

# HOSPITALIZATION PROCEDURES FOR THE MENTALLY ILL IN THE USSR AND OTHER EUROPEAN COUNTRIES

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As the various States of the United States assumed the responsibility for the care and treatment of their mentally ill subjects, each in turn adopted laws to provide for the admission procedure in keeping with the attitudes of the time. A few have made some attempt at modernization but the pattern established early in the 19th Century continues in force in a large majority. This consists of the following steps: (1) A petition for examination of the alleged mentally ill person is filed in the local probate court by a relative or police officer; (2) Notices of a hearing and the date are sent to the ill individual, interested relatives and others; (3) One or more physicians are appointed by the court to examine the patient and report to the court; (4) A hearing is held at which the patient may or may not be present; (5) If the judge concludes that the person concerned is mentally ill, an "adjudication" is issued and made a matter of public record and the ill individual loses his civil rights in varying degrees; (6) A commitment to an appropriate institution is issued; (7) The sheriff's department is ordered to transport the ill person to the receiving hospital. These archaic procedures, suggestive of a criminal trial, remain in force in most States, including Ohio, despite modest efforts at renovation.

The majority of European countries have abandoned these obsolete practices. A 1955 publication of the World Health Organization<sup>1</sup> contains an excellent survey of the commitment procedures of its member nations. That study, in addition to being complete with citations to applicable laws and containing charts for graphic comparison of the various commitment procedures, also contains the following summation of European trends in this area:

One important tendency, illustrating the more humane approach to the problems of mental patients, is that of changing the terminology at present in use in such a way as to remove its criminal flavour.

A recurring proposal is for legislative provision for full psychiatric care in the community, including preventive action and the institution of in-patient and out-patient clinics providing early treatment as well as arrangements for screening and advising persons in need of hospitalization. . . .

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<sup>1</sup> Hospitalization of Mental Patients (World Health Org. 1955), reprinted from 6 Int'l Dig. of Health Legislation 1-100 (1955).

A suggestion put forward in one country, although not yet adopted, is that mentally disturbed persons who need psychiatric care and who are dangerous to themselves or others and are unwilling to receive care voluntarily should be placed under supervision, which would be exercised by a psychiatric social service. According to this project, the patients could be under supervision while living outside a mental hospital, that is, in their own homes or elsewhere. If it became necessary to admit them to a mental hospital, this could be done with little formality. If discharged from hospital, they would automatically remain under supervision. There is also general agreement that where it is necessary for a patient to be admitted to a mental hospital, the admission procedure should be simple, due regard being given to the protection of the rights of the patient. Thus, where voluntary admission is not provided for, it is proposed that this should be done. Moreover, it has been suggested that medical certification and official sanction before the admission of a voluntary patient might be dispensed with, as might also any limitation on the duration of stay and the requirement to change a voluntary patient's status if he loses the power to express himself as willing or unwilling to receive treatment.

Some statements or model provisions have been made in favour of admitting involuntary patients by medical certification alone, with the proviso, in some cases, that the certifiers should be specially qualified practitioners. Another suggestion is that medical superintendents of institutions should have wider powers to arrange direct admissions.

In certain discussions of ways of improving existing legislation, it has been stated that detention should only be compulsory if the patient is unable or unwilling to consent to care and treatment. There is disagreement as to the necessity for judicial intervention in commitment procedures. According to some, prolonged treatment under compulsory detention should be covered by judicial order; others consider that the role of the judicial authority should be limited to control and intervention, if necessary, after admission. Still others propose the creation of administrative commissions to make exhaustive inquiries into each case; such decisions would, however, be open to review by the appellate courts and the person concerned would have the right to a writ of habeas corpus. In any case, the majority opinion is against compulsory attendance of the patient at a court hearing, admission of the public to such hearings, and trial by jury.

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Although some statements on improvements are in favour of simplifying release procedures by giving the medical superintendents of institutions wider powers in this respect, others prefer the creation of special medico-legal discharge commissions. Another principal enunciated is that there should be provisions for continuous review of the mental conditions of patients and for conditional release and discharge when the patient's mental condition justifies it."<sup>2</sup>

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<sup>2</sup> *Id.* at 78-80.

This article does not attempt to duplicate the World Health Organization Monograph but presents instead a psychiatrist's first hand impressions of the practical application of these procedures. The source of information was the author's recent European tour during which he visited mental hospitals in Scotland, England, Switzerland, Czechoslovakia, USSR, Finland and Sweden and talked with doctors specializing in psychiatry or the administration of mental hospitals. It should be admitted that no inquiry was made of attorneys or judges.

In all of the countries mentioned, the care of the mentally ill is considered to be a health problem rather than a legal one and consequently the procedures followed are carried out primarily by physicians or health officers. In the USSR, for example, if a physician considers his patient to be mentally ill the patient is referred to a psychiatric clinic. If the psychiatrist, who examines the patient or takes the patient under treatment, concludes that inpatient treatment is indicated, he simply refers the patient to that psychiatric hospital serving the district in which the patient resides. The hospital psychiatrist examines the patient and reviews the report of the referring physician and makes the final decision regarding admission. He has the privilege of refusing the patient and of returning the patient to the clinic if he considers this advisable. A similar pattern was found to be used in most of the countries visited.

