowed to apply for an involuntary placement order. Under the nationwide guardianship law, the guardian of a person concerned is the only one entitled to apply.
Once the application is made, a physician has to confirm the criteria by means of a medical assessment. Most State laws require that these assessments be made by trained psychiatrists, whereas in some Federal States, medical examinations can be conducted by physicians who are not necessarily trained in mental health care. On the basis of the expert's testimony, a judge issues a compulsory admission order. Judges are free in their decision, which in principle can differ from the expert testimony.

Besides the routine procedure, emergency procedures allow the detention of a mentally ill person for a defined period of time (which differs from 24 hours to 72 hours depending on the Federal State), after which at the latest an expert testimony has to be certified by a physician or psychiatrist. As in the routine procedure, a judge rules immediately afterwards.
A compulsory admission order by a judge usually covers six weeks. Legally defined are maximum periods of time of one or even two years, depending on the Federal State.
Co-operation of all persons or authorities involved in the compulsory admission procedures (police, courts, authorities, psychiatrists or mental health facilities) is reported as being usually good.

Criteria

Neither civil nor public laws define mental disorder as narrow concepts. Thus, almost all major psychiatric diagnoses as classified by ICD-10 are covered, including personality disorders or mental and behavioural disorders due to psychoactive substance use. However, some State Acts limit compulsory admissions to severe conditions "equivalent to psychosis".

Practice

In Germany, special accredited psychiatric hospitals or the psychiatric departments of general hospitals are usually designated for the involuntary placement or treatment of mentally ill patients. In a few cases, patients might be compulsorily admitted to nursing homes, though. Involuntarily placed patients are not separated from voluntary patients. Whether or not common wards are open or closed depends on various local circumstances. Although both options are possible in principle, an open ward policy is generally preferred, indicating a rather liberal philosophy in routine care.

Although many regions in Germany provide good standards of community-based mental health care, and there is statutory stipulation of the least restrictive settings for involuntary regimes as well, State Acts do not mention any option of compulsory outpatient treatment. However, aftercare after involuntary inpatient episodes is suggested in most of the State commitment laws, and the role of the social psychiatric services is emphasised in this process. In some Federal States patients are referred automatically to community services upon discharge from involuntary inpatient stays. Moreover, four State commitment laws stipulate a referral without the patients' consent, even when the involuntary status does not prevail after discharge. Commitment laws of fifteen Federal States explicitly permit the interruption of involuntary episodes for defined periods and certain purposes, including vacation.

Patients' rights

From a legal as well as a procedural point of view, patients' rights in Germany are safeguarded in many ways.

- Continuous reforms of mental health acts have increasingly emphasised basic human and legal rights.
- The basic distinction between involuntary placement and treatment, requiring the patients' consent for most therapeutic interventions, strengthen the autonomy of the persons concerned, although this might limit their chances for adequate treatment.
- The independent decision by a court or a judge guarantees compliance with the most basic democratic principles during all stages of the procedure.
- Patients have the right to appeal to courts at any stage of the procedure. Patients have to be heard. Patients' advocates are approved during all stages.
- Control commissions supervise quality standards at various levels (procedures, facilities, treatments etc.)
- Coercive measures have to be strictly recorded.

Epidemiology

Varying legal standards yield heterogeneous outcomes across the sixteen German Federal States in terms of compulsory admission rates or quotas. Unfortunately, regular health reporting in Germany does not cover annual frequencies of involuntary placement or treatment of the mentally ill. Applications for compulsory admissions are recorded by the Department of Justice, however. It is estimated that approximately 90% of all applications result in legally ordered involuntary placements. Thus, results from this study, relying on data provided by the Department of Justice, suggest that compulsory admission quotas have remained more or less stable due to a general increase in psychiatric inpatient episodes (see chap. 4), although several studies have reported a remarkable increase in the total numbers of compulsory admissions of mentally ill people in Germany during the last ten years (Spengler 1994, Crefeld 1997, Darsow-Schütte et al. 2001).

Conclusion

Among the rather unique organisational and legal variety across the German Federal States, it is hard to decide which approach might be most appropriate for regulating the involuntary placement or treatment of mentally ill persons. In a way, the German situation reflects the heterogeneity at the European Union level. Nevertheless, an overall tendency to emphasise civil rights is probably the most common characteristic of legal mental health frameworks in Germany.

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Greece

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Legislation

The first Greek law regarding the hospitalisation of mentally ill patients dates back to 1862 and was entitled „Establishment of Mental Hospitals“. This law considered patients' rights, safeguarded patients' liberties and specifically made it illegal to keep patients in police stations. It did not mention compulsory admission, and patients, although frequently kept against their will, were considered “informal“. For the patient's discharge a certificate signed by the doctor in charge was issued stating that the patient was „cured“. The asylums also established the practice of „discharge to the care of relatives“ as a prerequisite for a patient's discharge; obviously this put the patient at the discretion of his or her relatives, who, by refusing to accept him/her back, prolonged indefinitely the duration of hospitalisation.

This law remained in force with various additions, modifications and alterations until 1973. Subsequently, it was replaced by Law 104/73 („About Mental Health and Treatment of the Mentally Ill“). This law explicitly mentions compulsory admission, although it does not distinguish between compulsory admission and compulsory treatment. As in the previous law, the procedure for compulsory admission could be initiated by anybody by means of an application to the Public Prosecutor. However, in cases of emergency (and this, in practice, meant in almost all cases) the patient could be taken to a psychiatric hospital without an order by the Public Prosecutor. This could be done with a simple medical certificate or even with a simple certificate by the police or the local mayor. After admission, the responsible medical officer (psychiatrist in charge) sent a report explaining the need for discharge or, alternatively, the need for continuing hospitalisation. The duration of compulsory admission could not exceed six (6) months, though it could be increased if the psychiatrist in charge requested it.

This law was further modified in 1978 by means of a ministerial decree that stated that involuntary admission could be requested by a relative by means of an application to the psychiatrist head of a psychiatric clinic. The psychiatrist or his nominated deputy should then visit the patient at home with a second psychiatrist and decide whether involuntary admission would „improve the patient's health“ or „avoid deterioration“. If the two psychiatrists agreed, then they should complete a form explaining their decision and send it to the Public Prosecutor, who then should order the Police to take the patient from his abode to the hospital. The patient or a relative could appeal against this decision to the Public Prosecutor, who then would set up a panel chaired by the Professor of Psychiatry. This law was obviously much more restrictive of the patient's liberties and reserved a very decisive role for the psychiatrist. The developments in Forensic Psychiatry in Europe and well-publicised problems, which highlighted the curtailment of personal freedom, made imperative a change in legislation. This need was further

reinforced by the promotion of programs provided in the EEC regulation 815/1984 for „vocational training and social rehabilitation of persons suffering from mental disorders". Within the scope of this regulation, a committee authorised to deal with the reform of the Greek legislation on the involuntary hospitalisation of the mentally ill was established. The committee elaborated a text, which after legal processing has become the valid Law 2071/92 on mental health.

Currently mental health in Greece is regulated by the General Health Law 2071/92 entitled „Modernisation and Organisation of the Health System" (158 articles, 45 pages), and by the Law 2716/1999 entitled „ Development and Modernisation of Mental Health Services". The sixth of the nine chapters of law 2071/92 is devoted to mental health and of this chapter, articles 94-100 (two and a half pages) refer to involuntary hospitalisation and treatment.

Major changes in practical procedures determined by recent reforms:

The new legislative regulation of involuntary hospitalisation requires a reliable diagnosis of a severe mental disorder, takes into account the patient's need for treatment and his/hers dangerousness whilst trying to maintain the patient's personal rights and respect of his/her personal freedom.

The basic points of the law, as they result from the text and the explanatory instruction of the 504/1996 interpretative circular of the General Attorney of the Supreme Court of Appeal, are as follows:

One of the following requirements must be met before a patient can be involuntarily admitted:

1. The individual must suffer from a mental disorder, not be in a position to judge what is best for his/her health, and lack of hospitalisation will deprive him/her of the treatment for his/her condition.
2. The hospitalisation of a patient suffering from mental disorder is necessary in order to prevent acts of violence against himself or others.

The new legislation, for the first time, involved directly lawyers and the court system, which up until then were not an integral part of the service. At the beginning of the implementation this created some misunderstandings about the correct procedure, as lawyers and psychiatrists differed in their understanding of the law. This resulted in Public Prosecutors implementing the law, as they understood it, to fit within their area of responsibility. This created the need for further clarification that was attempted with the already mentioned circular 504 that was issued in 1996.

The major changes can be summarised as follows:

- Only someone closely related to the patient, the caretaker, and a judicially appointed guardian can apply to the public prosecutor for compulsory admission of the patient. If these persons do not exist or cannot be found, as can happen in cases of emergency, only the Public Prosecutor can ask for assessment for involuntary hospitalisation. A third party cannot request this procedure as provided by the previous law.

- The Public Prosecutor orders the patient's transfer to a public psychiatric hospital for drawing up the required written opinions of two psychiatrists. The patient's stay in the unit for the assessment is for no more than 48 hours, something that was not specified by the previous law and which had led to prolonged admissions.

Procedure

The application for psychiatric assessment to the Public Prosecutor (of the patient's place of residence) is brought in by the spouse, or by someone closely related to the patient, i.e. father, son, grandfather, grandson etc. or by someone collaterally related up to the third degree, i.e. brother, cousin, or by a judicially appointed guardian. If these individuals do not exist or in cases of emergency, the Public Prosecutor of the court of the place where the individual to be assessed lives, can ask for assessment.

If the examination is feasible, the petition is accompanied by the written opinions of two psychiatrists or by those of one psychiatrist and one physician in areas where there is no second psychiatrist available. The Medical Council appoints the psychiatrists and the other doctors for a period of two years. The doctors should not be related to the patient. If the two opinions differ, the Public Prosecutor can order the admission of the individual for assessment to a public Mental Health Unit or bring the case to court hearing. This procedure was originally applied in some cases, but as years went by it became more and more rare. Recently there is no record of a formal admission according to this procedure. Instead, the emergency procedure is the one used daily as standard.

Emergency procedure

The Public Prosecutor orders the patient's removal to a public Mental Health Unit for drawing up the psychiatric opinions. The medical certificate should mention any symptoms of illness, any previous acts of violence, previous psychiatric hospitalisations, reasons why outpatient treatment is not feasible. and should conclude with the most likely diagnosis. Provided that the two psychiatric opinions agree on the need for involuntary admission, the Public Prosecutor orders the patient's admission to a suitable Mental Health Unit. If they differ, the Prosecutor follows the procedure already mentioned. As soon as the patient is taken to the hospital he/she is informed of his/her right to appeal. A record of the proceedings is drawn up and signed by the doctor or nurse or social worker who has informed the patient.

Further procedure

Within three days of the patient's formal admission, the same Public Prosecutor brings the case before the court, which sits within ten days and decides on the involuntary hospitalisation. Two days before the hearing, the patient is invited to attend and he/she has the right to appear with the aid of a lawyer and a psychiatrist of his/her choice. If the application for involuntary hospitalisation is not accepted, the patient is immediately discharged.

Two months after the court decision for involuntary admission, the patient or the responsible medical officer (who is usually the psychiatrist in charge of the unit to which the patient is admitted) may appeal to the court. The Court of Appeal judges within 15 days of submission. The court is entitled to ask for an independent psychiatric report or anything else considered useful to the court.
The patient, a relative or a guardian can apply for cessation of the involuntary hospitalisation. The Public Prosecutor is obliged to bring the application straightaway to the court. If the application is not accepted, a new one can be lodged after three months.

Major disadvantages of current legislation

The law is bureaucratic with a lot of paperwork involved. Sometimes this cumbersome procedure is not fully observed, leading the hospital staff to allegations of neglect. Also, the articles concerning aftercare and care in the community are often not implemented in practice due to a scarcity of proper funding and a lack of commitment on the part of the State to create a full network of these services.
The possibility that a psychiatrist might be legally prosecuted for an „unnecessary admission" and deprivation of the patient's personal freedom can give rise to „defensive medicine". This opens a window for malpractice if, in order to avoid legal prosecution for unlawful detention, the psychiatrist decides not to admit the patient although admission would be beneficial for the patient.

Advantages of current legislation

Overall, the changes introduced by the new legislation were mostly welcome. Compared to the previous legislation it pays more attention to the patient's wishes and individual freedom. It is now impossible to detain anyone against their will without a court order. This ended practices that gave rise to great concern regarding civil liberties. On the basis of the new law the Courts are obliged to review their cases at regular intervals. The patient also maintains his personal rights and can communicate with relatives or friends, participate in ward activities and is not kept separately from mentally ill patients admitted voluntarily. If his/her condition allows it, the patient can go out of the unit to organised activities and is allowed unsupervised home visits.

Neglected populations

As mentioned already, the law emphasises the need for the nearest relative to approach the system requesting involuntary hospitalisation. Understandably, the people that „slip easier through the net" are the ones with no relatives. When the law took effect in 1992, Greece was a fairly homogeneous country with no visible minorities apart from the Roma population (gypsies) and the Muslim population in Western Thrace, who were, however, Greek citizens. Since 1992, major changes have taken effect in the Balkans and Greece now has visible minorities, not only from the neighbouring countries but also from Africa and Asia. These individuals are on many occasions unsupported and isolated and have, despite some efforts

by non-governmental organisations, poor access to healthcare. From the mental health point of view, some individuals with life-threatening psychiatric problems, i.e. chronic IV drug users and alcoholics, do not fit well within the legislation and cannot be admitted against their will. The same stands for people with dementias who are not violent towards themselves or others and who might benefit from hospitalisation, as well as for some patients with chronic, non-florid schizophrenia for whom admission and medication would be expected to improve their quality of life.

Practice

Legislation for compulsory admission and involuntary treatment in Greece is used only as the „last port of call". The procedure involving the nearest relative's application for compulsory admission is complicated and imposes a serious responsibility upon the caregivers, who sometimes are unwilling to ask for it, fearing that the patient will hold it against them for the rest of his/her life. Clinical experience unfortunately proves that in some cases this holds true.

The duration of time that elapses between the submission of the application until the patient is assessed by the psychiatrists varies from less than a day to two weeks and in some rare cases is even longer, despite the law stating that the assessment should take place within 48 hours. This happens because the police do not consider bringing the patient for assessment as a high priority among their duties.

Despite the legislation requesting two opinions before applying for involuntary hospitalisation and treatment, the practice has always been the one already described under the heading „Emergency procedure". The Public Prosecutor's order is taken by the nearest relative to the police station which than organises a home visit and the transfer to the hospital for psychiatric assessment. This leads to the patient being taken from his home to one psychiatric hospital under police escort and after the assessment is complete, to be removed again with an ambulance escorted by a police car to another hospital, where a bed is made available.

Collaboration between police, courts and mental health experts

As already mentioned, the liaison between the public prosecutor and the police is established by the relative who requests the assessment. The court system, once the admission is completed, seems to be operating smoothly and the patient is informed that he/she is due to appear in court at least two days before the set date. Psychiatric reports are requested on time. However, there appears to be some time lag for the information to travel between the hospital and the court following the patient's discharge.

Police (role and competence)

The police consider the task of dealing with compulsory admissions and psychiatric patients as erroneous and not high on their list of priorities. They do not consider themselves to be sufficient in this area, but their behaviour is usually understanding, and reassuring to the patient.

Quality of supervision and/or aftercare of discharged patients

One of the problems with the current law is that it does not provide an adequate framework for aftercare. The patient discharged after an involuntary admission does not have any supervision unless he/she is referred to a day hospital or a day centre. Day hospital places, however, are very few and such is also the case with day centres. Thus, the network of support for the patients is not adequate. Fortunately, in Greece, the family is still functional and thus it provides support and protection to its weak members. Aftercare relies heavily on the family and on the relationship the psychiatrist would have formed with his/her patient, and of course on the degree of clinical improvement and insight.

Application of least restrictive alternatives before coercive measures

Involuntary admission is requested only when the patient is seriously ill and refuses medication. All other available options are taken into consideration, although, unfortunately, as mentioned earlier, options like a day hospital or a day centre are not widely available. If the patient accepts medication and attends a few days, it is the usual practice not to proceed with the involuntary admission.

Patients' rights

The current legislation for involuntary admission secures to a great extent the patients' fundamental rights and respects their dignity. Involuntary admission can be requested from the Public Prosecutor only by close relatives.

One can be admitted and treated involuntarily only when he/she suffers from a severe psychiatric disorder, this disorder makes the patient unable to look after his/her own well being, and (or) treatment is expected to improve his/her condition and reverse the deterioration of his/her mental health. („Parens partiae" approach). The other reason for allowing involuntary admission is to protect the general public from potentially dangerous patients and prevent violent acts of the patient towards others or himself („Police power" approach).

The decision for involuntary treatment is always taken by the Court. The Court gathering is not open to the public in order to respect the patient's dignity, and the patient is invited to attend. The patient can also have legal representation and an independent psychiatrist as a technical advisor to support his/her case. The patient can appeal against the court decision. Immediately after the admission, the patient has to be informed in writing about his/her rights and the right to appeal. Effort is taken to prevent renaming the involuntary admission to voluntary. For this, a written report by another independent psychiatrist stating that the patient is able to judge what is best for his/her health is requested. A copy of this report is sent to the Public Prosecutor.

The patient receives the same level of care as informal patients and is treated according to the same rules. The patient maintains the right to communicate with authorities or individuals, and to send and

receive mail without censorship. His/her ability for transactions is not considered impaired but the court can take measures to prevent squandering of the patient's assets.
Involuntary admission is for a defined maximum period and can be discontinued at any time by means of a court decision or a decision by the responsible medical officer.

