The Law and Mental Health: Harmonizing Objectives

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WORLD HEALTH ORGANIZATION GENEVA
The World Health Organization (WHO) is one of the specialized agencies in relationship with the United Nations. Through this organization, which came into being in 1948, the public health and medical professions of more than 150 countries exchange their knowledge and experience and collaborate in an effort to achieve the highest possible level of health throughout the world. WHO is concerned primarily with problems that individual countries or territories cannot solve with their own resources—for example, the eradication or control of malaria, schistosomiasis, smallpox, and other communicable diseases, as well as some cardiovascular diseases and cancer. Progress towards better health throughout the world also demands international cooperation in many other activities: for example, setting up international standards for biological substances, for pesticides, and for pesticide spraying equipment; compiling an international pharmacopoeia; drawing up and administering the International Health Regulations; revising the international lists of diseases and causes of death; assembling and disseminating epidemiological information; recommending nonproprietary names for drugs; and promoting the exchange of scientific knowledge. In many parts of the world there is need for improvement in maternal and child health, nutrition, nursing, mental health, dental health, social and occupational health, environmental health, public health administration, professional education and training, and health education of the public. Thus a large share of the Organization's resources is devoted to giving assistance and advice in these fields and to making available—often through publications—the latest information on these subjects. Since 1958 an extensive international programme of collaborative research and research coordination has added substantially to knowledge in many fields of medicine and public health. This programme is constantly developing and its many facets are reflected in WHO publications.
THE LAW AND MENTAL HEALTH: HARMONIZING OBJECTIVES

A COMPARATIVE SURVEY OF EXISTING LEGISLATION TOGETHER WITH GUIDELINES FOR ITS ASSESSMENT AND ALTERNATIVE APPROACHES TO ITS IMPROVEMENT

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CONTENTS

PREFACE .......................................................... 5

1. THE BACKGROUND ............................................. 5
   1.1 Introduction ............................................ 5
   1.2 Purposes ............................................... 6
   1.3 WHO comparative survey of 1955 ........................ 10
   1.4 1955-77: years of fundamental change ................. 14

2. COMPARATIVE LEGISLATIVE SURVEY ............................ 18
   2.1 Methodology of the survey .............................. 18
   2.2 Evaluation of national mental health legislation: some
        indicators ............................................. 21
   2.3 Programme administration ............................. 32
   2.4 Hospitalization procedures ............................ 40
   2.5 Protective measures for patients ........................ 50

3. GUIDING PRINCIPLES AND ALTERNATIVE APPROACHES .......... 57
   3.1 Introduction ............................................ 57
   3.2 Legislative systems .................................... 58
   3.3 Periodic evaluation of the law ........................ 65
   3.4 Administrative structures .............................. 74
   3.5 Access to treatment .................................... 79
   3.6 Human rights in mental health ........................... 87
   3.7 Mental health law in developing countries .............. 94

4. SUMMARIES OF LEGAL PROVISIONS ............................. 101
   4.1 Voluntary access to care .............................. 102
   4.2 Involuntary hospitalization ............................ 114
   4.3 Emergency hospitalization ............................. 145
   4.4 Observational hospitalization .......................... 151

REFERENCES ....................................................... 155

Bibliography ...................................................... 155
Legislation ......................................................... 158
ACKNOWLEDGEMENTS ................................................. 161
PREFACE

In many parts of the world, the mentally disordered are an underprivileged minority, usually denied the means of daily living, excluded from their social group, and without access to modern, effective treatment. Even in the industrialized countries where extensive mental health services have been established, there are often serious shortcomings in the care and treatment for elderly people with mental disorders, mentally retarded persons, patients suffering from chronic or episodic psychosis, and other groups. This report is concerned with ways in which law can be used to promote more effective and humane responses to mental disorders. It is the result of work carried out over an 18-month period in 1975-77, during which the legislation of a large number of countries was surveyed and a series of consultations, meetings, and discussions was held. In the report will be found the results of the survey, guidelines for the assessment of how existing legislation functions, and an account of alternative approaches to legislative improvement. We hope that the report, as a whole, will act as a stimulus to legislative review at the national level, will provide a framework for such a review, will generate fresh thinking and creative drafting in future legislation, and will lead to increased cooperation between countries in the field of mental health legislation.

The reader's attention is drawn to two important points. Firstly, this report is not concerned primarily with the problems of the mentally abnormal offender. The few references to this subject concern the linkages between civil commitment and the penal system. Secondly, the core of the report consists of the survey results to be found in sections 2 and 4. Through this information, those responsible for mental health services or for legislative drafting can share the experience and ideas of their colleagues in many countries. Many innovative ideas and approaches can be found in the summaries of legal provisions in section 4. Only the reader with extensive knowledge of a particular country will know which of these ideas and approaches could be adapted for use in that country. All countries can learn from the way in which others have tackled the difficult issues in this field such as involuntary treatment and hospitalization, the protection of the rights of the mentally ill, and the provision of services on an equitable basis.

1. THE BACKGROUND

1.1 Introduction

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

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

In the new WHO mental health programme, the sharing of information on critical issues is seen as an important contribution to technical cooperation between countries. Mental health legislation is now widely recognized as a critical factor which can either impede or facilitate development of mental health services. This provided the impetus for the work which led to the preparation of this report. As will be seen, the report presents information from countries of widely differing socio-economic and cultural backgrounds and proceeds to describe guidelines setting out the essential requirements of effective and acceptable mental health legislation and to discuss the advantages and disadvantages of various legal provisions.

1.2 Purposes

The World Health Organization frequently receives requests from its Member States for advice and documentation which could be useful in evaluating and updating their mental health legislation. The response has usually been based upon supplying them with a copy of the 1955 WHO comparative survey of legislation on the hospitalization of mental patients accompanied by references to the legislative recommendations made in various Expert Committee reports, copies of recent legislation of interest enacted by Member States, and other relevant materials.

It has, however, become apparent in recent years that the 1955 survey was out of date. The content and philosophy of the mental health law of many countries had been undergoing significant change over the intervening years. Methods of handling mental illness have radically improved, a wider range of mental illness and disability is being dealt with, and new patterns of service delivery have emerged. A large number of developing countries have gained independence since 1955 and are interested in establishing new laws which could contribute to the improvement of health conditions in their countries. The above-mentioned survey had not covered legal systems in most of these countries.
THE LAW AND MENTAL HEALTH

It was therefore decided that the World Health Organization should carry out a new and more extensive survey of the mental health legislation of its Member States.

The essential data for the international survey consisted of statutory material collected from selected nations in all of the WHO Regions of the world. Background information was obtained through a questionnaire survey. The legislation in each country was examined on a comparative basis. The various approaches of the nations to similar basic legal issues were classified and summarized in a standard format. The results of this analysis are given in the summaries of statutory provisions contained in section 4.

The discussion of the results of the comparative analysis appears as section 2. Our purpose has not merely been to supply the scholar interested in comparative law with up-to-date citations. Our primary concern has been to make these analyses directly useful to mental health administrators, lawyers, legislators, and patient groups and others interested in reviewing their own country's laws to see where changes and improvements are needed. To this end, the discussion begins with the examination of a series of "indicators" which we suggest can be used to evaluate mental health laws. The central theme of these indicators is related to the primary aim of the entire survey: namely, encouraging the development of mental health legislation which is in harmony with the needs of mental health programme operations, policy, and objectives. Too often in the past, the mental health law of a country has had little or no direct relationship to what the programme administrators were trying to accomplish. In some cases, the legislation has been a barrier to change and improvement. Many of the commitment laws enacted in the latter half of the last century were placed on the statute books as a means of control over the abuses of the asylum era. The legal procedures instituted at that time are still on the books of many nations and many have been obsolete for some decades.

The first three indicators of the status of the mental health legislation of the country can be summarized in question form:

(a) When were the major legislative provisions last amended or revised significantly?

(b) What groups are interested in change in the law of the country?

(c) Does the law still concentrate upon the hospitalization of patients in large institutions? (Or, is there legislation to deal specifically with alternative means of providing care and treatment, with community-based services, and with training, research, and programme development?)

The next three indicators are somewhat different and are related to particular objectives of the law. The first seeks to measure quantitatively the movement towards voluntary care. In a number of cases the available figures were described by respondents as "rough estimates". Many were already some years old, and covered only some of the
institutions and services in the country. Furthermore, the definition of "voluntary" varies considerably from country to country. These problems illustrate the difficulties in using comparative statistical data in this field. The second indicator in this group is based on a value judgement. It concerns the protection of the rights of the mentally ill and disabled. The objectives of the newer laws have been to remove social stigma and to preserve civil and political rights which the older laws tended to take away in broad fashion without regard to the condition of the individual patient.

The last indicator is more general in scope and is concerned with how well the public, the mass media, and various professional groups understand the mental health law of the country. The results from the questionnaire survey relating to this last indicator can be taken only as impressionistic. A similar exercise using more reliable methods may well be worth performing on a national scale in countries contemplating change in their mental health legislation.