There is an interesting variation in England and Scotland. There, a physician in general practice may contact the hospital directly and a psychiatrist from the hospital then visits the patient in his home. If he considers it advisable, he can then arrange for hospitalization. In these two countries from sixty-seven percent to eighty percent of admissions are voluntary. This is, likewise, the trend in the other countries studied.

If a patient refuses to enter the hospital voluntarily he may be "certified." "Certification" simply means that the examining physician prepares a paper stating that the individual is mentally ill and reports therein his findings. If the patient refuses to go to the hospital with relatives or other properly interested individuals, the coercive power of the state may then be employed.

While this process is similar in all of the nations visited, there are variations as to the number of certifying doctors required, the status of such doctors, the conditions under which a patient may be certified, the length of confinement permissible under this type of commitment, the rights of appeal, etc. For example, in England a patient may be "certified" only if he is "for the time being incapable of expressing himself as willing or unwilling to receive such treatment." The com-

mitment is limited to a period of six months at which time the certification must be renewed under similar conditions. Permanent or indefinite commitment is authorized only upon judicial order. However, in Finland, Switzerland and Sweden the patient may be certified whether or not he is capable of consenting and certification is the normal commitment procedure for both temporary or prolonged treatment.

Resistance to modernization in the United States frequently includes mention of "individual rights," yet the court procedure usually removes or limits the civil rights of the "committed" patient. In Europe, the "certified" individual retains his civil rights. However, participation in any legal transaction requires the written approval of the Superintendent of the institution indicating that the patient is sufficiently sound of mind to understand what he is doing and to act with appropriate judgment.

The risk that a sane person will be committed against his will is minimized by the requirement of a thorough medical examination, usually by specially designated experts. Further, all the commitment laws require notification of the authorities responsible for the liberty of individuals. Regular inspection of mental institutions is also provided.

The right of appeal to the judiciary, to independent boards of medical experts or to other independent governmental authorities is generally reserved. In Sweden, for example, the appeal is to the Mental Disease Committee which is composed of the Director-General of the Royal Medical Board and four other members, two of whom must be qualified psychiatrists and one a judge or former judge. In England the appeal from temporary commitment is to a commissioner of the Health Ministry. The impression received in the Soviet Union was that the hospital concerned had the final authority and no superior board is necessary. Rather than a board, the top health officer for the district could, if necessary, be contacted. This would certainly be a rare situation in view of the Russian's meek compliance to authority.

A question naturally arises in respect to the rights and authority of the hospital administration. Can a patient be compelled to accept treatment, e.g. insulin or electric shock, if he is disinclined to acquiesce? There seems to be no difficulty here in respect to "certified" patients, and if a voluntary patient refuses, he may then be "certified" and treatment proceed. However, in Finland and England mechanical restraint may be employed only when necessary for surgical or medical treatment, and in England quarterly reports of all such restraint employed must be made to the Board of Control. It should be added

that the practicing psychiatrists in the hospitals visited appeared to be free of the frequent and embarrassing suits for malpractice or damage now so frequent in this country.

The "certified" patient may be freed of this designation in England or Scotland in any one of three ways. He may sign a "voluntary" admission and continue in the hospital as a voluntary patient, he may be freed simply by discharge from the hospital, or by order of the proper reviewing authority.

Hospitalization for alcoholics is accomplished by much the same method although some of these countries provide special procedures and facilities for the alcoholic (Czechoslovakia, Finland). If the alcoholic refuses to enter a hospital, he may be ordered in by a legal authority in Czechoslovakia or in Finland.

It is of interest to note that the USSR, Czechoslovakia and Sweden have strong and vigorous programs to combat alcoholism and to treat alcoholics. Finland has a strong program to combat "driving while intoxicated" and to compel hospitalization, but I was told that the treatment program provided in special institutions was weak. In Finland a driver thought, by the apprehending officer, to be under the influence of alcohol is first subjected to some general tests of motor skill, and if the suspicion appears to be well founded a blood test is taken. The defendant cannot refuse the test, and the evidence is admissible in court. I was informed that eight milligrams percent of alcohol in the blood is considered firm evidence that the defendant was under the influence of alcohol.

Sexual psychopaths, a group neither law officers nor psychiatrists know what to do about, have been a source of study in Czechoslovakia. Considerable research work has been carried out with the conclusion that psychiatric treatment is not effective unless the subject comes voluntarily and prior to any criminal charges. Those referred by a court of law had an invariably poor response to treatment.

#### SUMMARY

Inquiry was made into the effectiveness and workability of modern mental health laws in the USSR and six other European countries. It was ascertained that the practices extant, leaving hospitalization procedures entirely in the hands of the medical and public health groups, are efficient, effective, practicable and acceptable. While still incorporating safeguards of individual freedoms, these modern procedures eliminate the unnecessary intervention of lay officials and thus permit early treatment of mental disease where required while eliminating the stigma attached to a judicial insanity proceeding. It is recommended that laggard States in the United States follow the European example.