Epidemiology

Data on involuntary admission are kept in the Public Prosecutor's office. It is our understanding that this information is not pulled together and, to our knowledge, there is no central bureau to gather this type of data. As a result we do not have information for the whole of Greece. The only information available comes from the hospitals in which the assessment for involuntary admission takes place.
For research purposes, data on all assessments that took place at Eginition University Hospital were kept for the years 1979 up until 1986 and for the year 1991 and years 1997 and 1998. The data kept included:
Date of assessment, time that elapsed between the application for involuntary assessment and the assessment itself, place of birth of the individual assessed, place of residence of the person assessed, family status, years of education, relation of the person who applied for assessment to the individual assessed, whether the person for assessment was escorted by a relative or friend (informant), past psychiatric history, years of psychiatric illness, history of past hospitalisations, number of previous involuntary admissions, previous drug treatment, time between when the individual assessed has stopped taking medication and assessment, reason for assessment, diagnosis and outcome.

Bearing in mind that the data presented do not represent Greece but the County of Athens (Attica), the following main observations were made:

1. Overall, there is no substantial increase in the number of assessments before and after implementation of the new legislation (about 650 per year).
2. In the eight-year period, 69.4% of all individuals assessed were male and 30.6% female. In the year 1997, 63.8% of the individuals assessed were male and in the following year 65.1%.
3. Although the majority of individuals were not born in Attica (59%), most individuals lived in Attica (Athens and the suburbs) (91%).
4. Age of the assessed individuals varied from 9 to 94, the majority being between the ages 25-35 (43%).
5. More than a quarter of the individual assessed were unemployed (29%).
6. With regard to family status: 56.3% were single, 13.2% separated/divorced and 18% were living alone.
7. The majority of applicants for involuntary treatment were members of the family (84.3%), especially parents (44%), and spouse (21.5%). Public Prosecutors requested the assessment in 1.1% of the cases, whilst the police, before the new legislation, requested the assessment in 4.8% of the cases (during the years 1979-1986). Under the new Law, the police have no right to request commitment.

8. The majority of cases (86.7%) had a previous psychiatric history and 69.1% had been hospitalised in the past. A substantial minority (16%) had more than five hospitalisations before the assessment.
9. Previous involuntary hospitalisation was reported in 15% of all cases.
10. At the time of examination 42% had never received drug treatment. 44.5% had stopped taking medication. 6.8% received some medication but not regularly and only 6.8 % were receiving their medication as prescribed by their psychiatrist.
11. The main reasons for assessment were: Aggressive behaviour: 37.5%, delusional behaviour: 37.3%, substance use disorders: 7.1%, self-destructive behaviour: 2.5%.
12. From all the assessed cases 75.6% were admitted involuntarily, 5.8% were asked to be examined again and 9.1% were given treatment and outpatient appointment.
13. From the involuntarily hospitalised patients 42.4% had dangerousness as the main reason for admission.
14. Half of all involuntarily admitted patients were taken to state psychiatric hospitals and half were admitted in private psychiatric clinics.

Overall, these epidemiological data from the University of Athens provide evidence that:

- The percentage of involuntarily committed patients remains high.
- Most of the committed patients were psychotic.
- A considerable proportion of patients (42.4%) had as the main reason for admission their dangerousness to others.
- The majority of the cases had a previous psychiatric history and most had been hospitalised in the past, indicating that for most of them there was no appropriate follow-up.
- A high proportion relapsed after stopping their psychiatric medication. Even irregular drug taking provides a remarkable protection against a relapse that leads to involuntary hospitalisation.
- After discharge from hospital, many patients fail their outpatient appointments and are not followed up in psychiatric services or support programs. This underlines the need for better and more proactive secondary psychiatric prevention.

Concluding remarks

The current legislation regarding compulsory admission and treatment of the mentally ill patients in Greece (law 2071/92), was introduced in 1992.

The patient is admitted only if he/she is suffering from a severe mental disorder, imposing danger to him/herself or others, or is in need of treatment but due to the illness he/she is unable to acknowledge this need. The legislation secures the patient's personal rights and respects his personal freedom. The decision for compulsory admission is taken by the court. Admission can be requested only by close relatives, the caretakers, a judicially appointed guardian, or by the public prosecutor. The admitted patient

has the right to appeal with a relatively simple procedure. Involuntary hospitalisation is for a limited period of time and is regularly reviewed.

A high percentage of committed patients have a long history of hospitalisations. We believe that a substantial proportion of involuntary admissions could be prevented if appropriate aftercare were available coupled with education of the carers for prodromal signs of relapse.

The law places great emphasis on the patient's rights and involves the judiciary system in the decision-making concerning involuntary admission. Protection of the patient's rights is undoubtedly of cardinal importance. A word of caution is, however, necessary. The emphasis on patients' rights may give rise to psychiatrists being prosecuted for "unlawful detention" (i.e. unnecessary admission). This, in turn, can give rise to "defensive psychiatry" and malpractice. The Law does not state but in some way implies that the psychiatrist is likely to abuse his/her powers. The psychiatrist's dedication to his patients and his ethical values are not taken into account. Thus the Law may weaken the therapeutic alliance between the psychiatrist and his/her patient.

Law 2071/92 represents an improvement over the previous law with respect to involuntary admission. Bearing in mind the experience from its application, we believe that a substantial revision is due so that it can place more emphasis on aftercare, be less bureaucratic and base its philosophy on the sensitive equilibrium between the protection of the rights of patients on the one hand and the preservation of the therapeutic alliance on the other.

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Ireland

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Introduction

With the passage of the Act of Union in 1800, Ireland became part of the United Kingdom of Great Britain and Ireland and ceased to have an independent parliament. The country of Ireland was administered by a Lord Lieutenant and his administration on behalf of, and subject to, the Westminster Parliament. Accordingly, mental health legislation, although applying exclusively to Ireland, was very heavily influenced in philosophy and in practical application by the statutes elsewhere in the United Kingdom.

Legislation of 1812, 1821, 1846 and 1875 set out the provisions to be put in place for the care of 'pauper lunatics' and the setting up and regulation of private 'madhouses'. This early legislation enabled, rather than obliged, local authorities to establish lunatic asylums throughout the country. In these early years, the compulsory admission and detention of lunatics in district lunatic asylums was a function of the local judicial authority, and the quality of care provided in the institutions was subject to the regulatory and statutory role of the Inspectorate of Lunacy, an office established in 1846. It was the legal responsibility of the Inspector to furnish a detailed and comprehensive report on the inspection of lunatic asylums to the Lord Lieutenant on an annual basis. The Inspector was obliged under law to inspect each public establishment at least once a year and each private establishment at least twice a year.

The distinction between private and public patients with regard to lunacy care was established from the beginning with the clear understanding that private individuals or their relatives were responsible for paying in full for their care and maintenance in private asylums, whereas the public individual without means was a charge to local finances.

The comprehensive legislation governing admission to and care in lunatic asylums was the Lunacy Act of 1875, which continued to cater for an expanded network of lunatic asylums throughout the nineteenth century and into the following one. With the foundation of a separate Irish Free State in 1921, British administration in the southern twenty-six counties of Ireland ceased and the mental hospitals system, as it had now become, was administered by the Irish Government from Dublin. Nonetheless, the provisions of the 1875 Act continued to operate until the putting in place of the Mental Treatment Act 1945. This new legislation, while still influenced substantially by the 1875 Act, was innovative in a number of areas, not least in establishing a category of voluntary admission to mental hospitals, which hitherto had been exclusively compulsory. A Mental Health Act in 1981 was signed into law but was found to be inoperable in practice and so never came into usage.

The present situation

As of June 2001, the legislation in force in Irish psychiatric care is that of the Mental Treatment Act 1945 as amended (there have been several amendments to this legislation over the years). However, as of the end of June 2001, a new Act, the Mental Health Act 2001, passed all the necessary procedural processes in both houses of the Irish Parliament, the Dail and the Seanad, and was signed into law by the President of Ireland in August 2001. The information given in this chapter relates exclusively to the new legislation, the Mental Health Bill 1999, even though the 1945 Act will continue to operate in practice until such time as new structures necessary for the operation of the 2001 Act come into being. It is expected that the new legislation will be operating in full towards the end of 2002.

The new legislation – the Mental Health Act 2001

The new legislation will balance individual civil liberties and the rights of the individual with the necessity for ensuring the right to treatment when necessary and the safety of individual members of the community. In doing so, it takes account of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and the United Nations Principles for the Protection of Persons with Mental Illness (1981). It ensures, through the setting up of a Mental Health Commission and, within the Commission, of Mental Health Review Tribunals, an automatic and independent view of every admission order of persons involuntarily admitted to psychiatric centres and of the extension of any admission orders which may follow the initial admission order after a period of three months. The new legislation abolishes the distinction in admission procedures and rights between public and private patients which endured from the nineteenth century into the Mental Treatment Act 1945.

From its inception, mental health legislation in this country has been separate from general health legislation and although, during the debate which preceded the formalisation of the new legislation, a minority view questioned the necessity for separate mental health legislation, the majority view was that such separation was necessary.

The scope of the new legislation

The new legislation is described as, 'an Act to provide for the involuntary admission to approved centres of persons suffering from mental disorders, to provide for the independent review of the involuntary admission of such persons and, for those purposes, to provide for the establishment of a Mental Health Commission and the appointment of Mental Health Commission Tribunals and an Inspector of Mental Health Services… and to provide for related matters'.

It can thus be seen that the main thrust of the legislation is two-fold. First, to regulate the detention process and open it automatically to legal and clinical scrutiny in all cases. Second, through the Inspectorate of Mental Health Services, to ensure a high quality of service delivery.

Definitions

The Act has as its target persons suffering from mental dsorder. 'Mental disorder' means mental illness, severe dementia or significant mental handicap where, because of the disorder, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons; or, because of the disorder, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission.

'Mental illness' is very broadly defined as a state of mind affecting an individual's thinking, feeling, emotion or judgement to the extent that the individual is perceived as needing care or treatment in his or her own interest or in the interest of other persons.

'Severe dementia' means a deterioration significantly impairing intellectual function and affecting thought, comprehension and memory, and leading as a consequence to severe psychiatric or behavioural symptoms such as physical aggression.

'Significant mental handicap' means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social function and abnormally aggressive or seriously irresponsible conduct on the part of the person.

A specific exclusion clause ensures that nothing in the Act will authorise the involuntary admission of a person to an approved centre by reason only of the fact that the person

(a) suffers from a personality disorder,
(b) is a social deviant, or
(c) is addicted to drugs or intoxicants.

A 'mental health centre' means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. A centre has to be registered and approved by the Mental Health Commission before it may receive detained patients. In practice, a mental health centre may mean a psychiatric hospital, a psychiatric unit in a general hospital, or a hostel based in a community setting. Centres will be specialised and designated for the treatment of mental illness, and equivalently for severe dementia and significant mental handicap. Under ordinary circumstances, it is not anticipated that there will be cross-reference between these centres; each will be a specialist centre, whether for mental illness, dementia or mental handicap.

The regulatory body – the Mental Health Commission

The Mental Health Commission will be autonomous and independent of any government body, with the exception that its membership will be approved by the Minister following nomination by appropriate

bodies and the Minister will nominate the chairperson from among its members. The representative bodies include those of psychiatry, psychology, social work, nursing, medical practice and the law. A representative of the general public and a representative of voluntary bodies promoting the interests of persons suffering from mental illness will also be included.

The Commission shall appoint an individual, who must be a psychiatrist, as the Inspector of Mental Health Services, and such other number of Assistant Inspectors, (who need not necessarily be psychiatrists) as the Commission feels appropriate. The function of the Inspector will be to visit and inspect every centre, to carry out a review of mental health services and to furnish a report to the Commission on the quality of care and treatment given to persons in receipt of mental health services, as well as other subsidiary functions. In effect, the Commission will exercise a power in relation to such centres as may not meet appropriate criteria to be laid down by the Commission in relation to the quality of service delivered and, in the case of such centres, may revoke their authorisation to receive patients.

Procedures leading to involuntary detention

There are three components to the procedure leading to the legal making of a admission order conferring power on the centre to receive and detain a person involuntarily.

The first of these is an application to a registered medical practitioner for a recommendation that the person so received be admitted. This application may be made by the spouse or a relative of the person or, subject to certain provisions, when a spouse is unavailable, by any other person. Particular categories of persons, such as an estranged spouse or a person on the staff of the centre concerned, are specifically disqualified from making such an application. The person making an application must have 'observed the subject of the application not more than 48 hours before the date of making the application'.

The second requirement in the making of an admission order is the recommendation for an involuntary admission given by a registered medical practitioner to whom an application has been made. The recommendation must state that the practitioner is satisfied, following an examination of the subject of the application, that the person is suffering from a mental disorder and that he or she be involuntarily admitted to a specified approved centre. This examination must be carried out within 24 hours of receipt of the application. The medical practitioner must inform the subject of the application of the purpose of the examination. The recommendation, once made, will remain in force for a period of seven days, after which time it will expire. If the medical practitioner is not satisfied that the person is suffering from a mental disorder, he or she will refuse the application.

In certain circumstances where a member of the police force (the Garda Síochana) has reasonable grounds for believing that a person is suffering from a mental disorder and that there is a serious likelihood of that person causing immediate and serious harm to himself or herself or to others, the Garda may take the person into custody and, if necessary, enter any premises by force where he or she has reasonable grounds for believing that the person is to be found therein. Following taking a person into custody, the Garda must then make an application to a medical practitioner for the examination of the individual and a decision as to whether or not a medical recommendation should be made that the person be conveyed to an approved centre.

It is the responsibility of the applicant to convey the person to the specified centre. If the applicant is unable to do so, then he or she may request the assistance of the centre and, if the centre finds itself unable to comply, then the applicant can request the police to so convey the person.

Once arrived at the centre, the third and final component of the admission order comes into being. This details that a consultant psychiatrist on the staff of the centre shall, 'as soon as may be', carry out an examination of the patient and, if he or she is satisfied that the person is suffering from a mental disorder, shall make the involuntary admission order which legally entitles the centre to receive and detain the individual; if the psychiatrist is not so satisfied, he or she shall refuse to make such an order. The admission order shall allow the person to be detained for 21 days from the date of the making of the order and shall then expire.

Conversion of a voluntary patient to involuntary status

Where a voluntary patient decides to leave an approved centre and a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the centre is of the opinion that the patient is mentally unwell to the extent that it would be inappropriate that the individual should leave, the staff member may detain the person for a period not exceeding 24 hours, by which time the consultant psychiatrist responsible for the care and treatment of the person shall either discharge the person or arrange for him or her to be seen by another consultant psychiatrist. If, following such an examination, the second-mentioned consultant psychiatrist is satisfied that the person is suffering from a mental disorder, he or she will issue a statement in writing that he or she is of the opinion that the person should be detained in the approved centre. If not so satisfied, the psychiatrist will issue a statement that he or she is of the opinion that the person should not be detained and the person shall thereupon be discharged.

Safeguards

In all cases where a consultant psychiatrist makes an admission order, he or she must forward a copy of the order to the Mental Health Commission. The psychiatrist must also give notice of the making of the order to the patient in writing, informing the patient that he or she is entitled to legal representation, that he or she will be given a general description of the proposed treatment to be administered during the period of detention, that the order will be reviewed by a Mental Health Tribunal, and that he or she is entitled to appeal to the Circuit Court against the decision of a Mental Health Tribunal if he or she is the subject of a renewal order.

Following the expiry, after 21 days, of an admission order, the period of detention may be extended by the making of a renewal order by a psychiatrist, utilising the same procedures as outlined in the making of an admission order, which entitles the centre to detain the person for a further period of three months. As in the case of an admission order, each renewal order is subject to review by the Mental Health Review Tribunal.

Once the Commission receives either an admission order or a renewal order, it shall refer the matter to a Mental Health Tribunal, assign a legal representative to represent the patient concerned and direct a

psychiatrist from a panel of psychiatrists established by the Commission to examine the patient concerned, to interview the consultant psychiatrist responsible for the patient's treatment, to review the records relating to the patient, and to present a report of such examination to the Mental Health Tribunal within 14 days of receiving the request from the Commission.

The Mental Health Tribunals

Mental Health Tribunals shall be established by the Mental Health Commission and shall be chaired by a legal assessor appointed by the Commission, a psychiatrist who is unconnected with the centre to which the patient has been admitted and a representative of the general public. Upon receipt of the report from the psychiatrist appointed by the Commission to provide such a report, the Tribunal shall either confirm the admission or renewal order or revoke it. This decision must be made within 21 days of the date of the admission or renewal order.

Scope of the legislation

This legislation shall apply only to individuals aged 18 or over. The legislation applies nation wide and there are no regional or other variations.

Notwithstanding anything contained within the legislation, there are no obstructions to appeal to higher courts, such as an application for habeas corpus under appropriate legislation.

No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of the Mental Health Act unless by leave of the High Court, and such leave shall not be granted unless the Court is satisfied that there are reasonable grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care. This, under ordinary circumstances, safeguards the rights of those applying the Act unless, of course, it can be proved that such action was taken in bad faith or without reasonable care.

Consequences and implications of the new legislation

There is no doubt that the new legislation will provide greater civil safeguards to mentally ill patients, both in regard to compulsory admission and detention and to the quality of care offered in psychiatric services, although this latter is currently the subject of scrutiny on an annual basis, or more frequently, by the current Inspectorate of Mental Hospitals operating under the Mental Treatment Act 1945.

There are currently 26,000 admissions to psychiatric hospitals and units in this country and 10 per cent of these are involuntary. It is undoubtedly the case that the more rigid scrutiny of admission documentation by the examining psychiatrist on behalf of the Commission and by the Tribunals will improve the standards of clinical practice and record keeping, while at the same time ensuring that unnecessary involuntary admission does not occur. The involuntary hospitalisation rate of approximately 70 per 100,000 of population far exceeds that of neighbouring western European countries and its reduction will be a considerable improvement on the existing situation.