Sections 2.3, 2.4, and 2.5 relate to the legislative basis for programme administration, the procedures for hospitalization and access to other forms of care, and protective measures in the law for the benefit of patients and retarded persons. Our purpose in section 2.3 on programme administration has been to stress the relationship of the law to current programme developments. An analysis is provided of the various forms of legal involvement at the federal level of government. The legal implications of the existence of separate categories of patients and special treatment programmes are also examined. In older law, all patient groups tend to be covered by a single law and one central administration. Under such laws alcoholism, for example, is not mentioned nor is drug dependence. At least in strict application of the law, patients suffering from such conditions could be admitted and treated in mental health facilities only if they were deemed mentally ill. The obsolescence of much of the legislation surveyed was also revealed in the examination of provisions for community mental health care. Many countries are currently operating extensive community-based programmes, but this is not reflected in their statutes or regulations. In our questionnaire survey, the majority of respondents answered that the law in their countries neither helped nor hindered growth of community programmes, since the subject was virtually ignored. Some reported that the law was a direct barrier to this trend. Nearly all, however, reported that the legislatures had not provided adequate funds for expanded community services. There is, of course, a relationship between these matters: the development of alternative systems of care, decentralization of mental health services, and their integration into general health services have no clear legal recognition in most countries.

The comparative survey of the mental health legislation in the countries reviewed takes up approximately half of the content of this report. Section 3 is devoted to suggesting alternative approaches to improving legal systems in this field. No single set of legislative guidelines is proposed. Instead, emphasis is placed on general principles
and on the gearing of legislative objectives to the resources available in the country and to the traditions and customs of the people. It is strongly suggested that individual countries should not seek "model" legislation from elsewhere. In some cases revision of existing laws or ministerial regulations or decrees may bring the law into line with programme needs. In other cases a major new enactment may be called for. A few countries have demonstrated that provisions for mental health can be included as part of a broadly based Public Health Act. In still others, after careful consideration, an "informal" system may be retained. These represent different options available and one of the main purposes of the legislative survey was to indicate such options not only for the overall form of the law but also for its detailed provisions. It is in this spirit that the guiding principles and alternative approaches should be read. They are meant to provide an analytical tool for evaluating existing legislation and a framework for evolving national solutions in the field of mental health law.

A basic statutory structure of 10 items is provided as a check-list for the development of a national mental health legislative programme (see pp. 58-63). Special attention is given to methods for ensuring public accountability by programme administrators. There is also a discussion of different methods of periodic review of the effectiveness and relevance of mental health laws.

The remaining parts of section 3 of the report are organized under similar headings to those utilized in the preceding section. Administrative structures are dealt with first, followed by discussion of methods for improving the law in relation to access to treatment and to protecting the human rights of the mentally disabled. Section 3.7 is concerned with mental health law in the developing countries and the special problems posed by the combination of limited resources and centralized custodial mental hospitals linked with legislation dating from the colonial era.

Certain themes will be found to run through our discussion. They have emerged from our communications with mental health professionals, lawyers, public health administrators, and others in many countries while carrying out this survey. There appears to be widespread consensus on the following aims:

1. The handling of mental patients as much like other medical patients as possible, thus removing the stigma associated with special treatment.

2. The provision of treatment on a voluntary basis under all possible circumstances and limitation of the use of involuntary measures to situations of last resort and to emergencies. (In an affirmative way, it could be stated that the patient should be handled under the least restrictive method available under the circumstances.)

3. The abolition of special legal "labelling" of the mentally retarded, and the requirement that the retarded receive proper education and habilitation in the same manner as other citizens.
4. The integration of mental health programmes into general health and social services, particularly at the point of delivery in hospitals and in the community.

On close examination, these aims will be found to be interrelated. Essentially, they seek a common goal of removal of stigma and separateness in the handling of mental health problems and the integration of mental health care into overall health and social services. In the past, the separate status of mental health services has led to a loss of human rights, the use of involuntary procedures, and the excessive and unwarranted attribution of dangerousness to all of the mentally disabled.

1.3 WHO comparative survey of 1955

1.3.1 The review of hospitalization laws and the WHO Expert Committee Report

In 1955, WHO published in the International Digest of Health Legislation a comparative survey of the legislation on the hospitalization of mental patients of a number of countries, the first such international survey ever compiled. The project was suggested by the WHO Expert Committee on Mental Health in its Third Report published in 1953. A circular letter was sent in early 1953 to Member States requesting copies of their mental health legislation. Information was received from 40 Governments. These materials, and other laws and regulations published in the Digest, along with an extensive review of available literature, were used to produce the analysis, which covered 37 countries.

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

1.3.2 Major features of the laws

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

Considerable attention was given to changes in terminology. Words such as “insane” and “lunatic” were being replaced by “mental illness” and “mental disease” in English-speaking countries. In France, still functioning under the Law of 1838 which used the term “aliénés”, the survey called attention to a Ministry of Health Circular of 1948 which referred to “malades mentaux”. In the Spanish-speaking countries of Latin America, the newer term was found to be “enfermos mentales”, instead of “alienados” and “dementes” used previously.

Along the same lines, the modern legislation was abandoning the expression “lunatic asylum” and replacing it by “mental hospital” or
There was also a movement away from "commitment" because of its criminal connotation and toward "admission" or "reception" in English-speaking countries, "admission" or "placement" in France, "ingreso" in Mexico, "intração" in Brazil, "Aufnahme" in the Federal Republic of Germany, and "intagning" in Sweden.

One of the most important trends affecting hospitalization procedures was found to be the enactment of voluntary admission laws. It was asserted that admission under such procedures then constituted the highest percentage of categories of hospitalization in several countries. Moreover, it was said that even in some countries without a legal provision for such admission it had become a common practice. The only statistics cited on voluntary admission were for the United Kingdom, France, and the United States of America. Of these, only the United Kingdom had high percentages of voluntary admission (70% for England and Wales; 67% for Scotland). In France there were 37% voluntary admissions while for the USA as a whole the corresponding rate was only 10%. It was not made clear in the survey where these estimates of rates of admission were obtained, or how much reliance could be placed upon their accuracy.

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

Hospitalization of non-dangerous patients by the judiciary was described as humiliating for both the patients themselves and their families. Attention was called to laws under which patients could be admitted, usually by application of a parent or relative, or by a person living in the same dwelling, on medical certification that they were mentally ill and in need of treatment. No judicial order was required. A table was drawn up showing the laws of 19 countries in this category under which hospitalization was for a prolonged, indefinite period. Among them was the oldest law of all those covered in the survey, the French Law of 1838. Another table analysed the laws of eight countries which provided for temporary hospitalization on medical certification without judicial order.

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

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

The survey encouraged efforts aimed at simplification of the admission and discharge procedures in the interest of ready access to care and treatment. At the same time, the necessity of safeguarding the rights of patients through the law was pointed out.

1.3.3 The Expert Committee's recommendations

The Expert Committee on Mental Health, in its 1955 Report, was critical of the mental health laws of its day. The following observation appears early in the Report:

"Most of the existing mental health legislation is unsatisfactory, although in some countries laws based on outmoded concepts of mental abnormality, when interpreted liberally, can be made to work fairly well in practice... The greatest single weakness is that purely legal considerations are given too much weight, and medical considerations too little."\(^3\)

The Committee did not explain what it meant by "purely legal considerations". No specific examples were given of problems created by giving too much weight to legal matters.

In its earlier Report in 1953, the Expert Committee had been equally condemnatory of the existing law when it had called for the comparative legal survey. It was concluded in that Report that few countries had legislation based on modern psychiatric knowledge. The commitment procedures for unwilling patients were described as "archaic".\(^2\)

Significant sections of the 1955 Report were devoted to laying out what the Expert Committee called essential requirements for effective mental health legislation. First priority was ascribed to the recruitment and training of specialized professional staff. One of the chief problems to be solved here was said to be the need to offer psychiatrists conditions for practice which would be sufficiently attractive and varied from a professional viewpoint. The Committee considered that good doctors could not be expected to devote themselves entirely to caring for "chronic and incurable patients in inadequately staffed establishments far from any intellectual or scientific centre". It was also noted that doctors and nurses should be given time to devote to extramural services and that physicians should be allowed time for private patients.

Second priority was given to making legal provision for adequate facilities, including a full range of preventive services, community services, psychiatric hospitals, special hospitals, aftercare and home-care organizations, and social and occupational rehabilitation centres. It was advocated that these institutions should not be too large. It was cautioned that specialization of institutions on the basis of acute
and chronic, or curable and incurable, patients should be avoided. The Expert Committee believed that institutions, whatever their size, should be under the direction of a psychiatrist.

Attention was next given to legal provisions governing the involuntary admission of unwilling or dangerous patients and to measures for guardianship and medical supervision of such patients. It was stressed that required treatment need not be given in a hospital but might be administered on an outpatient basis or in community facilities. As in the comparative legislative survey, court review prior to compulsory hospitalization was severely criticized as stigmatizing the patient. The non-judicial forms of hospitalization with appeal afterwards were believed to be much more desirable. The Expert Committee endorsed the principle of ready access to treatment with the opportunity for "easy appeal" by the patient at any time against his involuntary admission. Special attention was called to the fact that "in one country, recognized to be in the van of progressive legislation, it has been thought preferable for the appeal to be heard by a local board composed of a physician, a judge and a layman". The identity of the country was not given. (In fact, no specific laws of any country were cited anywhere in the Report.) No reference to such a procedure can be found in the comparative legislative survey. The Committee could be said to have been anticipating the 1959 Mental Health Act of England and Wales, which provides for appeal to a Mental Health Review Tribunal composed along these lines.