There has been some concern that the establishment of regional Mental Health Tribunals may be a difficult matter, given the expected difficulty in recruiting persons to serve on these Tribunals. There has been much discussion of the rather lengthy time, 21 days, between the making of an admission order and the decision by a Mental Health Tribunal on whether to confirm or revoke it. Originally, the Bill allowed for a period of 28 days but public opinion, as voiced in the media and in Parliament, has reduced this to 21 days. Even at this, there are many in government and voluntary agencies and from among the public who would like to see the period of 21 days further reduced. However, it is the view of the Department of Health and Children, the arm of government responsible for the legislation, that this would not be feasible for the reasons stated.

Difficulties may be anticipated in acquiring an applicant for the purposes of seeking a medical recommendation for an admission order in many circumstances, as many individuals, deemed by medical or social services to be in need of compulsory admission to hospital, may not have a relative. It has been a minority feeling that the necessity of having an applicant should be questioned, or that the applicant should be a medical practitioner who would make the application as well as giving the recommendation for an admission order.

The question of whether personality disorders should be specifically excluded by legislation was a controversial issue about which there was some debate in Parliament. As matters stand, the exclusion clause remains, with the stipulation that the Commission will be required to issue guidance on the definition of 'personality disorder' for the purposes of the Act.

It is not anticipated that the new legislation will have any major impact on matters such as the extent of the homeless mentally ill, the frequency of admission or re-admission or the restriction of rights of patients other than involuntary patients.

Review

The entire new legislation will be the subject of major review by both houses of the Irish Parliament, the Dail and the Seanad, five years after its introduction.

Italy

Mauro Carta

Legislation

In Italy, the matter of Involuntary Medical Treatment (IMT) is governed in accordance with Law 833/1978 (Establishment of the National Health Service, better known as the Health Reform text). This law confirms, underlines and extends the concepts introduced by Law 180/78 (also called the "Basaglia" law, named after the psychiatrist who was the law's most fervent supporter), and abrogates all laws enforced previously (law n.36/1904, Royal Decree n.615/909, Representative Decree n. 704/1916, Presidential Decree n.249/1961 and Law 431/1968) (1).

The laws enforced up until 1978 had been characterised by a conception of mental illness as an "alienation", thereby giving rise to the social banishment of the alienated: in this context, compulsory admission was authorised by the Judicial Authorities or by the Public Safety Authorities wherever mental illness had rendered the subject "a danger to himself or to others" or a source of "public scandal". The request for placement (exclusively of a compulsory nature) could be advanced by relatives, guardians and "any other person in the interest of the infirm and of society"; admission to a mental hospital was routinely dealt with by the Magistrate, on the basis of a medical certificate or, in urgent cases, by the local Public Safety official, again on the basis of a medical certificate. Internment in a Psychiatric Hospital implied a period of interdiction for the duration and consequent annotation on the subject's Criminal Records; indefinite internment was requested by the director of the Psychiatric Hospital following an observation period of no more than one month and was authorised by means of a decree issued by the Court, determining the legal incapacitation of the subject. It was only in 1968, in accordance with Law 431, that the possibility of a voluntary placement "for diagnosis and treatment, on authorisation of the physician on duty " was established for patients affected by psychic disorders.

Law 180/1978 had been issued in a radically changing social and political context and had been envisaged subsequent to the protests moved against traditional psychiatry; it viewed the institutionalisation of the mentally ill as one of the paradoxical causes of mental illness or the exacerbation of the latter. Law 180 was intended both to provide the basic principles for additional laws which would come into effect and was to have assumed a transitory nature. Indeed, psychiatry was finally to have been included on a definite basis within the far-reaching Health Reform elicited by law n. 833/1978 which established the National Health Service (currently enforced).

Law 180/78, as provided for by law 833/78, mainly refers to Involuntary Medical Treatments of a psychiatric nature; it does, however, include mention of several other cases in which IMT may be required (e.g. Infectious Diseases). With regard to the latter, however, no specific course is indicated as to

enforcement of the same, the professional figures involved, duration of treatments and structures to be referred to.

Art.33 of law 833/1978 was intended to guarantee the principles of the Italian Constitution regarding the freedom and inalienable rights of all subjects: it establishes that "all tests and treatments are voluntary" and that 'the health authorities may prescribe involuntary tests and treatments in respect of the dignity of a person and of his civil and political rights as guaranteed by the Constitution". Accordingly, the Involuntary Medical Treatments (IMT) are to be viewed as an exception, authorised by law and to be applied as an extreme solution to be adopted only once all other means of obtaining consent have been attempted; further attempts at obtaining the latter should also be undertaken throughout IMT (art.33, 5). A further guarantee of the right of freedom of the subject is imposed by the Legislator in underlining that IMT, albeit a coercive measure, in no way affects the "civil and political rights guaranteed by the Constitution"; such rights pertain also to "the free choice of a physician and place of treatment" (art.33, 2) and the patient's right "to communicate with whomever he may wish" (art.33, 7).

Article 34 of law 833/78 dictates that in the eventuality of prescription of IMT for the mentally ill, treatment "should take place in a hospital regime only in those cases where psychic conditions are such as to require urgent therapeutic intervention, if treatment is not consented to by the patient, and where circumstances do not allow the adopting of timely and adequate measures in an outpatient regime (art.34, 4). The latter conditions should be viewed as guidelines for the prescription of IMT and purposely do not take into account the aspect which, in the past, was seen as a fundamental motive for internment: the threat represented by the mentally ill subject, a reason which still today is accounted for in the legislation enforced in several countries. Moreover, the intention was to reduce the number of admissions for mental disorders by means of an accurate selection of cases in which no other alternative appears feasible (art.33, 6). In all other cases, the territorial outpatient facilities are called upon to provide not only for treatment, but also for diagnosis and prevention of psychiatric disorders by means of a network of facilities capable of ensuring an adequate therapeutic continuity (ibidem).

Article 35 of law 833/78 establishes the complex bureaucratic process underlying IMT; following a motivated proposal from a physician (generally from outside the structure where IMT is to be carried out), sustained by a second physician (working in a public structure), the mayor will authorise placement of the patient and will notify the Tutelary Judge accordingly within 48 hours. The magistrate will ensure that the patient's rights are guaranteed and that the mayor's authorisation is legitimate; moreover, after having gathered all necessary information and assessed the situation, he will either "approve or disapprove the motion", notifying the mayor of his decision within the following 48 hours (art.35, 6). Should the motion be applied to foreign citizens or stateless subjects, the Prefect will notify the Home Ministry and the Consulate concerned. The duration of IMT cannot exceed seven days, at the end of which the physician in charge of the psychiatric service may request an extension, if the conditions of the patient do not allow his voluntary placement or outpatient treatment. Once again, the motion will be issued by the mayor on the basis of the above-mentioned procedure, and will then be approved or disapproved by the Tutelary Judge. The mayor should be notified of interruption of IMT (whenever this may occur) by the physician in

charge of the psychiatric services; the former will subsequently inform the Tutelary Judge of the same within 48 hours.

Art. 35 also provides for the immediate interruption of IMT should the correct procedures not have been carried out, foreseeing (as long as no more serious crime has been committed) the offence of omission in public proceedings (art. 328 of the penal code). Whosoever (both the person who has undergone IMT or any other person involved) may lodge an appeal against the motion approved by the Tutelary Judge; the mayor may appeal against the lack of approval of the IMT motion within a 30-day period of the expiry date for notification of approval. These dispositions are aimed at providing a further guarantee of the citizen's rights in the face of possible errors or abuse of the Health Authorities. The Court Magistrate will hear both parties and will reach a decision concerning the request for suspension of IMT within ten days.

Heading n.3 (Transitory and definitive regulations) of law 833/78 establishes, in art.64, the definitive closure of Psychiatric Hospitals and prohibits the establishment of new hospitals (or "the use of pre-existing structures as specialist divisions of general hospitals, the creation of psychiatric divisions or sections in General Hospitals or the use of neurologic or neuropsychiatric divisions and sections for such a purpose"). Subsequently, it also provides for the suspension of all placements in these structures, with the sole exception of patients who had explicitly requested the latter (voluntary placement) or who had been admitted prior to the date of enforcement of law 180 (13/05/1978), up until the date of 31/12/1980. From the date of 01/01/1979 on each single region was required to set up psychiatric services contemplated in article 35, to be staffed by personnel from public psychiatric services and, following explicit request, personnel from private psychiatric concerns. Furthermore, art. 64 dictates that the wards in such psychiatric services should contain a maximum of 15 beds, to be arranged on the basis of provisions made for compulsory special services in general hospitals and similar structures, in the form of a network system linked to the other psychiatric services and departments throughout the territory.

On the basis of these three main points, the Legislator intended to further ratify the radical changes which psychiatric care was undergoing, forbidding the crowding together of the mentally ill and the creation of ghettos for these patients, as well as providing these subjects with the right to be treated on a continual basis, once the placement (both voluntary or coercive) had been terminated (2).

The judicial authority appointed to supervise the motions of coercive placement, namely the Tutelary Judge, is called upon to examine the request for IMT and to ascertain the effective necessity of treatment, as prescribed by law. In carrying out these tasks, the Tutelary Judge may freely request the opinion of persons in a position to provide useful information as to the psychic conditions of the patient, if necessary arranging for psychiatric assessment, all within the time limits established by art.35, 2) of law 833/1978.

The appointment of the Tutelary Judge as guarantor of the IMT procedures is not a casual choice: indeed, this figure represents the jurisdictional organ of choice, on the basis of art. 344 of the civil code, in matters pertaining to guardianship and care. The Tutelary Judge is part of "a category of magistrates widely distributed throughout the territory" and "who is competent in the guardianship of minors, of those deprived of civil rights, of the disqualified and disabled, in evaluating the opportunity of undertaking urgent motions necessary for the maintaining and administering of the patrimony of the invalid" (10). Similarly, art. 35, 6 of law 833/78 identifies the Tutelary Judge as the institutional figure better equipped to deal with

"the undertaking of urgent motions necessary for the maintenance and administration of the patrimony of the invalid". The latter motions refer mainly to the appointment of a temporary administrator and/or the sealing of goods and property, in order to avoid dispersion of the latter (art.752 ss, Civil procedure code), or arranging for an inventory to be performed, with the same aim. This type of motion does not affect the rights of the person subjected to IMT, but rather is seen by the Legislator in a wider context as a means of safeguarding the property of a citizen who, momentarily, is not able to act in his own interest (it should be mentioned here that in 1978 art.420 of the civil code, pertaining to the appointment of a tutor in the eventuality of an indefinite internment in a Psychiatric Hospital, had been abolished).

Practise

In 1988, ten years after enforcement of law 833, considerable debates were held in Italy with regard to the putting into practice of this issue; the debate was likewise concerned with the specific matter of IMT.

A study carried out in Sardinia from 1978 – 1988 to assess the psychiatric care available throughout the territory, evidenced a worrying tendency towards repeated placements and in particular, IMT (4). However, the authors of the study compared results obtained with (scarce) data collected on a national scale; they were able to conclude that the excess of involuntary medical treatments was typical of the southern regions of Italy and the islands, where the reform had not been applied and where no territorial health structures existed. The lack of a territorial network and of adequate treatment for numerous patients was such that the onset of a chronic illness represented the unavoidable fate for those affected by serious disorders.

A more recent study aimed at identifying the decisional procedure adopted in prescribing IMT, has evidenced how, in the opinion of the psychiatrists interviewed, the factors deemed to be of greater importance are, respectively: psychic status, diagnosis, severity of the illness and the efficacy of pharmacological treatment (in accordance with criteria indicated in law 833/1978). However, 23% of the sample studied indicated that the most important factor in prescribing IMT was represented by the danger to self or to others, a criterion which in theory had been abolished by the law (5).

Moreover, the physician who writes the initial certificate (request for IMT) is often not a Specialist Psychiatrist. Actually, law 833/1978 does not even specify what type of specialisation should be held by the physician who writes the second certificate (sustaining of IMT), but merely indicates that this must be "a physician working for the local health department" (art.34, 5). With the specific aim of settling the controversy which had arisen to this regard, in their regional health programmes several Italian regions (e.g. Tuscany) specified that the physician sustaining the request for IMT should necessarily be a Specialist Psychiatrist.

Additionally, law 833/78 does not provide for the intervention of the police force during the carrying out of the various stages of IMT; in spite of this, the latter frequently intervene. In view of the fact that the official in charge of authorising IMT is represented by the Mayor, it would consequently be the municipal police force (which is not trained in repressive actions) to become involved in the procedure, thus entering into conflict with the health officials on the issue of safeguarding of society (8). However, in order for the

above to occur, the Mayor himself would have to issue the necessary order; indeed, the latter rarely occurs prior to involuntary placement, where physical coercion is often required. Therefore, in view of the lack of enforcing regulations pertaining to the involvement of the police force, the actual implementation of involuntary medical treatments and, in particular of transportation, is left to the initiative of the individual officials (who act according to necessity) and to the local arrangements made between the health authorities and the police. The result being that a law intended to guarantee certain rights is actually far too muddled with regard to application of the same, to be effectively enforced.

One of the more controversial aspects regarding the implementation of IMT concerns the legality of using methods of physical or pharmacological containment on the subject undergoing placement. As law 833/1978 had abrogated the old dispositions which dealt with the matter in detail, but had not itself made any provision for the same, considerably divergent interpretations were often afforded. According to some, the resorting to coercive methods was to be deplored, in view not only of the abrogation of the old laws, but also of the continual reference of the current law to the safeguarding of civil and political rights and to the human dignity of the patient undergoing IMT (12). Yet others, however, deemed it to be the psychiatrist who, after having weighed the risks and benefits, would have to decide whether to use coercive measures in situations which could be envisaged as representing a "state of necessity" referred to in arts. 2055 of the civil code and 54, 55 and 384 of the penal code (8, 13). Furthermore, by appealing to "motivated reasons of a medical nature", some maintain that the supervision of patients undergoing involuntary placement is mandatory, being linked to "the particular therapeutic dimension of mental illness", although no regulations refer to such an aspect (ibidem).

Law 833/1978 is considered to represent the apex in the struggle against mental institutions and against the consideration of mental illness as requiring custody and social banishment. One of the underlying intentions of the Legislator was to increase the social visibility of the mentally ill, in order that these persons should no longer be generally viewed as a danger, and therefore worthy of banishment, nor as being affected by illness for the duration of their lifetime.

Epidemiological Aspects

A nation-wide information system has recently been set up with the aim of providing epidemiological data with regard to the use of services, including the rates of involuntary placement for IHT. At the current time no data pertaining to the entire Italian territory are available. The most recent regional data have been illustrated in a report drawn up by the Lombardy region, referring to the year 1999 but published in the year 2001 (14). A rate of placement for IHT of 3.6 per 10.000 adult inhabitants throughout the year is revealed in the region, versus a yearly rate of 29.7 per 10.000 for overall number of placements and a total of 17.7 patients per 10.000 subjected to placement (voluntary and IMT). Although these data refer to a single region, they appear to differ only slightly in respect to findings reported in three nation-wide studies carried out in the 1980s (15, 16, 17) which indicated a rate of IMT in northern Italy ranging between 1.8 and 2.7 per 10.000 inhabitants per year.

The above-mentioned studies relied on indirect methods of investigation and provided unreliable, incomparable results. Moreover, data were underestimated by approx. 2 cases of IMT per 10.000/year when comparing findings likewise obtained for the Sardinian region with those reported in a study based on actual clinical records, carried out in the same region during the same period (4).

It is rather hard to believe therefore that the cases of IMT in the Lombardy region have increased over the last ten years; accordingly, the fact that a study performed on the basis of regional records may be more accurate than by a nation-wide study using indirect methods cannot be excluded.

The three nation-wide studies carried out during the 1980s all evidenced higher rates of IMT in the south and on the islands in respect to northern Italy.

In the previous paragraph we referred briefly to an explanation for this phenomenon, in accordance with a description made by the CENSIS report (17) concerning the state of psychiatry in Italy in the 1980s. At the present time, results afforded by a national research project "Objective Mental Health Project", appear to report a better developed network of psychiatric care in respect to that available 15 years ago. However, to what extent this evolution may have affected the decrease observed in IMT is not clear.

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Luxembourg

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Mental Health System

The Grand-Duchy of Luxembourg with its 2,586 sq. km is the smallest member state of the European Union. 37.3% of the 44,1300 inhabitants are foreigners, mainly of Portuguese origin[1].
Health care in Luxembourg is financed by a system of compulsory insurance[2]. The health services are under the responsibility of the Ministry of Health, which spends 8% of its total budget for mental health. The practice of medicine is mainly liberal. In 2001, the country counted 52 psychiatrists (out of which 18 are neuropsychiatrists), around 120 psychologists, 149 psychiatric nurses and 151 social workers.

Within the field of mental health, the national authorities became aware at the end of the eighties that there was an urgent need of modernisation, custodial care being rather dominating. The Ministry of Health therefore instructed the Central Institute of Mental Health in Mannheim to examine the mental health care system of Luxembourg. The recommendations of this research group were published in 1993[3,4] and led to a final report of the Ministry of Health in 1994[5], a report establishing a pluri-annual reform program in the field of mental health. In the field of forensic psychiatry, a report has been published in 1996 by Professor Bernheim from Geneva[6].
Some of the recommendations in these reports have been implemented by the national hospital plan, published in April 2001 in its last version[7]. The plan divides the country into three regions (Centre, South, North) and distinguishes between general hospitals (> 175 beds), proximity hospitals (< 175 beds) and specialised institutions, like the Neuropsychiatric Hospital Centre (Centre Hospitalier Neuropsychiatrique, CHNP) in Ettelbruck, formerly known as the State Neuropsychiatric Hospital. Currently (in 2000), there are 445 psychiatric beds, including 127 beds allocated to general hospitals. The major change within psychiatry in the national hospital plan will be the future possibility of compulsory admission and involuntary treatment in these general hospitals, which was up to now the monopoly of the CHNP. In the year 2005, there will be 2,282 acute hospital beds in 11 hospitals nation-wide, amongst which 180 for psychiatry, and 564 beds for long-term illnesses, out of which 237 are planned in the CHNP and 50 for psychiatric rehabilitation (in extra-hospital rehabilitation centres or homes).
With this new system, the CHNP will progressively lose its asylum function and is specialising in psychiatric rehabilitation, including extra-hospital community-based facilities.

Legislation and practice

In Luxembourg, compulsory admission and involuntary treatment is governed by a special mental health act issued in May 1988[8,9], which abrogated the old 1880 law on the insanity regime[10]. In the year 2000, the law has been amended in order to regulate also the placement of mentally ill offenders[11]. Legal protection and guardianship is regulated by the 1982 law about the incapacity of adults[12,13].

According to the 1988 law, a person should, whenever possible, be treated in her/his usual environment and can only be involuntarily placed in case of the presence of a severe mental disorder *and* in case of dangerousness to herself/himself or to other persons. The reduction of mental faculties due to age is not in itself a sufficient reason for compulsory admission.

Involuntary placement requires a written statement by a concerned person (e.g. tutor, family member, judge, ...) explaining the major motivating circumstances *as well as* a medical certificate no older than three days written by a doctor who has no connection to the hospital in which the placement occurs (which is, up to now, the CHNP).

The law stipulates that the patient has the right to be treated according to her/his condition. A personal treatment plan has to be established and applied by qualified medical and paramedical staff. The treatment aims to reintegrate the patient into society and is given in respect of the freedom of thought of the patient, as well as her/his religious and philosophical convictions. Familial and social contacts should be encouraged, if possible.

The 1988 law has the merit of having introduced a few more safeguards to prevent abusive placements. It gives involuntary placements a more adequate legal background than the 1880 law did. It pays attention to appropriate treatment, multidisciplinary professional staff and psychosocial rehabilitation. The law has been qualified as rather "modern" and preceded the respective Belgian and French laws in the domain by two years.

Criticism of the law have been publicly expressed during the tenth congress of the Latin Association for the Analysis of Health Systems (CALASS) held in September 1999 in Luxembourg[14]. This criticism can be summarised as follows†[15]:

1) The 1988 law does not distinguish between a placement requested by a third party and automatic placement (as e.g., does the French law of June 27th, 1990).
   In the Luxembourgian law, five "interested parties" are the only ones allowed to present a written demand for placement: the tutor, a family member or any concerned person (with type of relationship described), the mayor or the local police authority, the public prosecutor, or the judge in charge of guardianships. In practice, around 40% of the requests are issued by family members. Frequently, people are, however, assigned to doctors on duty without a demand by a third party, due to the bureaucracy of administrative procedures or the total absence of any "interested party" (e.g., in the case of socially isolated suicidal persons who do not offend the public order).

2) The law does not make any difference between an ordinary procedure and an emergency (as e.g., does the Belgian law of June 26th, 1990).
   The medical certificate necessary for the placement must have been written no earlier than three days before admission. In case of an emergency, the certificate has to be "produced" within the next 24 hours. In practice, the legal model of the certificate is not always respected and placements are mainly made in emergency situations, thus multiplying the number of placements.

3) The juridical action of deprivation of liberty is defined in the law as a medical act and not as a legal one.
   In Luxembourg, doctors play two roles in the placement procedure: they treat the patient and decide about the continuation of the placement. The law does not systematically, like e.g. in Belgium, introduce a judge into the decision taking, neither in the observational period, nor in the first maintenance year. As a matter of fact, the legal power is rather absent in the law.

4) The distinction between observation period and maintenance of placement is of poor rigour and without real impact.
   Art. 9 of the law distinguishes between an observation period of 14 days that may be prolonged once and the maintenance of placement. It is the doctor who decides after observation on the maintenance of the placement. Again, there is no systematic legal procedure after the observation period, which might eventually prevent abusive placements.

5) The CHNP still has the national monopoly on involuntary placements.
   Even though the system is about to change, as mentioned above, with the future possibility of placements in general hospitals (in principle 4 times 15 closed-ward beds are planned), the CHNP in Ettelbruck currently still constitutes the only authorised closed psychiatric ward in Luxembourg. The number of beds at the CHNP has passed from 860 in 1990 to currently 318 that will be reduced to 237 in the future. The number of placements per year, however, remain constant and is close to 400, which currently creates major problems. Moreover, once placements will take place in several locations, better regulations will be needed- the one planned in art. 3 of the 1988 law about the fixing of norms for closed wards, however, is still not published.

6) Placement in Luxembourg is still strongly stigmatising.
   Since placement is only possible in one hospital, there is still a connotation of asylum attached, the name "Ettelbruck" having become synonymous with madness, insanity and public dangerousness. Major emotional reactions by family members of first-episode psychotic patients and turbulent minors are experienced, when it is announced to them that the person has to be placed in the CHNP in Ettelbruck.

7) Placement motives are mainly related to alcohol problems and drug abuse.

Medical motives of placements in Luxembourg are in more than half of the cases related to alcohol (36.3%) and drug abuse (21.4%) - only a quarter of them (26.7%) are due to psychotic disorders. Neither the police offices, nor the emergency wards of several general hospitals are equipped to deal with the emotional and behavioural crises of people presenting substance abuse. On the other hand, the 1988 law does not allow to retain a patient during 24 hours before a definite decision is taken, although this would avoid a lot of placements, allow adequate secure medical supervision and give doctors the possibility of disconnecting the crisis from the emergency and orienting the patient in a more appropriate manner.

8) Criteria like "dangerousness towards others" and "protection of public security" predominate over protection of the individual's health.
   Even though the 1988 law emphasises the right of the patient to appropriate treatment, protection of society as the main reason for placement predominates in current practice. Half of the written demands for placements are introduced by public authorities for disturbance of the public order, which can be considered in a certain way as a psychiatrisation of social problems. On the other hand, the increase of legal procedures against doctors may lead to a "no-risk" psychiatry: placing each person who expresses the slightest suicidal tendencies.

9) Some people are placed because of a lack of socio-sanitary facilities.
   Placement is often used for quicker hospitalisation of a psychogeriatric patient ("the aggressive demented") or a drug abuser ("the suicidal drug addict"), the lack of adequate structures in this domain and the limited number of places having created waiting lists. Placement is also more frequent if the socio-medical infrastructure of the region or the referring institution is inadequate. A hospital like the State Hospital in Luxembourg, better equipped within psychiatry than other hospitals in the capital both in staff and infrastructure, sends proportionally and significantly fewer patients to be placed.

10) The law does not stipulate to explicitly justify and record each involuntary treatment or coercive measure.
    Art 4 of the law stipulates that the patient receives treatment "based on an individual treatment plan" and "in respect of the freedom of thought of the patient, as well as his/her religious and philosophical convictions", but the law does not stipulate that this treatment be written down or require special authorisation.

This summary of the placements in Luxembourg reveals structural deficits in both the legal and the socio-sanitary areas, as well as a current practice that needs to be improved. A major problem remains the absence of adequate structures for aggressive minors, who are therefore often placed in the CHNP. And there also is no institution other than the prison and the CHNP that is able to deal with mentally ill offenders.

At the time of discharge, the law allows the stipulation of certain conditions of residence and medical care (art. 16). In case of non-observance of these conditions a re-placement is in principle possible up to three months after discharge, a period which is rather short compared to those in other countries (e.g., Belgium has a one-year period). In practice, discharge conditions are seldom stipulated since non-observance does not lead to a re-hospitalisation if the patient does not prove again to be a danger to himself or others. The quality of supervision and aftercare of discharged persons therefore relies very much on their compliance and the patient-doctor relationship, and patients with poor insight quickly stop taking medication and seeing therapists since there is no legal pressure on them to do so.

Patient rights

The 1988 law evokes the respect of human rights and freedom. Concerned persons like e.g. family members or tutors are informed in the event of an involuntary placement. The law also stipulates the inclusion of a board of control ("commission de surveillance") if necessary, which, however, plays a rather virtual role in practice. As mentioned before, a systematic free legal presence (advocate and judge) would certainly improve the rights of the concerned persons even more.

Epidemiology

The CHNP remaining currently the only hospital with closed psychiatric wards in Luxembourg, epidemiological data for research purposes are rather easily gathered. The number of patients admitted compulsorily (including all the regular placements, the emergency placements and eventual changes from voluntary to involuntary status) is close to 400 per year and represents approximately 30% of the total annual number of admissions in the CHNP. About 2/3 of these involuntarily placed patients are male.

The placement of patients with mental disorders in Luxembourg has been examined by two different studies published in one paper†[16]. The first one examined the profile of the 367 involuntary placements in 1993. The young, unemployed, single, native men, with a diagnosis of substance abuse or dependence were particularly overrepresented in this population. The second study examined the evolution of the profile of the population placed from 1984 to 1995 in order to evaluate the influence of the 1988 law on the placement practice. The number of involuntary admissions per year remained rather constant, but fewer placements maintained after the observation period were registered.

Finally, as mentioned above, Luxembourg is currently in a situation in which the CHNP has already partly reduced the number of its beds, while the closed wards in the general hospitals will only be fully functional in 2005. This may lead to a certain bottleneck in the coming two years.

Conclusion

The mental health reform in Luxembourg has only been implemented in part until today. The privatisation of the CHNP has taken place, but the hospital currently retains its exclusive placement function, since closed wards in general hospitals are only planned for 2005. The domains of adolescent and forensic

psychiatry are still rather poorly developed in the country and there is also a risk that community-based structures may prove to be insufficient in the future, even though sheltered living and work places have been strongly developed in the last decade. Besides, despite several information campaigns by the Ministry of Health ("What kind of psychiatric care for the year 2000? Another view on illness. Together let's dismantle taboos."), stigmatisation of mental disorders and placements remain considerable.

In the field of compulsory admission and involuntary treatment, the 1988 law is certainly far more advanced and modern than its 1880 predecessor. In practice, however, changes have been too few. Protection of society dominates as the main reason for the placement, and the aspect of protecting the patient is not emphasised enough. The political interest in the placement issue (and in mental health in general) may be qualified as rather low and the legal presence within the field is scarce, leaving the psychiatrists alone in the decision making as regards maintenance.

Finally, even though there are some legal regulations for care after discharge, they are rarely applied in practice, thereby precipitating treatment stops and unnecessary re-hospitalisations.

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The Netherlands

Willem J. Schudel

General State of Affairs

Mental Health Care Policy has been on the Dutch political agenda more or less permanently over the last thirty years. Policy targets, however, have been less consistent at least in sofar as organisational and financial aspects are concerned. The ideal blueprint for the mental health sector has not yet materialised. One might nevertheless be grateful, while ongoing changes in demand and demography require a constant adaptation of goals and targets. The long procedure, however, of the renewal of the Dutch Lunacy Act of 1884 into a more up-to-date legislation was not caused by mere political indecisiveness, but rather by the growing importance of judicial decisions of European institutions. The current Psychiatric Hospitals (Compulsory Admissions) Act is by no means perfect but its philosophy is evident and widely accepted in the Netherlands. Unmistakenly the act shows symptoms of a "lawyer's law" in comparison with the more "doctor-oriented" Lunacy Law. But the review-paragraph within the law is satisfactory to all professional disciplines. Modernisation and adaptation to forthcoming jurisprudence will no doubt continue.

Yet psychiatrists (in residential as well as community care) continue to worry about the legal limitations to intervene in cases without an imminent danger. In the Netherlands chronic psychotic people used to be a rare sight in public places; nowadays they constitute a substantial part of the homeless population in night shelters and railway stations. Family advocacy groups, never before prominent in Dutch society, show increasing activities and influence. The definite answer to the long-standing dilemma of individual autonomy, even if this leads to suffering, versus professional intervention to provide necessary care on the basis of beneficence cannot be expected soon. However, overall: it should be better but it could be far worse.

Legislation

The Psychiatric Hospitals (Compulsory Admissions) Act was enacted by the Dutch legislature in 1992 and went into effect on 17 January 1994. The new law replaced the Lunacy Act dating from 1884. The main purpose of the new legislation was to strengthen the legal position of psychiatric patients in accordance with international jurisprudence, in particular as formulated by the European Court of Human Rights. In comparison with the replaced Lunacy Act, the new law emphasises explicitly the legal position of a patient during his of her involuntary stay in a psychiatric hospital. This so-called internal legal position includes ample attention to the patient's right to information, the requirement of his consent to treatment, the

decision-making process in respect to incompetence, the use of restraints and restrictive measures, and the right to access to various authorities such as lawyers, boards of complaints, courts, official representatives etc.

Another major difference between the Lunacy Act and the Psychiatric Hospitals Compulsory Admissions Act is the scope of the latter, which includes not only involuntary admissions to general psychiatric hospitals, but also to psychiatric departments of general and teaching hospitals, nursing homes and institutions for the mentally handicapped. The Act recognises a separate admission procedure involving committees giving a judgement on the necessity of admission to the latter two types of institutions.

A third new provision in the law requires the Act to be reviewed periodically, for the first time within three years of its implementation (thus in early 1997) and subsequently every five years. These reviews are to be formally sent for approval to the Dutch Parliament.

The Act covers involuntary admissions of all individuals of twelve or more years of age. The Act also provides for a complaints and compensation procedure for the patients and their (legal) representatives. and lays down rules for discharging patients and the granting of leave.

The mental health care sector is managed on the basis of three related pieces of legislation: the AWBZ (Exceptional Medical Expenses Act) regulating entitlements and accreditation, the WZV (Hospital Provisions Act) regulating planning and building, and the WTG (Health Care Charges Act) regulating charges and fees. The current legislation, which is based on separate mental health care facilities, is supply-driven and no longer in line with the developments in the field. The regulations are not sufficiently geared to providing a service that is tailored to the needs of the insured, while achieving co-ordination with other sectors. The Ministry of Health, Welfare and Sport intends to develop a new consistent package of laws and regulations to achieve more integrated management tools, but a complex trajectory of long duration is to be expected.

Besides these laws on management issues, the most relevant general health laws are: The Mentorship Act, the WMO (Medical Scientific Research on Humans Act) and the WGBO (Medical Treatment Agreement Act). The WGBO in particular overlaps in some respects the scope of the Psychiatric Hospitals (Compulsory Admissions Act (WBOPZ). This WGBO, being the general law, allows a physician to act (intervene) even against the will of a (temporarily) incompetent patient if the doctor is convinced that non-intervention will lead to “a severe worsening” of the patient’s medical condition. The above authorisation of the responsible physician’s action evidently is broader under the WGBO than under the WBOPZ.

Until today this discrepancy has not been decided upon by (Appellate) Court rulings. In all cases of incompetent patients the physician's foremost obligation is to consult a spouse, parent or family member for approval, but he is not obliged to act accordingly, if this is in contrast with his professional opinion.

In comparison with the old Lunacy Act, the current BOPZ Act provides many advantages. Probably the most prominent of these are a direct result of the strengthening of the patient’s legal position as the cornerstone of the legislation. The new law particularly elaborates on various aspects of the internal legal

position (i.e. the legal rights of the patient during his involuntary stay), the external legal position already rather satisfactorily having been covered by the previous legislation.

The basic reasoning behind this development is based on the assumption of the desirability to protect the patient's autonomy as much and as long as possible. The boundaries of this area of protected autonomy are formed by the "high risk zones" of dangerous behaviour towards oneself or towards other individuals and/or society in general. The consequences of the legislative principle of protected autonomy are not only beneficial. An involuntary admitted patient will remain formally competent in many other respects apart from leaving the hospital, not seldom leading to deadlock situations such as refusal of treatment or other evident uncooperative or disturbing behaviour.

On the other hand, the changing of the law definitely has improved and equalised the patient-doctor relationship. More than before the doctor has to convince his patient of treatment options and clinical policy issues to receive the patient's consent or that of his legal representative. In the large majority of involuntary admissions no serious problems arise, but psychiatrists in the Netherlands would strongly support a less strict legal division between involuntary admission and involuntary treatment.

The central position of the judge in the decision-making process with doctors in an advisory role only, is consistent with the old Lunacy Act and widely respected by professionals and the public alike. Over time the variation in judges' decisions in different parts of the country has decreased, sometimes stimulated by case decisions of Courts of Appeal or even the Supreme Court. The same may be concluded of the role of the Public Prosecutor as the protector of public security and the interests of individual patients. The new law in general shows signs of over-regulation, leading to too many and overly complicated administrative procedures. As a result, hardly any psychiatric hospital fulfils its legal-administrative obligations to follow the law faultlessly, and the resulting paperwork at the various offices is enormous.

Another shortcoming of the current legislation is the lack of a possibility to impose compulsory treatment on an outpatient. Under the current law, admission is necessary for compulsory treatment, even in cases (for instance, chronic psychotic patients) where ambulatory treatment is indicated. A last possible improvement would be the instalment of more extensive self-binding procedures, again with the protection of the patient's autonomy in mind.

But finally while the legislature within the law itself has provided for regular evaluations, improvements such as the above-mentioned might as well be on their way.