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

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

The fourth area of priority was the establishment of an organizational framework for the provision of community psychiatric services. In countries with a central or national health authority, it was recommended that this authority should have responsibility for mental health services and that there should be a separate body charged with inspection of psychiatric services not subject to the authority of the unit responsible for providing those services. It was cautioned that such an inspection body should not be separate from other health service surveillance mechanisms but should be a part of such a programme if it existed in
the country. The Report also advocated local responsibility for locally provided psychiatric services.

The 1955 recommendations of the Expert Committee displayed an experienced eye for detecting the weakness of existing legal systems of that time and considerable sophistication and wisdom about what the law should contain. In the intervening years, many of the Committee's suggestions have been put into practice in a number of countries, particularly in regard to the movement towards smaller hospitals, community-based services, and a wide range of alternative treatment and patient management methods. Many countries have simplified their admission laws in ways similar to those advocated in the Report. Although by no means all of the suggestions have been followed, as of 1977 the Report still reads, on the whole, as a realistic and thoughtful approach to improving mental health legislation.

1.4 1955-77: years of fundamental change

1.4.1 Development of national independence and human rights

Much has happened in the world since 1955. Perhaps the most striking development from a political and legal standpoint has been the wave of independence among the nations of the developing world. In 1955 there were 84 Member and Associate Member States in the World Health Organization. In 1977 there are 152. On the African continent alone there are now 50 nations. In most cases independence in Africa was gained in the 1960s from the colonial powers of Belgium, France, and the United Kingdom. The legal structures set up in the colonial years were largely continued in such matters as mental health legislation. So also were the methods of medical and psychiatric practice, with emphasis on the large mental hospital constructed in colonial times. Only in recent years are many of the developing countries beginning to break away from the mental health practice of earlier years, and the necessary changes in the law have been slow to emerge.

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

1.4.2 Techniques of treatment

The 1955 Expert Committee Report appeared at a time of growing therapeutic optimism in the field of psychiatry. The techniques of
insulin coma therapy (introduced in 1930), electroconvulsive therapy (introduced in 1938 and in "modified" form during the 1940s), and pre-frontal lobotomy (introduced in 1936) were being widely used. In addition, new and powerful tranquilizing drugs such as reserpine and chlorpromazine had been introduced in the early 1950s, and offered far more effective, active therapy for various psychotic illnesses than had been previously available.

In the period 1955-65 further substantial advances in therapeutic knowledge took place which profoundly influenced the treatment of mental disorders. More psychotropic drugs became available, particularly those effective in depressive illness; safer forms of "minor" tranquilizers were also developed. A wider range of anti-psychotic drugs became available and some more hazardous drugs such as reserpine were therefore used much less. The efficacy of lithium salts in the prophylaxis of manic-depressive psychosis was clearly demonstrated. Initially these new drug treatments were used almost exclusively by psychiatrists. Increasingly, however, non-specialist physicians have been treating patients with psychotropic drugs and this has greatly widened the scope of such treatment. There has even been some criticism of "excessive" use of such drugs.

There has also been a more critical approach to other physical treatments based on carefully conducted therapeutic trials. Both insulin coma therapy and pre-frontal lobotomy are now used on a very limited scale. In the latter case, the occurrence of post-operative sequelae related to irreversible brain damage has led to great caution. In the Soviet Union a decree prohibiting all forms of brain surgery carried out in the treatment of mental disorder was issued by the Ministry of Health as early as 1950. On the other hand the value of electroconvulsive therapy in the treatment of severe depressive illness is widely accepted.

Considerable advances have also been made in non-physical methods of treatment for mental disorders. Briefer forms of psychotherapy are now widely used not only by psychiatrists but by general practitioners, nurses, and social workers. Group psychotherapy is also more widely available. Behaviour therapy has been shown to be effective in certain forms of neurotic disorders.

In the case of the severe psychoses, particularly schizophrenia, various forms of "social therapy" have been introduced and are often used in conjunction with anti-psychotic drugs. One of the main aims of such treatments is to combat the inactivity and apathy which readily occurs in institutionalized patients and constitutes a serious bar to successful rehabilitation.

The main advances in treatment since 1955 can be summarized as follows:

(a) a much wider range of effective drug treatments is available for the treatment and control of mental disorders. As a result, the prognosis in many disorders has been greatly improved, many more
patients can be treated outside hospital, and the average length of stay in hospital can be reduced;

(b) simpler and briefer forms of psychotherapy have been introduced. Behaviour therapies have also become one of the definitive treatments available for the relief of mental illness;

(c) non-specialist physicians are more actively involved in the treatment of mental disorders;

(d) the importance of the social environment of patients has been recognized and "social therapy" has become an important facet of rehabilitation;

(e) a pragmatic approach to the assessment of therapy has been evolved. As a result many psychiatrists now advocate a combination of different forms of treatment and certain treatments are now used much less than formerly.

1.4.3 Organization of mental health care

Large mental hospitals constituted the major part of available mental health services in almost every country in 1955. Many of these hospitals were built in the 19th century as asylums, remote from centres of population. The conditions in these hospitals were poor, with overcrowding and inadequate physical facilities. In many countries psychiatric beds made up about half the total hospital bed capacity but the turnover was very low. The resident mental hospital population reached its peak in the mid-1950s in many of the industrialized countries and has steadily declined since then (although the rate of decline has slowed in recent years). Mental hospitals remain an important part of mental health services but their function has been supplemented and to some extent replaced by a range of other services.

In the United States of America community mental health centres have been introduced since the early 1960s to provide a range of diagnostic, treatment, counselling, and aftercare services. Characteristically, such centres are staffed by multidisciplinary teams and the professional roles of psychologists, social workers, and nurses in mental health care have grown considerably. In many European countries, outpatient clinics have been developed in close association with general health facilities and the role of mental health in primary health care has been emphasized. In the socialist countries of Europe special emphasis has been placed on development of outpatient facilities in "dispensaries". Another striking development has been the establishment of psychiatric units in general hospitals and in some areas units now have responsibility for the provision of all inpatient psychiatric care. Day-patient facilities have expanded rapidly in some countries. All these changes have been accompanied by a steady improvement in public attitudes toward the mentally ill. Prejudices still exist but public recognition of the frequency of minor forms of mental disorder and of the improved
prognosis in most forms of mental illness has facilitated community-based programmes and integration of services.

On the other hand, differentiation within mental health services has grown strikingly since 1955 in those countries with available manpower and resources. Separate clinics and units for children, adolescents, patients with alcohol problems, and psychogeriatric patients exist in certain countries while separate care for mentally-disordered criminal offenders is found in most countries.

1.4.4 Organization of services in developing countries

Over the past two decades there has been a thorough reassessment of the mental health needs of the developing countries and the way in which their services should be organized. It is now clear that the frequency of seriously incapacitating mental disorders is at least as high in the developing countries as in the developed countries. It is also clear that the mental hospitals established during the colonial era of many developing countries and used primarily as instruments of social control are particularly unsuited to the rural-agrarian societies of the Third World. Collomb, commenting on the state of psychiatry in Africa at the end of the colonial era, pointed out that there were "only a few prison-like facilities, completely insufficient to meet the demand, which in most cases is not for care but for custody, i.e. removal of the individual from his family and the community". For millions of people the only source of help in the event of mental disorder has been, and remains, some form of traditional health care. Such care can undoubtedly be effective and helpful, but malpractice and mistreatment also occur and traditional systems are not able to offer the benefits of modern psychopharmacology.

The key question for the developing countries is therefore as follows. How can mental health care be made available to widely dispersed rural populations, given that resources are seriously limited? The WHO Expert Committee on Mental Health, in its Sixteenth Report devoted to the organization of mental health services in developing countries, has provided clear answers to these questions in its recommendations, which have received wide support. As well as strongly endorsing the policy of decentralization of mental health services and their integration into general health services, the Committee advocated the provision of "basic mental health care" by primary health workers. Another important recommendation made by the Committee concerned the development of collaboration with non-medical community representatives, such as traditional leaders, teachers, police officers, and religious leaders.

1.4.5 Legal implications

The changes which have occurred since 1955 and which have been outlined above have far-reaching legal implications. Until now, these have only been reflected in legal changes to a limited extent. In
many countries discordance has arisen between the existing law and current programme objectives. This discordance underlies the main theme in this report — the need for harmony between law and programme objectives. Legal provisions need to take account of the shift of the centre of gravity of mental health services from the mental hospital to other less centralized facilities, of the widening involvement of non-specialists, including auxiliary health workers, in mental health care, of the multidisciplinary team approach, of the range of treatments now available and the need for their proper control, and of changing public attitudes to the mentally ill and their acceptance in the community.

2. COMPARATIVE LEGISLATIVE SURVEY

2.1 Methodology of the survey

In 1972 the World Health Organization held a consultation on mental health legislation. Prior to this consultation information had been collected from a number of countries and an extensive bibliographical review had been prepared. Following the consultation, draft Introductory Guidelines to Mental Health Legislation were produced. On the basis of this preparatory work it was decided to launch a more intensive effort to conduct a systematic survey and analysis of existing mental health legislation in the world.