Practice

The number of beds in psychiatric medium- and long-stay facilities in the Netherlands has been steadily decreasing over the last twenty years, albeit less drastically compared with other countries in Western Europe. Admission wards, however, have more or less kept their total capacity including the "locked" or compulsory admission facilities. The availability of residential care beds/units for this particular category of patients is, generally speaking, sufficient all over the country. Also mostly adequate is the quantity as well as the expertise of the various kinds of professionals: psychiatrists, psychologists, psychiatric nurses, social workers, etc., although the economic boom of the late 90's has had a negative effect on the

"marketing" of all caring professions, including education and health care, leading to an increasing and worrisome number of vacancies. All available postgraduate training posts in psychiatry, however, have been permanently filled.Continuous post-graduate education for doctors and allied professions has achieved priority with the government and employers alike. Neither do real financial bottlenecks exist for care providers nor for patients. The Dutch Health Care Insurance System urgently needs revision but the mental health paragraph is not our main concern. In the meantime an increasing percentage of the population applies for professional help, mostly in the community. Regarding the ongoing demographic changes towards more elderly and more (first of second generation) immigrants, this development is likely to continue.

Next to the commentary already made in paragraph (2.3) on legislation of this chapter some other issues concerning the practical aspects of the law are relevant.
Firstly, the existence of a distinct emergency procedure next to the regular (compulsory admission) procedure has proven its usefulness.
The emergency procedure (IBS) more often than not is a "law-and-order" intervention to prevent additional harm of any kind to any individual (the patient or others). Usually the responsible non-medical officials (mayor or burgomaster, judge) attain enough leniency towards the application of the legal formulations to allow the psychiatrist to do a proper job. The attitude of the judge in the regular procedure (R.M.) tends more often to be controversial with regard to the opinion of professionals and their institutions. The absence of proper definitions of crucial words such as "danger" or even "mental disorder" leaves too much room for uncertainty and discussion, usually unfavourable to all concerned. Secondly, the law maker has given the involuntarily admitted patient ample opportunity to disagree with almost everything the hospital has to offer, as well as to complain about the care and the household rules. Sometimes this no-go situation leads to the forced discharge of a patient whose admission not long before had been deemed necessary. In such a battle between medical and legal professionals the patient's welfare might be neglected.
Nevertheless over the years many Supreme Court of Justice Rulings have excised some of the sharpest edges of the law towards a more common-sense explanation and application. The third and last issue has already been mentioned (under 2.3) and concerns the administrative procedures regulations within the law. The law makers' inclination towards perfectionism opens the possibility that in some, complicated, cases the doctor-in-charge has to send letters and/or reports to seven or more addressees, and not once but several times during the same admission. Files of the patient concerned, limited or more elaborate, could as a result have been stored in at least four offices besides the doctor's office. It certainly is difficult to value the necessity, even the usefulness of these regulations, and not only with concern for the patient's privacy.

Besides the doctor, responsible for the care of his patient, at least three other categories of professionals have formal tasks in the procedures. The most important of these is the judge, or rather the (acting) president of the District Court. This magistrate has decisive power to confine an individual to the status of

psychiatric inpatient for a period of three weeks (the emergency procedure) to six months (the regular procedure) without the obligation for an evidence-based decision. Luckily in most of the 19 lower, District Courts in the Netherlands the acting presidents (like other judges) are appointed and not elected and keep their jobs usually for many years. They not only become experienced in the psychiatric terminology, but they also learn to know the psychiatrists in their region and what to expect of whom in the way of consistency and reliability. In due course the mutual understanding between the two professions tends to flourish, but of course with some exceptions.

The second legal professional and a key figure in the whole procedure is the public prosecutor, who acts as the gatekeeper. All formal requests, initial ones and follow-ups, pass his desk and require his action. All information on admissions, discharges, transfers and terminations for any reason are (also) sent to the public prosecutor. He represents the patient's family whenever necessary and also society in most cases. As long as the psychiatrist sticks to the (time) rules he'll find the prosecutor to be his ally in his determination to convince the judge. By the way, the prosecutor also is a non-political "career" professional lawyer.

The third professional holds an almost idiosyncratic role. This Mental Health Inspector usually is a psychiatrist (sometimes a psychologist or a psychiatric nurse) and runs an office covering one or more Dutch provinces. The Inspectorate has a very long tradition and dates back to 1841 (First Lunacy Act). The original task of this civil servant was to keep an (unrestricted) eye on the quality of the delivery of mental health care within his geographic domain. He had and has the power to complain formally and to bring professional mischief before a disciplinary and/or a criminal court. The position of the Inspectorate, however, tends to be disputed almost continuously. The combination of the varying tasks of advisers, controller, law enforcement agent, advocate for patients and independent expert would suit supermen and -women only. In daily practice the Inspectorate is the scapegoat whenever serious problems in the Mental Health Care System arise. But still a survival of over 160 years credits the Inspactorate to a greater extent than can be undone by its (many) critics.

Patients rights

With the enactment of the Psychiatric Hospitals (Compulsory Admission) Act the recognition of the fundamental civil rights of psychiatric patients has become indisputable, in line with the Dutch Constitution and international treaties. The primary restriction, even in the case of severely disturbed and dangerous patients lies in their freedom to move around, in particular to leave the hospital without permission. All other restrictions of civil liberties as far as they are mentioned in the law (or in regulations funded under the law) are only allowed under specified conditions and for a limited period of time. Almost all restrictive medical decisions, including a declaration of incompetence, are open to be contested by the patient or his legal aid either in a complaint procedure or formally before a court. This refers to both the external as well as the internal legal position. The patient's right to contact authorities (including his lawyer) to take legal (including financial) action, to vote or to practice his religion is inviolable. His right to communicate freely with people outside the hospital (with the exception of the above can only be restricted on the basis of

section 40 of the Act. But, as mentioned earlier in this chapter, the most controversial legal rights issue still is the patients' right to refuse treatment. Several Supreme Court rulings have defined the legal boundaries of this core issue in psychiatric law. Consequently the next review of the law will probably provide a solution to the actual frustrating paradox. Concluding the new legislation evidently has rightfully updated and improved the legal position of psychiatric patients without too many negative consequences of prioritising autonomy over beneficence and the protection of society. Surely this story will be continued…

Epidemiology

The quality of the epidemiological data for the Netherlands regretfully is rather limited, as is the number of data in general. Psychiatric hospitals usually collect and produce data on admissions, deaths and discharges, but not divided into data of voluntary and compulsorily admitted patients. One of the reasons for this lack of information could be the absence of any financial stimulant according to the Dutch Health Insurance system. A study by the Health Inspectorate showed that the total number of committal orders in the psychiatric sector (including mental handicap and psychogeriatrics) rose by 32.5 percent in the period from 1993 to 1997.

In particular in the three largest cities of the country (Amsterdam, Rotterdam, The Hague) unofficial findings show a steady increase of the emergency-procedure commitments over the last five years. We have no evidence for the assumption that such would be the same for the whole country. Neither can other unexpected epidemiological finding be reported.

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Portugal

Miguel Xavier

Mental Health System

Health care (organisation and delivery) in Portugal is based on a National Health Service (NHS), which was created in 1976. The development of the NHS has ensured free access to comprehensive health care for the entire population (10 million inhabitants). Although in 1990 a number of changes placed certain limits on completely free care, the NHS continues to ensure the provision of public health programmes, including primary health care, hospital treatment, diagnostic procedures and drugs.

The whole country is covered by a network of health centres and general hospitals, which are responsible for inpatient treatment (hospitals only) and outpatient clinics. Unless a problem is acute, access to a general hospital is always subject to referral by a GP.

Beginning in 1985, mental health services have been progressively integrated into the general health system. In the public sector there are 6 psychiatric hospitals, 27 psychiatric departments in general hospitals, 3 regional centres for child psychiatry and 3 regional centres for alcohol-abuse-related disorders (80 beds). In 2000 there were 2,868 beds in public psychiatric facilities (0.3 beds per 1,000 population) [1].

The organisational structure of the psychiatric and mental health services (at the local, regional and national levels) is regulated by Executive Law nº 35/99. The statute's general principles recommend that (depending on each patient's needs) care be provided in the community and that both users' associations and family members play an active part in the life of psychiatric services [2].

Legislation

In Portugal the involuntary placement of people aged 14 or more is governed by the Mental Health Act (Law nº 36/98) [3], which was published on the 24th of July 1998 and took effect nationwide in January 1999.

Until then this practise had been regulated by Law nº 2118, which dated from 1963. Although this Law had been considered very advanced when it was written, the issue of the new Constitution of the Portuguese Republic in 1976 meant that it was no longer adequate.

The fact is that involuntary placement constitutes a restriction on personal freedom [4], and even though its purpose is purely therapeutic, in legal terms it conflicts with the constitutional right to individual liberty (Art. 27). This right may only be limited by a sentence imposed by a court of law (either as the result of an act

that is punishable by a prison term, or as a preventive measure following the commission of such an act, prior to judgement).

Although it regulates involuntary placement, the scope of the Mental Health Act is broader than this. It establishes the overall principles that govern the country's mental health policy: a community model approach, multi-disciplinary professional staff, the provision of care in the least restrictive setting possible, placement in a general hospital whenever possible, psychosocial rehabilitation in community-based facilities and the joint payment of the costs of the service by the Ministries of Health, Social Security, and Labour.

When it comes to involuntary placement, the Act is based on a judicial-type model[*]. The latter seeks first and foremost to guarantee fundamental individual rights – an aspect that is in accordance with the general philosophy underlying the Act as a whole, which attaches particular importance to the protection and promotion of mental health and focuses especially on primary, secondary and tertiary prevention.

Thus in Portugal involuntary placement must always be the object of a court order and is only permitted if (and for as long as) it is the only way of providing treatment that is itself absolutely necessary. What is more, it must be replaced with an outpatient regimen as soon as possible.

The issue of an involuntary placement order is also subject to certain conditions:

- "the person concerned must be a real danger to himself/others as the result of a mental anomaly, and must refuse treatment";
- "the absence of adequate treatment must entail a risk of further deterioration, of which the person himself is unaware".

The Act does not say which diagnostic categories are included within the concept of "mental anomaly", and for some professionals this may be a source of difficulty when it comes to performing psychiatric assessments, particularly in cases of mental retardation, personality disorders and drug-abuse-related problems [5, 6].

In these circumstances the Act is most often applied in situations involving decompensated psychotic disorders, but never to mentally ill offenders, who are subject to specific legislation that is regulated by the Penal Code.

Application, assessment and decision

In Portugal involuntary placement may be invoked in one of two ways: via a standard procedure; or by an Emergency Department.

Although the underlying principles are naturally the same, a number of differences between the two mean that it is best to describe them separately.

[*] As adopted by a number of international instances, such as the Parliamentary Assembly of the Council of Europe (Resolution nº 1235, 1994).

Standard involuntary placement takes place in three separate steps: application for a court order, psychiatric assessment, and a court ruling (see Figure 1).

Fig. 1 Compulsory admission algorithm (standard cases)

Step	**Responsibility**
Application (to a court)	Family member, health authority, guardian, physician, public prosecutor
Notification (family, public prosecutor) Appointment of an independent lawyer	Court
Psychiatric assessment	Two psychiatrists (public hospital)
Court session	Court + independent lawyer + public prosecutor
Ruling	Court
Admission	Psychiatric team (police, if necessary)

The Mental Health Act clearly defines the people/bodies (family members, public health authority, guardian, physician or public prosecutor) that can ask the court to issue an involuntary placement order. It also covers the situations in which it is necessary to turn a thus-far voluntary placement into a compulsory one (when so requested by the director of the psychiatric department in which the patient is placed).
Once the patient, his/her family and the public prosecutor have been notified, the judge appoints an independent lawyer and asks two NHS psychiatrists working in the patient's geographic area for a psychiatric assessment (request to be issued within a maximum of 15 days). Once the report has been received (within no more than 7 days), a court session is held with all the parties concerned, whereupon the judge must issue a final ruling (within a maximum period of 5 days).
In the event that the court orders an involuntary placement, the admission is conducted by the psychiatric service, which may call upon the police for assistance if necessary (the police are empowered to take the patient to hospital, but not to hold him/her themselves).
The procedure in emergency situations is slightly different: once the assessment has confirmed the need for an involuntary placement, the doctor on duty in the emergency room applies to a court for the appropriate order. The court must then issue a ruling within 48 hours (deadline for short placement).

In the event that the court does order an involuntary placement, the remainder of the process is similar to the standard procedure, except for the fact that the doctor who admitted the patient in the emergency room may not take part in the 2nd assessment.
It would clearly not be possible to adequately comply with any of the above rules if the co-ordination between the various people involved were not good. It should be noted that despite the fact that the

Mental Health Act only took effect in January 1999, the articulation and collaboration between the country's psychiatric services and the courts has worked quite well, albeit with an occasional problem or two [7].

Fig. 2 Compulsory admission algorithm (emergency cases)

Step	**Responsibility**
Take the patient to the emergency room	Police
1st psychiatric assessment	Psychiatrist (emergency room)
Application (to the court)	Psychiatrist (emergency room)
Confirmation (within 48 hours)	Court
Notification (family, public prosecutor) Appointment of an independent lawyer	Court
2nd psychiatric assessment (within 5 days)	Two psychiatrists (public hospital)
Court session	Court + independent lawyer + public prosecutor
Ruling	Court

Practice

The Portuguese Mental Health Act does not distinguish between involuntary placement and involuntary treatment and it is not possible to compulsorily place anyone unless it is to provide them with treatment.

Patients may be involuntarily placed in the psychiatric department of a general hospital, in a psychiatric hospital, or in their own home (under a regimen known as compulsory ambulatory treatment).

There are no significant differences between the provision of care to patients who are admitted on a voluntary basis and those who are placed against their will, and they stay on the same wards (mentally ill offenders are placed in other facilities, however).

As is the case with voluntary patients, each care programme is defined in accordance with the state of the art in psychiatric practise. Two particular forms of treatment are subject to specific regulations set out in the principles governing the Mental Health Act: ECT (the patient's consent is mandatory); and psychosurgery (which requires both the patient's consent and a favourable report from two National Mental Health Commission psychiatrists).

The Act makes no specific mention of coercive measures, except to state the general principle that treatment must be the least restrictive possible.

The Portuguese Mental Health Act does not set either a minimum or a maximum term for involuntary placement. Inasmuch as the underlying philosophy is that treatment should be given in the least

restrictive setting possible (preferably in the community), the compulsory regimen is immediately suspended (and the court must obligatorily be notified thereof) whenever the patient accepts voluntary treatment. Longer stays are obligatorily subject to judicial review two months after admission.

In certain situations – namely once the subject has already been treated on an inpatient basis – involuntary placement can take place at his/her own home (compulsory ambulatory treatment). Such patients are regularly supervised by the psychiatric team.

Once a person has been definitively released, he/she then continues to attend an outpatient clinic in exactly the same way as any other patient.

Patients' rights

Patients' rights are safeguarded on two different levels: that of the general philosophy behind the Mental Health Act itself; and that of the procedural rules [8, 9]. From a conceptual point of view the judicial model adopted by the Act ensures respect for the fundamental individual rights set out in the Constitution. In fact, given that personal liberty is the most important fundamental right of all, it was actually necessary to alter the text of the Constitution itself (Art. 27) in order to make it legal to restrict people's freedom in cases of involuntary placement. Up until 1997 this had only been permitted following a judicial sentence (imposed as the result of an act that is punishable by a prison term or as a preventive measure following the commission of such an act, prior to judgement) [9, 10].

Even when that right is restricted – something that is itself only permitted when it is the only way to provide necessary and suitable treatment – the patient concerned retains all the rest of his/her rights (e.g. the right to vote, to communicate with his/her family and lawyer and the authorities, to send/receive correspondence, to receive visits, to worship and to confidentiality).

Consequently the judge in each case is not only responsible for conducting and legitimating the involuntary placement process, but must also ensure respect for the fundamental rights of the person in question, as set out in the Constitution.

From the procedural point of view patients' rights are safeguarded at every stage of the process – i.e., during application, psychiatric assessment and decision:

- Once involuntary placement has been applied for, the court is responsible for informing/notifying both the person's family and the public prosecutor (a judicial officer who is independent of the judge), as well as for the immediate appointment of an independent lawyer, free of charge.
- The patient is entitled to reject the independent lawyer appointed by the court and to opt for a lawyer of his/her own.
- Unless his/her clinical state makes it completely impossible, the patient has the right to be present at the court sessions and to be heard by the judge. He/she may always appeal against a ruling in favour of involuntary placement.
- The patient must be assessed by two psychiatrists. In the event that they disagree, the court may not order involuntary placement and must request a new assessment from two different psychiatrists.

- Although the final decision is in the hands of the judge, he/she may not order involuntary placement against the opinion of the psychiatrists.
- On the other hand, however, in cases where either the legal preconditions or the legal deadlines therefore are not met the judge may refuse any proposal for involuntary placement made by the medical assessors.
- Involuntary placements must obligatorily be reviewed two months after admission to hospital. However, the patient, a family member, the independent lawyer, a guardian or the public prosecutor may request a review before this.
- The patient is entitled to contact the "Commission for the Supervision of the Mental Health Act" at any time.
- Once a patient has been discharged, his/her fundamental individual rights are no longer subject to restrictions of any kind.

Epidemiology

The passing of the Act also led to the creation of a commission ("Commission for the Supervision of the Mental Health Act") composed of psychiatrists, jurists and representatives of family members' and users' associations. It possesses supervisory functions and is responsible for visiting psychiatric services, gathering and analysing data, collecting suggestions and drawing up proposals for modifications to the text of the statute.

A database has been created for the data gathering and analysis element of this task, but at the moment is still in the final stages of the process involved in obtaining authorisation under the terms of the General Law governing the Protection of Computerised Data. For this reason no epidemiological data are available as yet, except for the total number of involuntary placements and the proportion of the overall number of psychiatric placements that they represented in 1999 (513 – 2.8%) and 2000 (618 – 3.2%).

Problems

The introduction of the new Mental Health Act was not a consensual process within the psychiatric and legal communities and it gave rise to divergences both in relation to a number of theoretical aspects and as regards its practical application [7, 11].