A questionnaire was drafted and produced in English, French, and Spanish. The information sought in the questionnaire was in the following areas:

(i) summaries and citations of mental health legislation currently in force, with copies of statutes and regulations where available;
(ii) legal provisions dealing with voluntary and involuntary treatment, rights of patients, appeal procedures, inspection of and standards for mental health facilities, and administration of mental health services;
(iii) evaluation of the measures for protection of the rights and welfare of patients, for example in preventing exploitation of patient labour;
(iv) special or separate legislation dealing with mental retardation, alcoholism, drug dependence, and sexual deviancy;
(v) provisions prohibiting, limiting, or regulating certain modes of treatment such as electroconvulsive therapy, psychosurgery, and the practice of traditional or folk medicine;
(vi) provisions concerning special licensing of mental health personnel;
(vii) the degree of understanding of the mental health legislation by various groups in the country;
(viii) desire for change in the law by various groups in the country;
(ix) education and training programmes in mental health law for various groups in the country;
(x) relevance and functioning of mental health laws in relation to mental health programmes.

The questionnaire was circulated, and completed by 66 respondents in 48 countries. The respondents were drawn from the following groups:

(a) Members of the WHO Expert Advisory Panel on Mental Health. The Director-General of WHO has the authority to establish expert advisory panels on any health-related subject and since 1948 over 40 such panels have been created. Panel members serve on a personal basis and are not expected to represent their country officially. The Expert Advisory Panel on Mental Health has about 100 members drawn from 50 countries. The majority are psychiatrists. Many occupy senior positions of responsibility in mental health services of their countries. A smaller number are non-psychiatrists — sociologists and psychologists, for example. The overall membership represents a very wide range of expertise and experience in the field of mental health care. A number of members have been personally involved in the assessment and drafting of national mental health legislation. This group was responsible for completion of the largest number of questionnaires (48 from 33 countries).

(b) WHO Representatives. In many countries (particularly those in which there is a significant level of technical cooperation) there is a resident WHO Representative. In some cases such a Representative may be responsible for a group of neighbouring countries. The WHO Representative is a member of the staff of the Regional Office and reports directly to the Regional Director. The WHO Representatives in seven countries completed the questionnaires. In order to obtain the necessary information the Representatives had access to national health authorities and mental health experts within the country concerned.

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

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

The data collected in these questionnaires was primarily useful as an indication of the mental health legislative provisions of the countries.
surveyed. It was not intended to provide a detailed analysis of the actual operation of the mental health laws in these countries.

The review of the mental health legislation was conducted by utilizing the statutory and regulatory materials supplied by the respondents to the questionnaire, by examination of the laws published in the *International Digest of Health Legislation*, and by analysis of the collections of national legislation in the Law Libraries of the United Nations and the International Labour Office in Geneva. The research staff also reviewed comprehensively the WHO documents and reports and the available literature on mental service programmes in the countries selected for review. Consultations were held with various legal and health agencies to seek advice and assistance in the conduct of the project. Among the groups consulted were the International Commission of Jurists, the World Federation of Mental Health, the Public Health Division of the Council of Europe, the Division of Social Development of the United Nations, and the International Labour Office.

The total number of countries included in the comparative legal survey was 43. The selection was made to include countries of varying population size, level of socioeconomic development, political system, structure and history (e.g. time of independence), cultural background, pattern of health services, and development of mental health care. At least two countries were included in the survey from each Region of the World Health Organization.

Twelve countries were found to have *no* specific legislation covering treatment or hospitalization for mental disorders. These were classified as operating under "informal systems". The remaining 31 countries were found to have specific mental health legislation and were therefore classified as operating under "formal systems".

The countries included, by Region, were as follows (those operating under "informal systems" are indicated by an asterisk):

* Region of the Americas: Brazil, Canada, Costa Rica, Peru, Trinidad and Tobago, the United States of America, and Uruguay.
* European Region: Denmark, France, Norway, Poland, Romania, Switzerland, the Union of Soviet Socialist Republics, and the United Kingdom.
* South-East Asia Region: India and Thailand*.
* Western Pacific Region: Australia, Fiji, Japan, and Malaysia.

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*Ethiopia was in the Eastern Mediterranean Region at the time the survey was carried out but in 1977 it became a Member State of the African Region.*
For countries with a federal structure it was not practicable to include an analysis of the law in every state, province, or canton. The decision was therefore made to include an analysis of two states or the equivalent in each federal country (except in those where the major mental health legislation was at the federal level). An effort was made to select two jurisdictions having different characteristics and located in different geographic sections of the country.

It will be seen that a higher proportion of countries was selected from the Eastern Mediterranean Region than from other Regions. This was because the preliminary results of the survey and the first draft of this report were scheduled to be discussed at a meeting of senior mental health administrators in the Eastern Mediterranean Region. This meeting took place in June 1976. The discussions and recommendations, which have already been reported elsewhere, provided the basis for further revision of this report, particularly the elaboration of the guidelines and alternative approaches in section 3.

2.2 Evaluation of national mental health legislation: some indicators

2.2.1 Years of enactment: origins and obsolescence

There are fashions and cycles in mental health legislation just as there are in any other area of law. The cycles do not affect all countries uniformly nor at the same time. However, certain trends affecting many countries can be detected. Most of the commitment laws stressing judicial or police involvement were enacted in the middle of the nineteenth century. Emphasis on formal structures and court review continued during the asylum era. The mentally ill and the retarded were segregated and generally lost their legal capacity and civil rights. Significant changes in treatment methods and in public attitudes towards the mentally ill did not tend to have an effect upon the law until the middle of the current century. The mental health legislation of many countries was significantly revised after 1950. The last two decades have seen more varied and often more piecemeal changes in response to the greater complexity of the mental health systems themselves and the lesser concentration upon long-term hospitalization of the chronically ill.

In the developing countries, a particular pattern of existing laws was found. Many operate under informal systems in regard to their hospitalization and treatment services. Others function under statutes of colonial origin adapted from the domestic laws of the former colonial power. We found these laws to be many decades old and long since repealed in the home country. It is doubtful that these laws were ever very applicable to conditions in the developing countries. In a very small number of the newly independent nations, entirely new laws specially applicable to such nations and their mental health programmes have been adopted.

Table 1 gives the period of enactment for the major mental health legislation in the nations reviewed which were operating under formal
### Table 1

**YEARS OF MAJOR ENACTMENT OF MENTAL HEALTH LEGISLATION**

<table>
<thead>
<tr>
<th>Period</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-1976</td>
<td>Canada (Alberta), Costa Rica, Senegal, Sudan, Trinidad and Tobago, Union of Soviet Socialist Republics, United States of America (Indiana and Massachusetts).</td>
</tr>
<tr>
<td>1965-1969</td>
<td>Roumania, Switzerland (Geneva), Syrian Arab Republic.</td>
</tr>
<tr>
<td>1960-1964</td>
<td>Canada (British Columbia), Lesotho, Norway, Switzerland (Basel-Stadt).</td>
</tr>
<tr>
<td>1955-1959</td>
<td>Australia (Victoria), United Kingdom (England and Wales).</td>
</tr>
<tr>
<td>1950-1954</td>
<td>Japan, Malaysia, Peru, Poland.</td>
</tr>
<tr>
<td>1930-1949</td>
<td>Australia (South Australia), Brazil, Cyprus, Democratic Yemen, Denmark, Egypt, Fiji, Tanzania, Uruguay.</td>
</tr>
<tr>
<td>1900-1929</td>
<td>India, Nigeria, Pakistan.</td>
</tr>
<tr>
<td>Pre-1900</td>
<td>Ghana *, France **.</td>
</tr>
</tbody>
</table>

* The system is based on an 1888 Law, amended in 1957; a 1971 enactment is not yet in operation.

** There have been frequent adaptations through Ministerial Circulars, etc., notably in 1960 and 1972.

Statutory structures. Specific citations to the relevant laws, including the date of enactment, are collected at the end of this Report (pp. 158-160) for all the countries covered.

It cannot be assumed that recent enactment of a mental health law necessarily means that the legislative programme is functioning adequately in relation to the country's needs. Some such laws were virtually obsolete at the time of passage. Others were advanced forerunners which have remained effective for many years. The Lunacy Act of 1890 in England and Wales was in the former category, according to Kathleen Jones. The French Law of 1838, on the other hand, has been a fundamental and enduring basis for both the development of psychiatric services and for access to treatment. Keeping in mind this point, we can make certain observations about the current status and origins of the law in the various countries. These will be reviewed with reference to the six WHO Regions.
Among the new nations in the African Region, only Senegal was found to have recently adopted an entirely new law specifically adapted to the conditions of the country and in accordance with modern psychiatric treatment and practice. Colonial origins are still apparent in the law and practice in Benin, Nigeria, and Rwanda. As noted in Table 1, the current law in Ghana dates back to 1888. A new law was approved in 1971 but it has not yet been put into operation. In Tanzania, the Mental Disease Ordinance was originally enacted in 1937 and later amended on a number of occasions. A large-scale revision is now in progress. The mental health legislation of Lesotho was adopted in 1963 repealing the law in force since 1879. The new law is based on the English-Welsh Mental Health Act of 1959 and includes provision for the establishment of Mental Health Review Tribunals. Our respondent observed that the new law was not well known in the country because the text is available in only a few places and is in English and, unless new mental health manpower is made available, is not apt to be implemented to any great degree. He also commented that unless special interest in the matter is created, the law will not be changed again in the next 30 years or so.