From a conceptual standpoint the main area of disagreement concerns the model's overall orientation and philosophy, which some professionals consider to be too judicial in terms of the procedures involved and the language employed in the statute [7, 10, 12].

On the same plane the failure to distinguish between involuntary placement and involuntary treatment has also been criticised, as has the length of time it takes to carry out the standard procedure [7, 12].

When it comes to the practical implementation of the Act in the field, a number of problems have arisen, particularly as a result of the shortage of human resources. In overall terms, however, the collaboration between the psychiatric services and the courts has been positive [7].

The truth is that the main difficulties have resulted from the considerable period of time that is spent on procedural formalities, which include various psychiatric assessments, drawing up reports and taking part in joint sessions in court, all of which is inevitably detrimental to routine clinical work, especially for departments that do not have many psychiatrists.

Similarly, the shortage of human resources makes it harder to supervise patients who are subject to the compulsory ambulatory treatment regimen, particularly in departments that operate in a more centralised manner and/or have access to fewer community resources.

Finally, some people have said that it is necessary to create special PICU- (Psychiatric Intensive Care Unit) type units with a higher staff/patient ratio than that which prevails in general psychiatric wards. These would serve to provide short-term care for patients who are in a more intense state of agitation and who sometimes constitute a risk either to themselves or to other inpatients and staff.

Conclusion

Generally speaking and despite the operational problems that the introduction of new legislation always entails – problems that are almost always related to a shortage of human and logistical resources – the implementation of the Mental Health Act (Exec. Law 36/98) in Portugal can be considered to have been positive.

Besides the fact that it reformulated the key principles and objectives of the country's mental health policy and formally legalised the involuntary placement process, the main advantages offered by the current Act are the possibility of providing suitable treatment to people suffering from psychotic disorders who had not previously had any contact with psychiatric services, while respecting the principles that ensure the fundamental rights provided for by the Constitution [8, 9, 13, 14].

The epidemiological data analysis that will shortly become possible will be a tool that will be of great importance to the practical evaluation of the Act. It will enable us to more precisely determine both the patterns and the types of diagnosis that are most commonly used in cases of involuntary placement.

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Spain

Francisco Torres-Gonzalez

There are five distinct characteristics of the legal context related to people with mental illness in Spain:

a) There is not ***a*** specific national mental health law in Spain. A special interdisciplinary commission created *ad hoc* by the Government in the 1980s advised against the establishment of such a law. According to the commission report, an eventual specific mental health law would have the following inconveniences: the possible discriminations it might create, even given its objective to fight against all sorts of discrimination. The advice was that any specific legal consideration that mentally ill people might need should be settled within the ordinary legal bodies.
b) The specific rights of the people with mental illness, as well as the type of care they should receive, are regulated in a non-specific way, together with the rights of other types of patients, by the General Law of Health, of 1986 (Laws 3/1986 and 14/1986) (2)
c) The specific rights of the mentally ill are preserved also within the common law that, based on international agreements, is oriented to protect the human rights and the dignity of the human being with respect to biological and medical interventions (3).
d) Regarding involuntary treatment, Art. 10, 6b of the General Law of Health, says that there is not a need for a patient's consent "whenever the patient is not capable to make decisions on his/her own". However, this general principle is not developed by any legal procedure and, in practice, involuntary psychiatric treatment in Spain is not undertaken without involuntary placement under the ordinary civil laws. Beside that, it only happens under the criminal law, where explicit regulation is established.

   However, the involuntary placement in hospital implies that the psychiatrist in charge of the patient has the authority to administer any treatment on only his professional responsibility. Consequently, the involuntary admission implies that the psychiatrist in charge of the patient (in some cases, the psychologist) has the authority to order any involuntary treatment or any coercive measures. Some of them (i.e.: ECT, coercive procedures) are subject to special protocols
e) The Civil Code and the Civil Procedure Law regulate involuntary admission to psychiatric units, either at general or at psychiatric hospitals (1,4).

Only the laws related to involuntary placement will be considered from here onwards.

The first legal regulation of involuntary psychiatric treatment was put forward in 1931 by the Spanish Republic regime (1931-1936). At the time, it was one of the most advanced laws in Europe. According to it, only a judge could authorise a non-voluntary psychiatric admission. During Franco's rule (1939-1977)

the law was kept without change, and although judicial authorisations gradually became a mere formality, it was enough to prevent the political use of psychiatric admissions, as has frequently happened under other dictatorships.

It was not until 1983, six years after democracy had been restored, that a completely revised Civil Code was introduced, and with it new regulation of involuntary admission on evidence of psychiatric disorders. According to this 1983 regulation (Art. 211 of the Civil Code), the judge was kept as the key figure, acting as a public guarantor that the right to freedom is not unduly taken from anyone. Consequently, only a judge can authorise an involuntary admission.

Very recently (2000), a new Law has been introduced: the Civil Procedure Act (*Ley de Enjuiciamiento Civil),* which partially modified the previous norm. However, the central role of the judge has not been changed.

The clinical criteria that justify an involuntary hospitalisation have not changed much, but the new law is not very precise in this respect. In practice, any clinical circumstance that strongly requires the provision of treatment under hospital conditions would be sufficient, but the guarantees of the legal procedure have been further developed and strengthened.

The new text (Art. 758 to 763) says:

> "The admission due to a *psychological disturbance of a person* who is not able to consent, even if he or she is under guardianship, will need judicial authorisation...". In addition, it is also said: "Before giving the authorisation... *the court will hear the person*... and [the judge him- or herself] must examine the *person*... and to be acquainted with a medical report...". Finally, the patient can be represented by an attorney and has the right to appeal.

Art. 763 is named: "Involuntary admission due to psychological disturbance", but there is not a proper definition of involuntary placement anywhere else within the text of the Law.

Art. 763, 1 says afterwards that involuntary admission to hospital may be undertaken "due to the psychological disturbance of a person who is not capable to make the decision (to come into the hospital) by his/her own".

In emergency situations the hospital doctor may decide in favour of involuntary hospitalisation, but this decision must be communicated to the court authority within twenty-four hours.

Anyone may trigger an involuntary hospitalisation procedure, but usually the patient's relatives are the ones who take the initiative.

The initial involuntary hospitalisation does not need to specify duration. There is not a formal legal act of re-approval. After the admission, however, the professional in charge (i.e.: psychiatrist or psychologist) of the hospital must periodically inform the court about the need to maintain the patient on an involuntary basis. The judge may decide the frequency of the required report, but in any case there must be a report no less than every six months. These reports must always justify the need for maintaining the involuntary placement.

The decision to discharge relies on the psychiatrist in care of the patient in agreement with the patient concerned.
Since the main role of the court in this procedure is to guarantee the patients' rights, they may be discharged without the prior permission of the judge, but the judge must be informed immediately after the discharge.

What happens if the person concerned wants to appeal the judge's decision? First of all, it must be taken into consideration that within the Spanish legal system, the *Fiscal* or "Public Ministry" acts as the public and official advocate before the judge and, eventually, before the Court if his assessment does not agree with that of the judge. Besides that, the person involuntarily admitted may, in principle, have the right to be assisted by an advocate, although it is more a principle than a reality.

As it has been seen, in Spain there is a very simple way to afford the problem of the involuntary placement. We have a psychiatrist that advises the admission and a judge that looks after the person's rights, among them the right of freedom. Once the judge is convinced that the person should be admitted without his/her consent, everything else relies on the psychiatrist's professional, ethical, and eventually legal responsibility.
The involuntary treatment without hospital placement, however, is a problem still to be solved.

Involuntary admissions. Data from Andalusia (Andalusia represents 17% of Spanish population)				
No. of services that have been contacted			17	
No. of services that have answered			8	
Total no. of involuntary admission in 1990			2,364	
Total no. of involuntary admission in 2000			2,224	
2000	Proportion of involuntary/total admissions		43%	(23-92%)
	Gender proportion	Men	66.8%	
	Diagnosis	Schizophrenia	42.9%	(29-53%)
	Mean length of stay in days		19.75	(13-24)

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Sweden

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Legislation

All patients have the right to be treated according to the Health Care Act (Hälso- och sjukvårds lagen), which in today's revised version, states that the care should:

- be of good quality and satisfy the patients' need of safety,
- be easily accessible,
- be based on respect for the patient's autonomy and integrity,
- promote a good relation between the patient and staff, and
- as far as possible be planned and carried out in consultation with the patient.

The Compulsory Mental Care Act of January 1, 1967 (LSPV 1966:293) was an exception to the general Health Care Act, which should always be the foundation of the care and represented an important step in the mental health hospital tradition.

The Compulsory Psychiatric Care Act (LPT 1991:1128) and the Forensic Psychiatric Care Act (LRV 1991:1472) of January 1 1992 have, together with the Health Care Act in which mandatory quality systems in all health care has been stipulated since January 1, 1997, been the legal basis for the compulsory admission and involuntary treatment of mentally ill patients. The legislation for the compulsory admission and involuntary treatment was reformed on January 1, 1992 to:

- strengthen the legal safeguards for the patients,
- restrict the use of compulsory care and coercive measures,
- enhance the collaboration with the next-of-kin and the community (revised version July 1, 2000– 2000:353 and 2000:354),
- ensure that all compulsorily admitted and involuntarily treated patients have a documented treatment plan with regard to the medical and psycho-social aspects (revised version July 1 2000), and
- improve the safeguard for the next-of-kin and the community (applies to the Forensic Psychiatric Care Act).

The new legislation is based on a partly changed view of mental illnesses and comparable mental abnormality. The term "serious mental disturbance" has been introduced as a manifestation of this. There

are three conditions which have to be met simultaneously in order for compulsory psychiatric care to be permissible:

- The patient must be suffering from a serious mental disturbance.
- The patient must have an absolute need for full-time psychiatric care owing to his mental disturbance and personal circumstances.
- The patient must object to the care which is needed or, on account of his mental state, be incapable of expressing a considered decision.

When assessing the patient's need for care, it must also be considered whether, as a result of his disturbance, he is a danger to the health or safety of any other person. A compulsory care order must be based on a care certificate issued by a physician other than the one deciding to admit the patient. This order must be issued within 24 hours of the patient's arrival at the institution of care. Voluntary care may not be converted into compulsory care unless there is a manifest danger of the patient inflicting injury on himself or some other person. The duration of compulsory care is restricted to four weeks. If care needs to be continued beyond that period, the matter must be referred to a court of law. Care may then be prolonged by four months and subsequently by six months."

The law changes from January 1, 1992 have resulted in a diminished number of compulsorily admitted patients and shorter treatment periods. The Compulsory Psychiatric Care Act and the Forensic Psychiatric Act reflect and enhance a changed view on psychiatric patients, which has its roots in the 1970s and the sectorisation movement in psychiatry. Patients today are mainly treated in out-patient settings and take an active part in their treatment. The number of hospital beds has been extensively reduced (in the county of Värmland with 280.000 inhabitants from 1.200 in 1972 to 133 in 2001). Next-of-kin and the community, when needed, are involved at an early stage. Evidence-based treatment strategies are the foundation for the treatment plans with medical and psycho-social dimensions.

Another effect of the restricted view of the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act on compulsory admission is that a few patients, for instance those with manic and paranoid disorders, either do not get the treatment they need until a late stage or do not receive any treatment at all, with sometimes tragic consequences for the patients and their next-of-kin. In a limited number of cases the very restricted view on discharge with treatment conditions also results in negative consequences for the patients not being able to keep an apartment or their being a heavy burden on their next-of-kin.

The Forensic Care Act is under consideration at this moment. The early discharge in some cases and discharge without conditions under the appropriate period of time being the issues of discussion.

Practice

In Sweden the police are the only authority that is allowed to use force in society at large. Thus the police are often involved in compulsory admission cases. If possible plainclothes police in collaboration with

health-care personnel should be used. Generally speaking, the collaboration between the health system and the police works better in small communities and towns than in the major cities.

The civil court involved in the judgement of compulsorily admitted patients (Länsrätten) always has an independent specialist in psychiatry assess the patient.

The purpose of care according to the Laws of compulsory admission and involuntary treatment is to get the patient into a condition which makes it possible for him/her to participate in voluntary treatment settings. It is also clearly stated and practised that involuntary treatment and coercive measures always should be proceeded by less restrictive measures. All involuntary treatment and coercive measures must be reported to the National Board of Health and Welfare.

Discharged persons are followed-up by psychiatric out-patient teams in collaboration with the next-of-kin, and the community when needed. During the sectorisation process when the number of hospital beds drastically diminished, the out-patient services increased. Financial problems and budget cuts are a constant danger to the quality of psychiatric care, since the in-patient resources are reduced before they are transformed into out-patient services. The professional view is that out-patient settings of good quality need more resources than the former in-patient settings. The quality of the care is followed-up by the mandatory internal quality systems, peer-review visitations, and visitations by the National Board of Health and Welfare.

The psychiatric institution is responsible for the diagnostic process, treatment, and psychiatric rehabilitation; the community is responsible for living accommodations, occupation, and social rehabilitation. This presumes a well-organised and well-functioning collaboration between the psychiatric institution, the community, and the patient with his next-of-kin. When the collaboration fails or the budget cuts are too extensive, the patient is the loser.

Patient Rights

The Health Care Act with the mandatory quality systems and the Laws of 1992, revised in 2000, focus on extensive patients rights. Sometimes there is a conflict between the security aspects, old traditions and patients' rights. The Patient Committee of the County, the support-person mandatorily appointed if the patient wishes, the Ombudsman of the Parliament, and the National Board of Health and Welfare are authorities with which the patient can lodge an appeal. In addition to that, the National Board of Health and Welfare makes visitations based on indications from patients, the quality systems, or as projects. During 2001 some 80% of psychiatric institutions treating compulsorily admitted patients will be visited by the Board of Health and Welfare in conjunction with patients' rights issues.

Epidemiology

Most patients and their next-of-kin are satisfied with the community-oriented psychiatry as opposed to the mental hospital tradition. There are some disadvantages though, some of which have been previously mentioned, such as the increased burden on family and next-of-kin, an increasing number of homeless

mentally ill, a few patients who do not get the appropriate treatment, and in a very limited number of cases, safety aspects.

The diminished number of hospital beds and increased out-patient settings are part of the community-oriented approach to psychiatry. Patients' rights and the patient as the focus of the treatment process reflect changes in society. Today's Health Care Act and Laws on compulsory admission and involuntary treatment are part of the movement from a psychiatry oriented to mental hospitals towards a community-oriented psychiatry. The Laws reflect and catalyse the process, a process which is a part of a changing society. Budget cuts and diminished resources are another aspect of a changing society to which the psychiatric care has to adjust, but there is also a responsibility to have an alarm function.

All compulsory admissions, all discharges from compulsory admission, all involuntary treatments and all coercive measures are reported to the National Board of Health and Welfare. Unfortunately there is a time-lag before the statistics are accounted for.

United Kingdom

David V. James

Scope of this chapter

Mental health legislation is not uniform throughout the United Kingdom. This chapter concerns the legislative situation in England and Wales. Separate legislation applies in Scotland and in Northern Ireland. The differences between these regions are noted later in this chapter. Further changes in legislation are planned by the current government (Department of Health, 2000). These are outlined at the end of this chapter. The chapter concerns only civil admissions, though some reference will be made to admissions from the courts, where there is an overlap in procedures.

Mental Health Legislation and its History

Mental health legislation has existed in the UK for more than 200 years. Over this period, changes in the law have reflected changes in patterns of care and, latterly, advances in treatment and improvements in prognosis. The Act Regulating Madhouses of 1774 introduced controls over the conditions in private madhouses. Between 1808 and 1891, there were more than 20 Acts of Parliament dealing with the care of mentally disordered patients in public or private institutions. Procedures for compulsory admission were introduced by the Lunacy Act of 1890, but it was not until 40 years later that voluntary admission was permitted, under the Mental Treatment Act of 1930.

A major revision of legislation occurred with the Mental Health Act of 1959, which brought together for the first time in one Act a comprehensive framework of mental health law. The Act was framed to reflect advances in treatment, which enabled an increasing proportion of patients to be treated in open wards and to be returned to the community after treatment. The Mental Health Act 1959 encouraged voluntary admissions. Authority for compulsory detention became a matter for doctors, social workers and hospitals. Magistrates, who had previously been involved in compulsory detention procedures, no longer had any role.

An extensive revision of the 1959 Act occurred with the Mental Health Act 1983, which remains the current legislative framework in England and Wales. This Act introduced new mechanisms to safeguard the legal rights of patients, and reintroduced an independent inspectorate of psychiatric institutions, which had been abolished in the 1959 Act. The 1983 Act is concerned with compulsory admission to, and treatment in, hospitals and mental health nursing homes. It does not contain any provision for compulsory treatment in the community. In this respect, it has been seen as increasingly out-of-date, as a greater proportion of patients have come to be treated outside hospital. In addition, the lack of any power to treat

compulsorily in the community has lead to a pattern of "revolving door" admissions, which needs to be addressed by changes in legislation. Parallel concerns for public safety on the one hand, and the protection of individual rights on the other, are reflected in the outline for a new mental health act, published by the Department of Health.

Relevant legislation

Other than the Mental Health Act 1983, compulsory detention is possible under other acts: the National Assistance Act 1948; the Children and Young Persons Act 1969; the Children Act 1989; and, in forensic cases, the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, and the Powers of Criminal Courts Act 1973. The number detained under these other acts is insignificant.

The Mental Health Act 1983 has been subject to minor amendment, and to minor extension in the form of the Mental Health (Patients in the Community) Act 1995. Although the Act remains substantially unchanged, it has been interpreted, refined and rendered more complex in its execution by case law, there having been hundreds of relevant court decisions since 1983.