In the Eastern Mediterranean Region, many of the countries function under informal systems. In Sudan new legal provisions concerning compulsory treatment of the mentally ill were adopted in 1975 as part of a general public health law. In Saudi Arabia a draft law was published in 1976. In Egypt, there is considerable interest in revising the Mental Health Act of 1944 which is considered outmoded and not in accordance with modern public health and psychiatric service objectives in the country. A committee of psychiatrists has recently been formed in Pakistan (where the 1912 Lunacy Act — also applicable in India and Burma — remains in force) to consider major revision of the mental health legislation in that country.

In the European Region, there were substantial legal reforms at the end of the 1950s and in the early 1960s, but legislative interest has not been extensive since that time. The only country considering fundamental revision in the law at present was reported to be Poland where the current law dates from the early 1950s. In England and Wales a review of the 1959 Mental Health Act is currently in progress and some changes are anticipated.

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

In the South-East Asia Region, India and Burma were found to be functioning in large part under the Lunacy Act of 1912 introduced by the British colonial authorities. Our correspondents in India indicated widespread interest in changing the law in that country. Bills were prepared in 1950 and 1959 by psychiatrists and were presented to the Ministry of Health, but no action was taken. Another reform bill was drafted and presented to the Ministry in 1971 and is currently
under review and examination. A bill was under consideration by the legislature in Punjab in 1975.

In the Region of the Americas the legislative picture is varied. In Canada and the United States of America, there is considerable legislative activity in the mental health field, both in regard to protection of patients' rights and in regard to development and expansion of mental health services. New proposals are being reviewed by the legislatures in some of the Provinces of Canada and one of those surveyed, Alberta, passed a new mental health law in 1972. Many of the States in the USA have adopted new legislation during the 1970s, particularly concerning patients' rights in relation to commitment. This followed a wave of new community mental health laws in the 1960s. In Costa Rica, the General Health Law of 1973 contains a number of provisions encouraging the development of mental health services on a voluntary basis. Trinidad and Tobago enacted a law in 1975 that includes some innovative provisions on personnel and introduces two new appeal mechanisms for protection of patients' rights.

In South America, only limited legislative activity is evident in the mental health field. A study in 1966 by the Pan American Health Organization found voluntary hospitalization laws in only five countries, namely Brazil, Chile, Peru, Uruguay, and Venezuela. Our legislative survey covered three of these countries (Brazil, Peru, and Uruguay). The laws in all three date back some years — Peru to 1952, Brazil and Uruguay to the 1930s. We are not aware of efforts to change the law in any of these countries, but psychiatrists and other health professionals in Peru and Uruguay were reported as desiring fundamental changes. In Peru, it was reported that there was an "urgent need for adequate legislation", but that it was extremely difficult to interest legislators in the problems of mental health.

2.2.2 Interest in change in the law

An important indicator of the current status and effectiveness of mental health legislation in any country is the interest in fundamental change among professional and other groups whose work brings them into close contact with the law. The questionnaire responses revealed dissatisfaction with some aspects of the current legislative system in a majority (28 out of 43) of the countries surveyed. The most commonly expressed complaint was that the legislation was generally outmoded and not in keeping with current needs. There were more observations that the law was too simple than that it was too complex. Only in a few countries was the law found to encourage expansion of services into the communities, or to make further options for care and treatment available. Many respondents noted the reluctance of legislators and government administrators to provide the needed financial support for an effective mental health programme throughout the country. It should also be noted that in a substantial minority (15 out of 43 of the countries surveyed) there was general satisfaction with current law.
This was true even for some countries operating under "informal systems". For example, Dr Fakhr El-Islam, consultant psychiatrist to the Ministry of Public Health of Qatar, made this comment: "In the Arabian Gulf Region where the family takes responsibility for everyday affairs of their mentally 'normal' members (e.g. marriage, management of property, ... etc. ...) it is not surprising that within these social norms the family should decide on the care of its mentally 'sick' members when advised by the psychiatrist. Therefore, admission and discharge from inpatient psychiatric care as well as extramural support and cooperation in follow up remain the joint responsibility of the family and psychiatric team in a free discussion unbounded by legal stipulations. The provision of legal mental health regulations independent of traditions seems to be grossly out of context and out of keeping with the sociocultural development of this closely knit society where the family is still the best and most effective psycho-social agent."

We also examined the question of interest in change by asking what groups in the country were advocating fundamental or radical amendment of the current legislation. Most frequently mentioned were psychiatrists, including those working outside government institutions. Next were other mental health professionals. These groups were most active when they believed that the law was substantially obsolete and not facilitating the development of more comprehensive mental health programmes. Next most frequently mentioned were social workers, who wanted to see the removal of legal barriers to effective services and who wished to protect the rights and welfare of mental patients and their families.

In a few industrialized countries where the law is quite sophisticated, lawyers and patients' rights groups were reported to be seeking substantial change in the legislation regarding protection of patients' rights. In some countries, such pressure groups were also seeking radical changes in the law regarding the hospitalization of mental patients and the right to refuse psychiatric treatment.

The police were also seeking changes in mental health legislation in a few countries to aid them in handling disturbed individuals in emergencies and to deal with growing problems of drug abuse and illegal drug distribution.

2.2.3 Concentration on hospitalization procedures

In the past, mental health services were centred on large mental hospitals providing largely custodial care. In recent decades there has been a move towards a much wider and less centralized range of services with emphasis on community care, crisis intervention, and day and foster care. Mental health care is also becoming less of a specialized branch of medicine and more of a public health concern. The extent to which mental health legislation concentrates mainly on hospitalization procedures is therefore a significant indicator of harmony between law and overall programme objectives.
We therefore examined the legislation in the countries surveyed to see if there was evidence of legal change to accompany the shift in policies and programmes. On the whole, this was not a rewarding effort. With few exceptions, the laws of the countries surveyed are concerned with hospitalization procedures, with empowering police, social workers, and others to apply for the admission of patients, and with the protection of the rights and welfare of hospitalized persons. Many countries make provision for foster care mainly in order to establish guardianship authority, or to assure government support for the care provided. These provisions are particularly detailed in the USSR, where foster care is widely used.

The recent Senegalese Law makes specific reference to treatment outside the hospital setting (for example, in family care, outpatient clinics, and "psychiatric villages"), while Norwegian legislation provides for compulsory treatment outside mental hospitals. In the USA, the development of community mental health centres was greatly stimulated by federal legislation in 1963. In France, the development of a range of psychiatric services serving a defined population has come about through a series of Ministerial decrees and circulars. The 1838 French Law, still in force, makes provision for the planning of services by each département in France. Early in the operation of this Law, the principle of Ministerial circulars modifying the criteria for adequate services was established. In recent decades, this flexible use of the French Law has encouraged the implementation of the "sectorization" policy and the development of outpatient and community services (see section 2.3.3).

There is no doubt, however, that in most countries the change which is taking place in mental health services is not reflected in the law, even when sophisticated and detailed mental health legislation has been enacted fairly recently. It seems that legislatures and government authorities find it unnecessary and often inadvisable to spell out these matters in the statutory law. Of course, there are substantial advantages in leaving the detail of programmes and their interpretation to agency regulations or other statutory instruments, directives, or circulars.

The potential disadvantage of a total absence of either statutory or regulatory provisions on important aspects of a mental health programme is that it may result in a lack of specific accountability to the public through the legislative and political system. These issues will be discussed at greater length in section 3 of this report.

2.2.4 Movement to voluntary care

Quantitative indices of progressive movement are difficult to define in the field of mental health legislation. The only quantitative index we found available in most countries was the ratio of voluntary admissions to all admissions to the mental hospitals. The significance of these figures was described in 1966 by the Canadian Royal Commission on Health Services as follows: "The number and proportion of all voluntary admissions is alleged to be, to some extent, an index of
Table 2
REPORTED RATES OF VOLUNTARY ADMISSIONS

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>Fiji*, India (Punjab)* Malaysia*, Pakistan*, Syrian Arab Republic, Uruguay.</td>
</tr>
<tr>
<td>11-40</td>
<td>Bahrain, India (Uttar Pradesh)*, Japan, Tanzania, United States of America (Indiana).</td>
</tr>
<tr>
<td>41-60</td>
<td>Australia (Victoria), Benin, Democratic Yemen*, Jordan, Norway, Switzerland (Geneva), United States of America (national)**.</td>
</tr>
<tr>
<td>61-80</td>
<td>Australia (South Australia), France*, Trinidad and Tobago, United States of America (Massachusetts).</td>
</tr>
<tr>
<td>81-90</td>
<td>Ghana, Iran*, Lesotho*, Poland, Rwanda*, Switzerland (Basel-Stadt)*, United Kingdom (England and Wales).</td>
</tr>
<tr>
<td>91-100</td>
<td>Cyprus, Denmark, Egypt*, Iraq, Kuwait, Senegal*, Sudan, Union of Soviet Socialist Republics***.</td>
</tr>
</tbody>
</table>

* Estimate.  
** Latest national figures for 1972 give an estimate of 48.6% voluntary patients in the 50 States.  
*** Between 96 and 99% in 1975, according to a number of indices.

acceptance of and attitudes toward psychiatric treatment by the country.”

Table 2 indicates the proportion of voluntary admissions in the countries covered in the survey where figures are available. Those where only an estimate was made by our respondents are specially marked. For some countries no data on admission status were currently available.