The 1983 Act determines that the Secretary of State (in effect the Department of Health) prepare, and from time to time revise, a Code of Practice to offer practitioners guidance on how to carry out their functions under the Act. The Code of Practice is published as a substantial volume which details good practice in terms of procedures for compulsory detention and treatment, but also covers in detail areas not dealt with in the primary legislation, including restraint, seclusion, and after-care. The Mental Health Act does not impose a legal duty to comply with the Code, but as it is a statutory document, failure to follow it could be referred to in evidence in legal proceedings. In practice, it is used as the standard by the independent commission which monitors the implementation of the Mental Health Act in individual hospitals. As such, it is for the most part rigidly adhered to. The annotated version of the Mental Health Act, including notes on interpretation and case law, relevant rules and government circulars and the Code of Practice, now runs to 700 pages in small font (Jones, 1999).

Scope of the legislation

The majority of people with mental health problems are treated in the community, and 90% of admissions to psychiatric hospitals are on a voluntary basis. Mental health legislation applies only to those compulsorily detained in psychiatric hospitals for assessment or treatment, and therefore concerns only a small minority of those with mental health problems.

The legislation concerns people with "mental disorder", and applies to any age. Mental disorder comprises four categories: "mental illness" (which is not further defined); "arrested or incomplete development of mind (mental impairment)", "psychopathic disorder" (in effect, personality disorder), and

"any other disorder or disability of mind". Specifically excluded from the scope of the Act are "immoral conduct, sexual deviancy or dependence on alcohol or drugs". The definitions of "mental impairment" and of "psychopathic disorder" specify that there must be "abnormally aggressive or seriously irresponsible conduct" for the persons concerned to fall within the scope of the Act.

Procedures for compulsory detention

There is no role for the courts or the judiciary in civil detention. Compulsory admission and treatment are based on the recommendation of doctors. Application for admission is made by specially trained social workers (or, rarely, the patient's nearest relative). Patients are legally detained by the managers of the hospital to which they are admitted. The admitting hospital is determined by the domicile of the patient.

There are three types of admission orders: emergency orders, the procedures and criteria for which are less stringent and which only last 72 hours; assessment orders, which also allow treatment, but are limited to 28 days; and treatment orders, which can be renewed indefinitely where sufficient grounds exist.

Emergency admission orders can be made in the community by one doctor and a social worker. Provision also exists for an order to be made by the police. For those already in hospital, emergency orders can be made by one doctor acting alone. Provision also exists for such detention to be authorised by a trained nurse, although such detention is limited to six hours. Those on emergency orders will be assessed for detention under substantive orders before the period of emergency detention ends.

For orders other than emergency orders, two medical recommendations are required, one of which must be from a trained psychiatrist. The two doctors concerned must not be on the staff of the same hospital, and (where possible) one should have previous knowledge of the patient. The same provisions apply to patients already in hospital as to those in the community.

Criteria for compulsory detention

The criteria for detention specify that the patient must be suffering from a mental disorder "of a nature or degree" which makes it "appropriate" for the patient to receive assessment or treatment in hospital (as opposed to in the community). In effect, this means that treatment in the community must be impractical or impossible, the latter being most commonly because the patient cannot be relied upon to be compliant with assessment or treatment on a voluntary basis.

In addition, detention must be necessary, either in the interests of the patient's health, or his safety, or for the protection of other persons. It should be noted that the main reason for detention is in the interests of the patient's health, and there is no dangerousness criterion that must be fulfilled.

In the case of treatment orders in those with psychopathic disorder or mental impairment, there is a further condition, namely that treatment must be "likely to alleviate or prevent a deterioration" of the condition in question.

Compulsory treatment

Orders other than emergency orders permit treatment as well as detention. Exceptions are for ECT, where either consent or permission from an independent "second opinion" psychiatrist is required: and for psychosurgery and the surgical implantation of hormones, for which both consent and a second opinion are required. In addition, in all people involuntarily detained, after compulsory treatment has been administered for three months, a second opinion as regards the desirability of treatment must be obtained before it is continued, unless the patient consents to treatment.

Extension of treatment orders

Treatment orders last for six months, and can be extended for a further six months, and then annually. Extension of a treatment order is decided upon by the treating psychiatrist, who must examine the patient and determine that the preconditions for compulsory treatment still apply. The continuation of detention is then examined by the hospital managers at a review meeting, at which the patient and a legal representative may be present, if the patient so desires.

Appeal procedures

Patients may appeal against detention either to the hospital managers or to an independently constituted Mental Health Review Tribunal. The latter will include an independent psychiatrist who will examine the patient. Both bodies will receive written reports from the treating psychiatrist and social worker (who are unlikely to be the same as those involved in the original detention). The appeal bodies may also hear evidence from these professionals and from the patient, whose case is usually put by a legal representative. The cost of the latter is met by the State. Both appeal bodies have the power to discharge the patient from hospital.

Discharge from detention orders

The orders cease to have effect at the end of the statutorily determined period, unless renewed by the treating psychiatrist. The psychiatrist has the power to end the order at any point without reference to any other body or authority. There are no defined criteria that have to be met before release.

The nearest relative may also apply to the hospital for a patient's release from compulsory detention for treatment. The relative's wishes can be over-ruled by the treating psychiatrist, whose actions in this respect will usually, but not automatically, lead to review by the hospital managers.

Places of detention

Patients may be detained in hospitals or registered mental health nursing homes. Each district has a psychiatric unit. These are either attached to general hospitals, or are stand-alone units in the community. The old large psychiatric institutions no longer exist. Most wards are open, although some areas will have a locked ward. Voluntary patients and those compulsorily detained are mixed together in the same wards. Forensic facilities comprise one or more medium secure units in each region, and three maximum security hospitals for England & Wales. Most forensic patients (other than serious offenders) are cared for in general psychiatry units, on the same wards as voluntary patients and civilly detained patients. Forensic facilities contain civilly detained patients, as well as those admitted from the criminal justice system. Most patients admitted from the criminal justice system can be discharged by the treating psychiatrist in the same manner as civilly detained patients, without reference to any court or exterior authority. All admissions through the courts can be discharged by the independent Mental Health Review Tribunals. There is also a tendency (and government encouragement) for minor offenders to be dealt with at court by visiting psychiatrists under civil detention procedures. A degree of overlap therefore exists between civil detention, and detention sanctioned by the criminal courts.

Community provisions

The Mental Health Act 1983 contains “guardianship” provisions for patients in the community. These are little used. The procedure for applying them is similar to that for compulsory admission for treatment. The legislation enables a patient to be placed in the guardianship of the local social services department or some individual deemed suitable by that department. There is no obligation on any agency to accept such duties, and many social service departments are either reluctant, or simply refuse, to take on the role of guardian. The powers conferred by guardianship are limited: the patient can be required to reside at an address, to allow access to approved persons, and to attend for appointments. There is, however, no sanction, if the patient decides not to comply with the order.

A new community provision, “after-care under supervision”, was inserted into the Mental Health Act by the Mental Health (Patients in the Community) Act 1995. This has not been successful, and its use has been limited. It applies only to those previously detained in hospital for treatment. Its purpose is to try to ensure more effective after-care. In effect, it differs little from guardianship, except in that it gives the power to “take and convey” a patient to a location where he is required to be for treatment, education or training. It does not offer the means to effect this, nor does it offer any power to keep the patient at the location in question, nor to treat them compulsorily.

Independent supervision of the Act

An independent Mental Health Act Commission is charged with the duty of reviewing the use of compulsory powers within the Mental Health Act, of investigating complaints, and of inspecting facilities in

which patients are compulsorily detained. A system of regular inspection of facilities and of compulsory detention records is in place. Such inspection is searching, and includes the practice of unannounced visits, some being at night. Other than reviewing the use of the Act, the Commission reviews the conditions in which patients are detained, and compliance with the guidance given in the Code of Practice. Their duties extend to the inspection of seclusion policies and records, and of practices concerning other aspects of practices impinging on patients' rights, such as search policies, the withholding of mail, and restrictions on visitors. Their reports on individual hospitals are made available to relevant agencies, and progress in addressing criticisms of practice is reviewed upon subsequent visits.

Aftercare

Health and local authorities have a statutory duty to provide community after-care services to those previously detained in hospital for treatment. However, the nature of such services is not specified by statute. They do not extend beyond what the authorities are already obliged to supply under other legislation, such as medical outpatient supervision, social work support and forms of accommodation. Services need only be supplied for as long as the supplying authorities deem them to be necessary. There are no powers to oblige patients to accept such after-care, if they chose not to.

Scotland and Northern Ireland

Compulsory detention in Scotland is dealt with under the Mental Health (Scotland) Act 1984, amended by the Mental Health (Detention) (Scotland) Act 1991. The principle different from the situation in England and Wales is that applications for detention for more than 28 days require the approval of a sheriff, a legally qualified judge. There are no mental health review tribunals in Scotland, and appeals against detention are also heard by a sheriff.

In Northern Ireland, the Mental Health (Northern Ireland) Order 1986 was clearly influenced by the legislation in England and Wales, but there are significant differences. The legislation differs from that in the rest of the UK in giving a definition of mental illness ("a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons"). There is no category of "psychopathic disorder" and, in fact, the Order specifically excludes personality disorder as a reason for detention. A further difference is that the detention criteria require evidence to be adduced, not only that the patient suffers from mental disorder warranting detention in hospital, but also that failure to detain him would create a substantial likelihood of serious physical harm to the patient or to others.

The legislation in practice (England and Wales)

Mental health legislation in England and Wales is comprehensive, detailed and relatively sophisticated. Its emphasis is on the patients' best interests in terms of their health. The legislation does not prevent psychiatrists from imposing compulsory treatment in hospital where this is thought necessary. Such

powers are balanced by a comprehensive system of safeguards and independent checks on their use and an emphasis on ensuring patients' rights.

However, there is a consensus that the legislation is in need of extensive revision. It was framed for an age in which most treatment was in lengthy hospital placements, whereas the focus of treatment is now in the community. The current legislation contains no powers for compulsory treatment in the community, and this has lead to a situation of "revolving door" admissions amongst a section of the most seriously mentally ill, with compulsory treatment in hospital followed by non-compliance in the community, relapse and further compulsory admission. Furthermore, after-care responsibilities are insufficiently defined in the Act, contributing to an inadequacy in aspects of community care. Such imprecision also affects the role of the Mental Health Act Commission, and therefore issues of patients' rights.

In addition, the use of the 1993 Act has become more complex with an ever increasing number of court decisions interpreting the statute, accompanied by a boom in legal practices specialising in mental health law. Some aspects of the Act have been found by the courts to be incompatible with the Human Rights Act 1998, and further findings in this regard are likely.

Epidemiology

The Department of Health collects statistics from each hospital group about those detained compulsorily under the Mental Health Act 1983. These are collected for each financial year, and subsequently published. Data are thought to be generally reliable, although some hospital groups are unable to differentiate between patients admitted compulsorily, and those detained compulsorily after voluntary entry to hospital (Department of Health, 1999b).

In 1999-2000, there were 26,669 compulsory civil admissions in England (which excludes Wales, Scotland and Northern Ireland). This compares with 16,297 in 1989-1990. There was no parallel increase in compulsory admissions through the courts (Department of Health, 2001), of which there were 1,638 in England in 1999-2000. In addition to the 26,669 people compulsorily admitted in England in 1999-2000, there were more than 20,000 compulsorily detained in hospital after being admitted compulsorily. In 1998-99, for which the figures are more readily accessible, the total number compulsorily admitted or detained after admission in England was 46,300, giving a compulsory detention rate of 93 per 100,000 population. There was a 100% geographical variation between the lowest and highest regional rates, although much of this might be accounted for by socio-economic differences and differing sex and age distributions of regional populations (Department of Health, 1999b).

The increase in compulsory admissions between 1989-90 and 1999-2000 is striking. Government publications suggest that it might represent a greater awareness amongst clinicians of their powers under the 1983 Act. However, it is relevant to observe that it follows trends in psychiatric services, with which the law has not kept pace: the closing of psychiatric beds and, in some areas, of all locked beds; shortage

of beds for admissions; consequent premature discharges; and high emergency readmission rates. As such, the change in figures may represent one aspect of the psychiatric "revolving door". It is noteworthy that, by 2000, the main expansion in inpatient services was in forensic psychiatry.

Proposals for a new mental health act

The government commissioned an expert committee to advise on reform of mental health legislation (Department of Health, 1999). When the government's draft proposals for a new mental health act were published in December 2000 (Department of Health, 2000), it was evident that some important recommendations of the review had not been taken up by the government.

The government's proposals for the new act emphasise the need to improve the quality and consistency of health and social services for the mentally ill, and the need to protect the rights of patients. The proposals address many of the problems with the Mental Health Act 1983, briefly referred to above, and are designed to be compatible with the Human Rights Act 1998 (which incorporates many aspects of the European Convention on Human Rights into UK domestic law).

However, the proposals make it explicit that there is a new emphasis on matters of public safety, which take precedence over the patient's individual interests. The existing legislation is criticised on the grounds that it permits patients to refuse treatment (once discharged from hospital). The tenor of the document is that compulsion and control will be expanded, and that the loss of liberties will be compensated by an improvement in quality of services and in the monitoring of legal powers. The most notable changes are: the removal of treatability criteria in the detention of those with mental disorder, so that patients with personality disorder may be compulsorily detained, even where no effective treatments exist; the expansion of compulsory treatment to all settings, including community placements; and the potentially indefinite preventive incarceration of those with so-called "dangerous, severe personality disorder", even when no criminal offence has been committed.

In order not to contravene Article 5 of the European Convention on Human Rights, compulsory treatment of an individual in the community must be sanctioned by a court of law or similar judicial body. The proposals deal with this problem by altering the mechanism for imposing compulsory treatment. Whereas the mechanism for admission for assessment and initial treatment would remain the same, treatment after 28 days would be sanctioned by a quasi-judicial body, the Mental Health Tribunal. This would essentially be the existing Mental Health Review Tribunal under a different name, and it would take over its predecessor's functions in hearing appeals against detention. Most of the existing mechanisms and criteria for detention and treatment would remain the same.

The most controversial aspect of the proposals is that concerning people with so-called "dangerous severe personality disorder", which has been met with almost universal condemnation by professionals and civil libertarian groups. Critics point out that the government has invented a new diagnosis, which it

has yet to define; that there are no proven treatments for the group that the government appears to be concerned with; that psychiatrists are unable to state with accuracy who will or will not be dangerous; and that the proposed measure represents an attempt by the government to introduce imprisonment without trial of those thought socially undesirable, under the spurious guise of a health intervention. Apologists for the government position point out that the measure would at least expand research into, and services for, a group which is currently largely excluded from care by mental health services – those with personality disorder. The harshest critics assert that the proposed measure is further evidence of a moral panic about supposed dangerousness, which is of trans-Atlantic provenance, is supported neither by evidence nor reason, and which also infects the criminal justice policies of a UK government that lacks courage or direction, despite the large majority that it currently enjoys.

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5 Synopsis

This chapter summarises the most significant compulsory admission regulations or procedures across the European Union as described in chapters 3 and 4 of this report in order to give an overview of the similarities and differences in the legal approaches of the Member States. Only crucial issues are included here, to allow global conclusions for common policies or actions on an EU level. For more details about certain Member States please refer to the tables in chapter 3 or in the various national chapters. Table 5.1 (see below) summarises the items most decisive for characterising differences between Member States. All other tables mentioned below refer to chapter 3 of this report.

Legal frameworks

The fact that almost all European Union Member States reformed their legal frameworks pertaining to the involuntary placement or treatment of mentally ill patients during the 1980s and 1990s, indicates that this is a most important issue on the legal or mental health care agenda of the Member States'. While most have enacted separate mental health laws regulating the procedures of compulsory admission, Greece, Italy and Spain also include statutes covering the detention of mentally ill people in their general health legislation or in other legal instruments (see table 1.1).

Whether or not they are regulated by a separate mental health act, legal regulations as well as routine procedures for detaining the mentally ill differ considerably across the European Union. Thus, the most significant characteristic of the European Union Member States' legal frameworks regarding involuntary placement or treatment is their variety. Although common patterns among Member States were identified upon comparison of crucial legislative or procedural details, these patterns were far from being consistent across all analysed items or approaches.

All Member States comply with basic human rights principles or guidelines as defined or approved by the United Nations, the Council of Europe, the European Court for Human Rights, or other organisations (see chapter 1). Nevertheless, reforms of the national mental health acts or specification of regulations present an opportunity to increase the harmony of national laws, acts or procedures according to the policies of or experiences made by other countries. One major problem, however, is the shortage of evidence for best practise. Currently, even within some Member States, there might be several legal instruments, each with a different regional scope or pertaining to selected patient groups, in effect simultaneously. The most significant example is Germany, with one nationwide guardianship law and sixteen state commitment laws (according to the sixteen German Federal States) currently in effect that differ remarkably with

regard to crucial details. Separate mental health acts are also in effect for large parts of the United Kingdom (Scotland and Northern Ireland) and Denmark (Greenland) (see table 1.4).

Thus, the main conclusion of this study is that national legal traditions, structures or standards of quality with regard to the provision of general health care, as well as national approaches or philosophies regarding mental health care, most strongly determine the legal frameworks or the practice of involuntary placement or treatment of mentally ill patients.
This constitutes a major obstacle to any mutual European actions or policies. However, ongoing activities in the Member States to reform or adapt their mental health legislation might offer opportunities for harmonising legal instruments across the European Union.

A comparison of the legal frameworks of the Member States or an evaluation of the effectiveness of their approaches entails serious methodological problems. International epidemiological research in this field has not yet developed a convincing statistical model for correlating changes in mental health care legislation to any outcome of compulsory admission procedures. Moreover, even the most basic outcome data, in terms of valid or reliable annual frequencies or rates of compulsory admission of mentally ill persons, are usually missing. Moreover, the complexity of the issue disallows the conclusion of simple causal relationships between certain features of legal regulations and any change of outcome. Most often, apparently, negative effects of given or lacking regulations might be compensated by other statutes, stipulations or procedural details. All these obstacles should be seriously considered when drawing conclusions or trying to identify preferable approaches from among the current policies of the Member States.

Legal criteria for involuntary placement

The acts or laws of all Member States outline that the compulsory admission of a mentally ill patient is legally permitted only when less restrictive alternatives might not be sufficient or available. Only the legal frameworks of France and Spain do not explicitly formulate such a stipulation (see table 1.6). Thus, across the European Union, compulsory admission is seen as an intervention of last resort, only to be applied in an acute crisis or state of emergency. Nevertheless, the legal criteria qualifying a person for involuntary placement in a psychiatric facility differ widely across the Member States. For a global overview, these criteria can be categorised into three groups (see table 1.10), providing probably the most significant distinction for characterising a Member State's legal approach towards involuntary placement or treatment of mentally ill persons.
A serious threat of harm to the person himself and/or to others ("dangerousness criterion") is an essential prerequisite for compulsory admission in Austria, Belgium, France (HO-procedure, see national chapter), Germany, Luxembourg, and The Netherlands. For another group of Member States including Italy, Spain, and Sweden, an ultimate need for psychiatric treatment is the crucial criterion qualifying a person for compulsory admission should the patient not comply ("need-for-treatment criterion"). Denmark, Finland,

Greece, Ireland, Portugal, and the United Kingdom apply either the dangerousness criterion or the need-for-treatment criterion to place mentally ill patients involuntarily.

Defined mental disorders

Although the legal frameworks of all Member States include a given mental disorder as the most basic prerequisite, the concept of "mental disorder" is not narrowly defined throughout the European Union (see table 1.11). Few national laws or acts specify "mental disorder" at the level of specific psychiatric diagnoses. Those that do so do not rely on descriptions or definitions as provided by internationally approved classification systems like ICD-10 or DSM-IV. When referring to serious mental conditions, the term "psychosis" might be included in certain acts, whereas only the Danish law limits compulsory admission to "psychoses" or conditions of similar severity. Some German state laws may use diagnostic terms, while not restricting compulsory admission only to psychotic conditions. Only the Irish and the UK-laws specifically regulate the conditions a patient with "personality disorder" must be in for getting detained against his will.

Only six Member States define specific conditions for excluding patients from involuntary placement (if these conditions or this behaviour appears without any other inclusion criteria, see table 1.13). The specified conditions are as heterogeneous as the inclusion criteria (e.g. mental retardation without psychotic symptoms, non-compliance, substance misuse, personal neglect, promiscuity, sexual deviance etc.). However, even among experts there is no overall agreement on how narrowly diagnostic concepts or inclusion criteria should be defined. Limiting involuntary placements to specific disorders at a legal level might principally exclude from the procedure patients with unclear conditions and weaken the testimony of medical experts, whereas detailed definitions of disorders or clear disease concepts might fortify the legal certainty during all stages of the process for all persons or authorities involved.

Medical assessment

The responsibility and expertise to assess the medical criteria for placing a person involuntarily are also heterogeneous across the Member States. The laws of several Member States permit physicians other than trained psychiatrists to be involved in the initial medical assessment of the persons concerned not only in emergency cases but also during routine involuntary placement procedures, whereas the expert testimony of a psychiatrist is mandatory in the remaining countries. Even when preliminary certificates, applications or assessments by non-specialist physicians might be confirmed or rejected by trained psychiatrists in further stages of the procedure (which is the case in most Member States), to restrict even preliminarily the freedom of persons on the basis of certificates from physicians not specifically trained in mental health care might well limit quality standards (see table 1.14). This is even more important in view of a tendency towards increasing compulsory admissions under emergency regimes, allowing the temporary detention of persons without clear confirmation of the criteria.

Tab. 5.1

	Criteria for placement	*Diagnoses legally defined*	*Psychiatrist mandatory for initial assessment*	*Deciding authority*	*Involuntary placement and treatment legally defined as different modalities **	*Detailed regulation of coercive measures*	*Compulsory outpatient treatment possible*	*Mandatory inclusion of patient counsel*	*% of compulsory admissions of all psychiatric in-patient episodes**	*Compulsory admissions per 100,000 population**
Austria	D	n.d.	yes	non-med.	yes	yes	no	yes	18	175
Belgium	D	n.d.	no	non-med.	no	no	yes	yes	5.8	47
Denmark	T or D	psychosis	no	med.	yes	yes	no	yes	4.6	34
Finland	T or D	n.d.	no	med.	no	no	no	no	21.6	218
France*	D	n.d.	no	non-med.	no	no	no	no	12.5	11
Germany	D	wide	no	non-med.	yes	yes	no	no	15.9	175
Greece	T or D	n.d.	yes	non-med.	no	no	no	no	n.a.	n.a.
Ireland	T or D	wide, PD	yes	med.	no	no	no	yes	10.9	74
Italy	T	n.d.	no	non-med.	no	no	no	no	12.1	n.a.
Luxembourg	D	n.d.	no	med.	yes	no	yes	no	26.4	93
Netherlands	D	n.d.	yes	non-med.	yes	yes	no	yes	13.2	44
Portugal	T or D	n.d.	yes	non-med.	no	no	yes	yes	3.2	6
Spain	T	n.d.	yes	non-med.	no	no	no	no	n.a.	n.a.
Sweden	T	n.d.	no	med.	yes	yes	yes	no	30	114
UK	T or D	wide, PD	yes	non-med.	yes	no	no	no	13.5	93

* France: HO-procedure

* Involuntary placement or treatment legally defined as different modalities: indicates only the legal separation of the modalities, regardless of whether or not in routine care, persons placed involuntarily must accept treatment

* Percentage of compulsory admissions / compulsory admissions per 100,000 population: most recent year available, usually 1999 or 2000 (see chapter 3).

Abbreviations:

Criteria: D = dangerousness, T = need for treatment; D or T = dangerousness or need for treatment

Diagnosis: n.d. = not defined, wide = diagnostic categories mentioned but no restriction to specific diagnoses, psychosis = restriction to psychosis or conditions similar to psychoses; PD = special regulations for personality disorder

Deciding authority: non-med. = non-medical, med. = medical

Rates and quotas: for most recent year available, see tab. 4.2, n.a. = not available

For the same reason, the stipulated inclusion of a second expert's opinion in the assessments is a crucial measure of quality assurance that is not a standard in all Member States (see table 1.15).

Decision responsibilities and procedures

Along with the basic commitment criteria (as described above), defined responsibilities for the final decision on involuntary placements or treatments mark another significant characteristic of the legal frameworks or approaches of the Member States.

There is a large group of Member States, including Austria, Belgium, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, and the United Kingdom, in which non-medical authorities such as judges, courts, mayors or even social workers (in the case of the United Kingdom) decide on placements, as opposed to Denmark, Finland, Ireland, Luxembourg, and Sweden, where the final decision remains a medical obligation. The latter approach might emphasise the medical or treatment aspects of the procedure, whereas the former tends to restrict and control the physicians' discretion.

Time limits for initial involuntary detainment as stipulated by the national laws vary remarkably, too, ranging from a minimum of seven days in Italy to nine months in Finland (see table 1.21). Unfortunately, there is no information available, on the degree to which the various Member States make use of the various time frames. Considering that involuntary placements are an ultimate measure of crisis intervention, it seems at least debatable whether legal definitions of time frames might not be obsolete, since involuntary placements should be for as short a time as possible. Consequently, Denmark, France, Portugal, and Spain do not define any maximum length of involuntary placement. Nevertheless, there is a need to legally regulate the periodic re-assessment and re-approval of initial decisions, which should be performed at short intervals. All Member States have achieved this in their laws, but again with considerable variations as far as the length of the intervals for re-assessment or re-decision is concerned (see table 1.21).

Emergency procedures

Almost all Member States distinguish between preliminary or short-term detention (for acute cases of emergency) and routine or non-emergency compulsory admission procedures. Only in Denmark, Finland, and Ireland are the two procedures similar. Usually, in cases of acute emergency, persons can be detained for short periods of time without the immediate confirmation of the authority responsible for the final decision on a placement. Again, the defined maximum length for short-term detention differs remarkably across the European Union, ranging from 24 hours to ten days (see table 1.20). Several experts contributing to this study reported an increase of in the number of placements under emergency regimes in their countries, possibly indicating a tendency to avoid the strict regulations for regular procedures. Since safeguards for patients are severely weakened under emergency regimes, a special

awareness of the appropriateness, the duration and the rules for application of emergency regimes might be recommended for future legal reforms.

Involuntary treatment

Until the late 1970s, most countries did not consider the involuntary placement of mentally ill people and the application of appropriate psychiatric treatment to be separate modalities. Particularly in the United States, this approach has changed remarkably, due to strong emphasis on the human rights aspects of involuntary placed patients. As a consequence, commitment statutes no longer aimed at ensuring treatment for mentally ill patients in the first place, but instead, at protecting them or others from negative consequences of their behaviour. In most cases this was achieved by merely institutionalising and carefully supervising the persons concerned. It was assumed that even when a patient had been admitted compulsorily to mental health care facilities, his competence to decide on a treatment prevailed. Thus, in order to treat involuntarily placed patients, their informed consent was required.

Similar to the development in the US, some European Union Member States (Austria, Denmark, Germany, Luxembourg, The Netherlands, Sweden, and the United Kingdom) define involuntary placement and treatment in their laws as, in principle, separate modalities (see table 1.22). Nevertheless, this does not necessarily mean that in these countries patients who are admitted compulsorily can refuse treatment in any case. E.g. in Sweden, Denmark, and Luxembourg, despite the acknowledgement of placement and treatment as separate modalities at a legal level, patients who have been placed involuntarily must nevertheless accept treatment, similar to the approaches in Finland, France, Ireland, Italy, Portugal, and Spain (see table 1.23).

The legal frameworks of some of the Member States include and regulate specific compulsory treatment measures in a rather detailed manner, while others do not (see table 1.25). Among these interventions are some that are rarely applied in current mental health care, as is the case with psychosurgery (regulated by five Member States), whereas the application of neuroleptic drugs - probably the most common type of intervention for severely mentally ill patients today - is included in the laws of only four Member States. The regulation of other coercive measures (e.g. physical restraint, seclusion, pharmaceutical restraint) is similarly heterogeneous (see table 1.26), suggesting an overall need to adapt the regulation of coercive treatments or interventions in the laws of the Member States according to current standards in mental health care.

Involuntary outpatient treatment, aftercare

To diminish a growing “revolving-door” phenomenon in community-based mental health care, aftercare as a continuation of the actual treatment episode has become increasingly important for involuntarily placed patients, as well.

However, continually changing patterns of mental health care delivery, which strongly emphasise community-based care over institutionalised care settings are hardly reflected in the commitment laws of the Member States, which still rely primarily on in-patient care when regulating involuntary placement or treatment (see fig. 2.4.). Six national laws discuss aftercare for patients discharged from an involuntary treatment episode as an option in a more general way (Belgium, Germany, Luxembourg, Portugal, Sweden, and the United Kingdom) (see table 1.7), whereas only four Member States provide a legal basis for compulsory outpatient treatment (Belgium, Luxembourg, Portugal, and Sweden) (see table 1.27). The efficacy of coercive outpatient treatment has currently not been confirmed by research. However, as there is a growing discussion in the United States, as well as in some Member States (e.g. United Kingdom), that favours outpatient commitment, future legal reforms towards a stronger emphasis on this modality might be expected.

Patients' rights

Although many legal reforms in this field were initiated to enforce patients' rights aspects of compulsory admission procedures, there is no overall common approach to safeguarding patients' rights in the legal frameworks of the Member States.

However, the most basic right of appeal to a court against an involuntary placement or coercive treatment is included in the laws of all Member States (see table 3.6). Due to a possibly reduced capacity for reasonable decision-making, the opportunity to be supported by a legal representative is crucial for any involuntarily placed patient. However, a mere six national laws (Austria, Belgium, Denmark, Ireland, The Netherlands, and Portugal) stipulate the obligatory inclusion of an independent patient counsel (advocate, counsellor, social worker etc.) in the commitment procedure (see table 3.2). In addition only a few Member States provide legal support to involuntarily placed patients free of charge (see table 3.3).

Further restrictions of liberty or basic human rights during involuntary placement or treatment processes are manifold (e.g. right to free communication, right to receive visits, private locker space etc.), but not regulated by all Member States at a legal level (see table 3.7). E.g., five Member States define criteria for restricting free communication, another seven regulate restrictions upon receiving visits. When regulations are included in the laws, usually clear criteria or time frames are defined. To better safeguard human rights, a detailed and comprehensive legal regulation of these restrictions by all Member States would be desirable.

Outcome

During this study, epidemiological data from various national sources was gathered to discuss the outcome of involuntary placements across the Member States in terms of total frequency or rates of compulsory admissions. Although more detailed and comprehensive time series than those currently provided by the international scientific literature were available, conclusions must be drawn rather cautiously, since data might be confounded in several ways. E.g., some Member States might apply

different definitions or concepts of compulsory admission. Some might register a patient's change from a voluntary to an involuntary treatment regime during the same inpatient episode (and vice versa), while others might not etc. Nevertheless, due to a shortage of sound research in this field, the data as presented in tables 4.1 to 4.5 are one of the most comprehensive overviews of the various Member States that is currently available.

Compulsory admission frequencies quotas and rates

Whereas total frequencies of annual compulsory admissions of mentally ill patients differ enormously according to the differing populations of the Member States (see table 4.2 or figures 4.2a and 4.2b), compulsory admission rates (annual admissions per 100,000 population) also vary remarkably, ranging from a mere six per 100,000 population in Portugal to 218 in Finland (see table 4.2). Compulsory admission quotas (percentage of involuntary placements of all annual psychiatric inpatient episodes), as another weighted and thus roughly comparable indicator, also display a very wide range across the Member States, from 3.2% in Portugal to 30% in Sweden in the most recent available year (see table 4.2).

Comparison of the time series of compulsory admission quotas during the last decade revealed a slightly more homogeneous pattern, suggesting an overall tendency towards more or less stable quotas in most Member States (see fig. 4.3). This finding defeats conclusions indicating a general trend towards increasing numbers of compulsory admissions of the mentally ill internationally, which is reported in various scientific papers. Similar assumptions might arise from this study as well, if only total numbers of compulsory admissions are considered, which were found to be increasing at least in Germany, France, England, Austria, Sweden, and Finland (see figures 4.2a and 4.2b). However, the increasing total numbers of compulsory admissions are obviously balanced by the effects of internationally changing patterns of mental health care delivery, which internationally shortens the mean length of stay in inpatient facilities at the expense of more frequent re-admissions.

When statistically correlating compulsory admission rates or quotas of the most recent year available to the qualifying criteria for compulsory admission (dangerousness criterion or need-for-treatment criterion, see table 1.10), no significant difference was found. Likewise, Member States relying on medical for the final decision on involuntary placements (see table 1.16) did not differ statistically with regard to compulsory admission rates or quotas from those which relied on non-medical authorities. However, Member States which stipulated the mandatory inclusion of an independent counsel in the procedure, showed significantly lower compulsory admission quotas, as well as a tendency towards lower compulsory admission rates than Member State without such a stipulation. This preliminary finding suggests further analyses of the hypothesis, to clarify whether better legal support for the persons concerned might help to lower compulsory admission rates or quotas.

Diagnostic profiles of involuntary placed patients

The limited data on diagnostic patterns or socio-demographic characteristics of compulsorily admitted patients submitted by some Member States also suggest further analyses. Overall, schizophrenia or related disorders seem to be a predominant disease in those Member States which were able to provide diagnostic overviews, without, however, giving a clear hint to a correlation to any legal or procedural approach (see table 4.4). However, when analysing the gender of compulsorily admitted patients, Member States preferring the dangerousness criterion clearly seem to place more male patients involuntarily than females (see table 4.5 and figure 4.5). This pattern might reflect general findings that mentally ill males are more violent, and thus are selected more frequently for compulsory admission when the dangerousness criterion is applied. Whether this result indicates any real influence of the criteria on the gender of compulsorily admitted populations has to be confirmed in further analyses, when controlling the proportion of compulsorily admitted males by the overall gender proportion of psychiatric inpatients in the respective Member States. Unfortunately, such data were not available for this study.

Conclusions

This study contributes dear evidence that legal regulations on the practice of involuntary placement or treatment of mentally ill patients are very heterogeneous across European Union Member States. Simple categories of a more legalistic or a more medical orientation of national commitment laws which are frequently discussed in the literature do not reflect the rather complex reality and might not adequately characterise the approaches of the Member States. Any assumption of unidirectional influences of legal regulations upon practice must probably be rejected. Besides legal regulations there are far more factors that determine actual practice or outcome. Different cultural or legal traditions, general attitudes towards mentally ill people, and the structure and the quality of mental health care systems or administrative procedures must be considered along with other factors when analysing or comparing the outcome from the legal frameworks the Member States.

In the future, applying coercive measures or compulsory interventions to mentally ill people will still be inevitable under specific circumstances, in order to avoid harm to the patients themselves as well as to the public. Compulsory admission and compulsory treatment, however, infringe fundamentally upon human rights; therefore appropriate legal regulations will be even more crucial in the future. It will be an ongoing task to adapt legal frameworks in all countries continuously to keep pace with developments and new achievements in mental health care, and in order to balance patients` rights and interests against their need and right for treatment, and public safety.

All in all, mental health care experts all over the world agree that the involuntary placement or treatment of a patient should be a modality of utmost crisis intervention, strictly restricted to situations where less restrictive alternatives have failed. Future efforts at reforming or harmonising legal frameworks across the European Union or in other regions should consider this as the most global guideline.

6 Appendix

Tables

Figures

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