It should be pointed out that these figures are based on different criteria and systems of data collection. Few countries compile nationwide figures on categories of admission status. In some countries, only the figures for publicly operated mental hospitals were included. In others, all hospitalizations were reflected, but only in rough estimation. It should also be recalled that the definition of “voluntary admission” differs from country to country. The figures are not therefore strictly comparable but they provide some indication of the rate of voluntary admissions as defined in each country.
It will be found that the countries with the highest levels of voluntary admissions were all developing countries, except the USSR. This result was due largely to the informality of the hospitalization procedures in those developing countries where most admissions were considered voluntary when not on police or court order in criminal or state security cases. Moreover, in some of these countries a considerable proportion of patients are hospitalized in psychiatric units in general hospitals which admit most patients voluntarily or informally.

Some clarification is needed in the case of Japan, where the Mental Health Law does not provide for voluntary admissions but specifies two types of hospitalization, termed "involuntary" and "compulsory" respectively. The former type, which is normally a "non-protesting" admission arranged by the patient's relatives, accounts for 50% to 60% of all admissions, while 20% to 30% are "compulsory". We have quoted the figure of 20% voluntary admissions which accounts for the remainder of admissions, this being allowed under separate legislation, viz. the Mental Treatment Law. Nine-tenths of all mental hospital facilities in Japan are privately operated and much of the legislation in force is concerned with complex social insurance provisions which create a financial disincentive to voluntary admissions.

2.2.5 Human rights

Following the Second World War, and as a result of the widespread revulsion at the massive deprivation of human rights before and during that period, there was strong pressure for international guarantees of human rights. The Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations in 1948. At its foundation are the inherent dignity and the equal and inalienable rights of all people.

Problems arise when it comes to the protection of the rights of handicapped persons, whether the handicaps are due to sickness, physical incapacity, mental incapacity, or socio-cultural deprivation. Many of the international and national codes on human and civil rights recognize, however, a special obligation upon governments to ensure protection of the rights and welfare of those among the handicapped who do not have means to protect themselves.

At the international level there have been a number of more recent specific Declarations of the General Assembly of the United Nations. The Declaration of the Rights of the Child, adopted in 1959, enumerates the rights and safeguards against denial of these rights, which are intended to "enable [the child] to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity." Principle 5 of that Declaration refers specifically to the special protection required by handicapped children. It states: "The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition."
The Declaration on the Rights of Mentally Retarded Persons was adopted in 1971. It reaffirms, as a just principle, that "The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings." It enumerates aspects of care, security, and protection to which the mentally retarded person is entitled and provides for very strong legal safeguards whenever any restriction or denial of these rights is found to be necessary: "Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities."

More recently, in 1976, the General Assembly of the United Nations adopted a Declaration on the Rights of Disabled Persons. The mentally ill are included in the definition of the term "disabled person". This Declaration also strongly reaffirms the principle that disabled persons have the same fundamental rights as their fellow citizens, and in particular the same civil and political rights. It also refers to the need for proper legal safeguards against any possible abuse whenever there is a justification for a limitation or a suppression of these rights.

The constitutions of many countries include guarantees of liberty and rights of the individual. These guarantees can be used as the basis of court actions on behalf of the mentally ill and they can establish important legal principles. Such general guarantees can be difficult to apply, however, and specific legislation may be more effective in securing the rights of mentally disordered persons.

Some national governments and political subdivisions within federal countries have adopted special protective legislation for the mentally handicapped. These laws can generally be classified into two different groups: those which place the individual under supervision or guardianship as a dependent, legally incapacitated individual; and those which give the person special opportunity to protest his hospitalization or classification and which have made efforts to ensure the retention of many or all of the civil, political, and social rights, privileges, and responsibilities by the mentally disordered. The former type of protective-dependency system provided for individuals designated as "insane" to be adjudicated as incompetent if they had property, and placed under guardianship and/or committed to a distant asylum. The first movement against this system came with the adoption of lunacy commissions or similar bodies and the establishment of methods of appeal against wrongful commitment. The very existence of a right of appeal implied a legal capacity on the part of the hospitalized patient, at least until the appeal was heard and the patient declared properly committed. The granting of other rights and privileges to hospitalized patients was designed to reduce isolation from families and friends, and
to allow trial leaves in the community. In the latest reform legislation mental patients are presumed to be fully legally competent unless special action is taken before the courts to have them declared incompetent. Such provisions have been enacted in various States of the USA and in certain Provinces of Canada. In Australia (Victoria), the law now requires the automatic transfer of control over all property of committed patients to the Public Trustee. The Report of a Committee of Inquiry into the Hospital and Health Services of Victoria (known as the Towns­end Report), published in 1975, recommends that the law be amended to require a special determination of the incompetence of the patient to handle his own affairs. Our survey revealed that very few countries have enacted special laws which grant privileges to patients in regard to receiving and sending mail, having visitors, wearing their own clothes, being paid for work done in the institutions, etc. Examples of provisions in these areas will be noted later in this report.

2.2.6 Understanding of the law and professional training

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

Our respondents were asked their opinions on the understanding of the mental health legislation of their countries among certain groups in the population. The results obtained can be considered only as impressionistic. None of our respondents cited any objective data to support their opinions. Nevertheless, we report their replies as useful and interesting observations from persons who are qualified and experienced in the mental health programmes in their respective countries. In most of the countries surveyed, the understanding of the mental health legislation was reported to be limited among the general public, whether urban or rural, among community leaders, and among the press and other media personnel. Regarding the level of understanding of the law by psychiatrists, social workers, police, magistrates, and lawyers, there was very little difference between countries. Psychiatrists were generally said to have the highest degree of understanding of the law, followed by police and social workers. Magistrates and lawyers had reasonably good knowledge of the legislation, probably related to specific matters coming before them.

Understanding of the mental health law by the general public and by the press and other media was reported to be very limited in India and Thailand and fairly limited in the countries of the African Region. In the Eastern Mediterranean and the Western Pacific Regions, the
understanding of the general public was said to be limited, but the press was reported as somewhat more knowledgeable by some observers. As might be expected, the questionnaire results were more varied in the European and American Regions. In Europe public understanding was reported as limited in the United Kingdom and limited to fair in Denmark, France, Romania, and Poland. In Switzerland and Norway it was reported to be reasonably good. Press-media understanding was reported to be reasonably good in Switzerland and Norway, but limited in the United Kingdom and Poland. In the American Region, knowledge was reported as virtually nil in Peru for the general public and the press. In Brazil and Uruguay, the general public's understanding was reported as nil in the rural areas and limited in the urban. Press and other media understanding was reported as limited in both countries. In Canada, our respondent reported understanding as reasonably good for all groups. In the United States of America (Indiana), public and media understanding was reported as limited.

We also asked about the adequacy of training given in mental health legislation to psychiatrists, physicians, nurses, lawyers, police, magistrates, social workers, and religious leaders. In India and Thailand only psychiatrists and magistrates were reported as having adequate training. In the African Region, it was reported that all of the groups received poor or limited amounts of training except in Ghana where it was reported that training is adequate for all but religious leaders. In most of the countries of the Eastern Mediterranean Region, only psychiatrists, social workers, and judges receive adequate training. In Malaysia, training was indicated as adequate for all but religious leaders. In Japan, training was reported adequate for psychiatrists, physicians, and social workers in the Tokyo area, but poor for others in that area and for all groups in other parts of Japan.

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

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

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

In the United States of America and Canada, legal medicine courses are not well developed in the medical schools, but have been
increasing in number in recent years. The law schools of the United States are currently giving considerable attention to law and psychiatry, with a good deal of emphasis on hospitalization law and the rights of the mentally ill, alcoholics, drug addicts, prisoners, etc. Interest in change in the mental health and human rights fields has also been accelerated by the growing interest in medical ethics.

2.3 Programme administration

2.3.1 Federal structure

A federal governmental structure presents obvious complications for mental health programme planning and development at the national level. Health matters, including mental health, are handled at the subnational level in many federal countries. Yet the central ministry or national department of health is often charged with promoting improvement in the mental health of the people as a whole. Legislation does have more significance in the mental health field than in most other areas, since it is concerned with behavioural matters, hospitalization laws, control of drugs and drug abuse, etc. National planning in mental health should pay due attention to these legal matters. Examples of alternative approaches can be derived from a study of the experience of the federal countries examined in our survey.

Our analysis revealed three types of federal structure: (1) countries where virtually all mental health law of the type surveyed was found at the subnational level (for example, Australia, Canada, and Switzerland); (2) countries where the mental health law was largely enacted at the federal level (for example, Brazil, India, Nigeria, and the USSR); and (3) those where there is considerable federal activity and standard-setting through the law with more detailed legal provisions covering programme administration and hospital admission enacted at the subnational level (for example, the United States of America).

The Federal Constitution of Nigeria reserves to the States such areas as health, education, social services, local taxation, and local police functions. The Federal Government of Nigeria has, however, recently taken over operation of most public mental hospitals in the country. The Association of Psychiatrists of Nigeria was recently commissioned by the Government to prepare recommendations for needed changes in the mental health legislation.

In India, mental health services are the responsibility of the individual States but the Indian Lunacy Act of 1912 covers the whole country. Under Section 91 of this Act, each State can enact laws to prescribe forms for any proceeding under the Act other than a proceeding before the High Court, to prescribe places of detention and regulate care and treatment, to prescribe conditions subject to which asylums may be licensed, and to regulate several matters concerning criminal lunatics.

In the United States there is wide variation in the mental health law of the fifty States, the District of Columbia, and the Commonwealth
of Puerto Rico. Most of the States have revised their mental health legislation substantially in the past five or ten years. Both States included in our survey adopted radical reforms in the 1970s. There are two ways in which the Federal Government has been influential in the mental health field. The first has been in providing federal funds for the development of new mental health service programmes, for psychiatric and behavioural science research, and for personnel training. The second has been in new federal laws setting standards in certain areas of mental health services, especially where federal funds are provided for the States, as in the development of community-based services. The Federal Government has also cooperated with the States in helping to develop what are called “interstate compacts”, or legal agreements among the States, concerning matters of cross-state importance, such as transport of patients and return of patients to their home jurisdictions for care and treatment. Currently there is an Interstate Compact on Mental Health and an Interstate Compact on the Mentally Disordered Offender.

There has been one other influential area of national legislation in mental health service programmes in the USA, namely health insurance financing. The Medicare and Medicaid programmes in force since the mid-1960s cover mental illness to a limited degree and set standards for care and treatment which must be met in the States by public and private providers. Any future expansion of national health insurance in the United States would probably cover mental disabilities to some degree and would carry with it further federal regulation.

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

It seems clear, however, that the alternatives of federalism in the mental health legislative field are quite extensive. In several federal countries, most mental health legislation was found at a federal level, even when service provision was the responsibility of the subnational jurisdictions. Even in those countries where the most important mental health legislation exists at the subnational level, federal legal activity in this field can be found to range across at least the following areas:

1. Encouragement of uniform, or at least adequate, levels of mental health care in all states (or provinces, cantons, etc.) by making
federal financial support contingent upon the maintenance of specified standards.

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

3. Federal financial support of mental health research and training through grants to the states and to individuals, universities, and voluntary agencies under federal law and guidelines.

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

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

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

2.3.2 Legal differentiation of mental disorders

One of the major debates concerning mental health legislation is whether all mental disorders should be grouped together.

In older legislation, all categories tended to be handled as medical-psychiatric responsibilities. The heads of the facilities were invariably medically trained. Even where the law distinguished (usually only by definition) between "the insane" and "idiots", the legal and administrative processing was indistinguishable. Both groups were considered universally to be legally incompetent for all legal and political purposes. Individuals in both groups were handled by alienation from society and were committed to institutions under the same legal provisions. Even after separate institutions, or "schools", were established for the retarded or feeble-minded, the law was slow to recognize any need to alter the legal procedures for admission to, care in, or discharge from these institutions.

Table 3 describes the current scope of the mental health laws in the countries with formal mental health legislation. Three basic classifications are used: those with general-scope legislation covering all categories; those which combine mental illness and retardation but have separate legislation for some other categories of mental disorder; and those which have separate legislation for mental illness and for retardation along with separate legislation for all, or nearly all, other categories. In the lower part of the table, several important special categories of mental disorder are listed showing which countries (or jurisdictions) have enacted specific legislation covering one or more of these categories.
### BASIC SYSTEM

1. **General scope**: Benin, Canada (British Columbia), Cyprus, Democratic Yemen, Fiji, Ghana, India, Iran, Kuwait, Lesotho, Nigeria, Pakistan, Romania, Sudan, Syrian Arab Republic, Tanzania, Trinidad and Tobago, United Kingdom, United States of America (Indiana).

2. **Combines mentally ill and retarded, but separate legislation for some other special categories**: Australia (South Australia and Victoria), Brazil, Canada (Alberta), Egypt, Japan, Malaysia, Peru, Poland, Senegal, Switzerland (Basel-Stadt and Geneva), Union of Soviet Socialist Republics.

3. **Separate legislation for all, or nearly all, categories**: Costa Rica, Denmark, France, Norway, United States of America (Massachusetts), Uruguay.

### SPECIAL CATEGORIES

1. **Alcoholism and drug dependence**: Australia (South Australia and Victoria), Brazil, Norway, Union of Soviet Socialist Republics.

2. **Alcoholism and alcohol abuse**: Costa Rica, Denmark, Egypt, France, Poland, Switzerland (Basel-Stadt and Geneva), United States of America (Massachusetts).

3. **Drug dependence and drug abuse**: Australia (South Australia), Costa Rica, Egypt, France, Japan, Malaysia, Peru, Senegal, Switzerland (Basel-Stadt and Geneva), United States of America (Massachusetts), Uruguay.

4. **Sexual deviancy**: Australia (South Australia), Denmark, Egypt, Norway, Switzerland (Basel-Stadt), United States of America (Massachusetts).

The first group in Table 3 was found to be the largest, with 20 jurisdictions. Some of the laws in these jurisdictions recognize different categories of disorder in their definitions, but make no distinction in operation of the legal procedures. An exception is the Mental Health Act of 1959 in England and Wales where the general definition of "mental disorder" covers mental illness, severe subnormality and subnormality, and psychopathy but where the same law does make some distinctions in the general admission and discharge provisions for the different sub-classifications. The sub-classifications are also separately defined in the Act. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-57) recommended abandonment of the previous system in operation for over 40 years in England and Wales under which separate legal codes covered the mentally ill and mental defectives. This recommendation was accepted by Parliament. The single new law enacted in 1959 covers all mental disorders of whatever character. We have therefore listed the English-Welsh Law in the first group.
Rather different in character, but included in the same category, is the law of the State of Indiana in the USA. In that jurisdiction, the legislation uses the term "mental illness" to cover all categories, specifically including "mental retardation, epilepsy, alcoholism and addiction to narcotic or dangerous drugs".

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

The third group was the most difficult to determine. Each of these countries has at least some special legislation establishing separate programmes for mental illness and for mental retardation and also for all, or most, of the other categories. Some of these countries do retain a general-scope law which may cover broad categories of mental disorder, but they function largely under separately identifiable laws and programmes for each group of patients or residents.

Table 3 also reveals a widespread adoption of special treatment and rehabilitation laws for alcoholism and drug dependence which are both among the most active areas of new legislation in the entire mental health field. Provisions concerning "alcoholics" and "drunken offenders" can, of course, be found, not only in mental health legislation, but in the criminal law, motor vehicle law, labour law, insurance-programme legislation, and in public health laws. A general review of this field was recently completed by WHO.35

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

New legislation related to drug dependence has been adopted in a number of countries in the past ten years, largely in response to the
spread of illicit drug use in the 1960s. The earlier laws dealt largely with serious addiction or dependence upon the narcotic drugs. More recent laws have also covered the barbiturates and amphetamines. Most of the laws have established specialized treatment and rehabilitation programmes, some of them compulsory, but they are less apt to have removed criminal provisions than in the alcoholism field. However, many of the laws allow treatment and rehabilitation to replace entirely, or to some extent, the criminal sentence of a person found guilty of illegal possession and use of drugs where the person is also found by medical examination to be drug dependent.

There has been extensive activity in the field of international narcotic drug control in the United Nations and its specialized agencies and among the nations of the world. The Single Convention on Narcotic Drugs, 1961, has substantially replaced earlier treaties in the field. The Convention on Psychotropic Substances has also been ratified by a number of nations since its initial approval in 1971 and entry into force in 1976. The Commission on Narcotic Drugs of the United Nations Economic and Social Council formulates United Nations policy and coordinates efforts of the international community in this field. The United Nations Division of Narcotic Drugs, located in Geneva, serves as the substantive Secretariat for the Commission on Narcotic Drugs. In 1971, the United Nations established the Fund for Drug Abuse Control, also headquartered in Geneva. At WHO, a number of important Expert Committee reports relating to drug dependence have been issued since 1952. A comparative survey of legislation concerning the treatment of drug addicts was published by WHO in 1962. Special attention has also been given to drug abuse and drug dependence, as well as to efforts to encourage cooperation to develop more uniform laws on control of drugs, in the Public Health Division and the Directorate of Legal Affairs of the Council of Europe.

A great deal of attention has been focused in recent years on drug problems in the USA so that some observations on legal changes in that country during this time should be of interest. In 1970 the National Conference of Commissioners on Uniform State Laws adopted the Uniform Controlled Substances Act. It has now been adopted in most of the States. A National Commission on Marijuana and Drug Abuse, which issued reports in 1972 and 1973, has had much less success in encouraging the States to adopt its recommendations, especially those relating to removing or reducing the penalties for private possession and use of drugs. A number of States have, however, adopted laws establishing drug dependence treatment and rehabilitation programmes.

It will be noted also from Table 3 that six of the countries surveyed have adopted mental health laws in the field of sexual deviation. The legal provisions on this subject are probably the most diverse of all of the special laws as regards legal philosophy and medical/psychological therapeutic techniques. Some of the laws in the Scandinavian nations authorize sterilization and castration of sex offenders. Sterili-
zation is also allowed in some of the American States, but not in either of the jurisdictions included in this review.

2.3.3 Community mental health care

As mentioned earlier, one of the most striking of all of the changes made in the delivery of mental health services in the past two decades has been the increase in community-based programmes and facilities. Some of the earliest evidence of legal change to community services can be found in items of French legislation promulgated over the years. In 1944, an Order was promulgated establishing a plan for the organization of a “colonie familiale”, or a special centre for placing former patients in foster homes in the community. A Decree dated 20 May 1955 established a programme of support for community mental hygiene clinics with central government funding on a sliding scale up to 80%. In the 1960s, a master plan was adopted to modernize the mental hospitals and to operate them on a “sectorization basis”, gathering the patients by sectors of the départements in France so that hospital and community follow-up services could be coordinated effectively. As a result of a Ministerial Circular of 15 March 1960, community mental health centres have been established in every département and in every city of over 20,000 inhabitants. Regulations within the national social security system have supported mental health treatment services in these community centres.

A number of countries have enacted laws providing for placement of patients in foster homes. Changes have also been made in guardianship laws in order to facilitate earlier discharge of mental patients or retarded persons, or in order to be able to keep such people in the community and out of hospital entirely. A few countries have enacted specific legislation on aftercare of patients in the community. The USSR legislation is especially extensive on both guardianship and foster-care placement. The basic systems are described in section 4.1.

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

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

The new legal provisions on mental health adopted in 1975 in Sudan provide for a Mental Health Board in each Province and direct these Boards to form local mental health boards in local executive
councils when the Provincial Board determines they are needed. Attention should also be called to the 1975 Senegalese Law which specifically provides for the establishment in each region of "psychiatric villages" to be made up of the mentally ill and their families. Such programmes exist in other African countries, but are not specifically mentioned in the available legislation.

In the USA, community mental health services, often grouped around a locally operated centre with a "citizen-board" in charge of the policy of the centre, developed as an outgrowth of child-guidance centres when these facilities began to be expanded to deal broadly with family problems. Special laws were adopted in a number of States during the 1950s and these greatly stimulated the growth of community mental health services, usually operated by county governments under grants-in-aid from the State governments. In 1959, the Council of State Governments produced a model for a state community mental health act based closely upon the Minnesota law of 1957. The entire field received further stimulus when, in 1963, the Community Mental Health Centers Act was signed into law; this provided for grants-in-aid to establish such centres throughout the country. The law required such facilities to offer a wide range of comprehensive community mental health services.

2.3.4 Time devoted to legal involvement

The 1955 Expert Committee Report noted that, in many countries, "numerous legal formalities have to be satisfied" before admission of patients. In regard to discharge, "cumbersome procedures" often had to be observed. The Report also mentioned "frequent and often unnecessary reports sent to a general authority by those in charge of the hospital". It may well be that these reporting laws were the "purely legal considerations" which the Committee criticized in its Report. It would seem clear that the Committee saw no significant benefit to patients in these requirements.

Our questionnaire included a specific question about the time devoted to medicolegal matters by psychiatrists under the current legislation in their respective countries. Also, we asked if there were psychiatrists specializing in medicolegal work in their countries.

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

Some specialization in medicolegal work was found to exist in most of the countries, but it was generally limited to a few psychiatrists. Exceptions were noted in France and in the USA (Massachusetts), where there were large cadres of specialists in forensic psychiatry. University medicolegal institutes were also active in forensic psychiatry in Denmark, Japan, Poland, Switzerland, and the USSR. There were a few forensic psychiatrists in the United Kingdom working in prison
programmes and probation services. The predominant activity of forensic psychiatrists in all countries surveyed throughout the world was concentrated in providing evidence and opinions in criminal matters, and in offering treatment in prison settings and in outpatient clinics attached to probation and parole services. In the USSR, time is set aside in the working day of psychiatrists (one half-hour per day in a six-day week) for providing medicolegal assistance to patients. In many other countries, staff psychiatrists in mental hospitals spend considerable time in treatment and in making reports on criminal offenders sent by the courts to the hospitals for observation concerning mental illness and criminal responsibility.

2.4 Hospitalization procedures

2.4.1 Classification of national systems

The legislative systems surveyed are grouped here into rough categories according to complexity and legal formality. In part this is a response to the widespread interest expressed in most reform movements in this field in "simplifying" the mental health legislation to make access to care and treatment freer and less cumbersome.

The nations grouped as "complex" in Table 4 are those with the most lengthy hospitalization codes and with a large number of alternative methods of admission, including at least two different modes of involuntary hospitalization. These nations all have at least one emergency procedure. In almost all of these systems, cross-references are made from one procedure to another, making for considerable

| Complex legislative systems: Australia (South Australia and Victoria), Egypt, Fiji, Japan *, Malaysia, United Kingdom (England and Wales), United States of America, Uruguay. |
|---|---|
| Moderately complex legislative systems: Canada, Cyprus, Democratic Yemen, France **, Ghana (new Act, 1971), India, Lesotho, Pakistan, Peru, Romania, Switzerland, Tanzania, Trinidad and Tobago, Union of Soviet Socialist Republics. |
| Basic legislative systems: Brazil, Costa Rica, Denmark, Nigeria, Norway, Poland, Senegal, Sudan, Syrian Arab Republic. |
| Informal systems: Bahrain, Benin, Ethiopia, Iran, Iraq, Jordan, Kuwait, Qatar, Rwanda, Saudi Arabia, Thailand, Yemen Arab Republic. |

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

** Combines 1838 Law with extensive administrative texts.
difficulty in interpretation. Nations listed in the "moderately complex" category have somewhat less complicated laws. In the category of "basic" are those legislative systems which contain only one set of procedures and much less complication. In the last category are those countries without formal legislation in this field.

It will be noted that a number of the countries listed in the most complex category have enacted reform laws relatively recently, or are large, urbanized, industrial nations with relatively widespread and diverse delivery systems in the mental health field. Their laws are a reflection of the complexity of their systems. Even where the intent of the most recent reform effort was to "simplify" the legislation, as was the case in England and Wales in 1959, the result was not necessarily achieved when compared with legislation in other countries.

2.4.2 Voluntary access to care

There has been a strong movement toward voluntary access to care during the past two decades in many parts of the world. This is most apparent in the growth of outpatient clinics, day hospitals, hostels, and community care, where the great majority of patients are voluntary. In the USSR, all patients placed in foster care must be voluntary.

In section 4.1 summary outlines are given of the legal provisions for voluntary access to care, in most cases referring to hospital admission. Information from 43 countries is given. For the four federal countries, there is information from two separate jurisdictions in each case, so that a total of 47 jurisdictions are included. Of these 12 have no specific legislation concerning admission to mental hospital. The usual practice in these countries is for voluntary admission to be arranged through the patient's family. Of the 35 jurisdictions with laws currently in force covering admission to mental hospital, there is no provision in law for voluntary admission in seven, while in 28 a definite legal basis for voluntary admission exists. Three categories can therefore be defined:

(a) 12 countries with no law covering admission to mental hospital and in which families play a major role in arranging voluntary admissions;

(b) seven countries with laws governing admission to mental hospital which include no provision for voluntary admission. In one such country, France, voluntary admission has been clearly established as a procedure through a ministerial decree. In three such countries, voluntary admissions are common despite the lack of a legal basis. In the remaining three countries there are few or no voluntary admissions;

(c) 24 countries (28 jurisdictions surveyed) with laws specifically providing for voluntary admission. The extent to which this provision is used varies widely. In nine of these jurisdictions, patients have to make a written application for admission. In 12 jurisdictions, a medical certificate is required either prior to or after admission. Thirteen jurisdictions provide specifically for a change to involuntary status in certain circumstances. In nine jurisdictions there is provision for a delay in
discharge following the patient's or the family's request. This delay varies from 1-21 days but is most commonly three days.

The most frequently discussed initiative in this area in the past 20 years is undoubtedly the adoption in the United Kingdom of an "informal" admission system. Voluntary admission had been pioneered in the United Kingdom. It had first been made available through administrative measures in parts of Scotland during the last decade of the 19th century. This experience led to recommendations for reform of the more rigid laws applying in England and Wales by the Royal Commission on Lunacy and Mental Disorder (1924-26), and as a result, the Mental Treatment Act was enacted in 1930, by which "voluntary admission" became legal. The proportion of voluntary patients rose steadily after 1930 reaching 75% by 1957, the proportion in some hospitals being as high as 90%. Nevertheless, the 1954-57 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency was disturbed at reports that some patients were being refused voluntary admission at some hospitals because the patient was believed by the staff not to be able to make a specific request for care and did not seem to understand his situation and need for treatment. A written application for admission made out and signed by the patient was required under the 1930 Law, as was the patient's formal notice of intention to leave the hospital. The Royal Commission recommended and Parliament enacted in the 1959 Mental Health Act a method of admission generally known as "informal" under which no requirements may be imposed on the patient to make an affirmative request for care and treatment and where the patient is not required to sign admission forms.

The new idea was highly popular with psychiatrists and other physicians in Britain at the time and also appealed to mental health administrators in many other countries. It seemed a clear departure from the tight restrictions of the legal systems so long imposed on mental hospitals. The admitting doctors could now make the decisions on admission and mental institutions could begin to become like other "hospitals" for sick people, with no legal controls on who could be admitted and under what circumstances. Another appealing feature of the new system was that it seemed to require no legal change for its establishment. If a hospital administrator wanted an "informal admission" procedure, all he needed to do was to instruct the admissions office not to require patients to make out papers or forms. The patients were not listed as "voluntary", even where the hospital had such a legal method of hospitalization. The Royal Commission had given its opinion that British hospitals did not have to await a change in the law to adopt the method. Indeed the 1959 Mental Health Act contains no specific procedure for informal or voluntary admission per se. Instead, it contains a declaration asserting that the Act shall not be construed as preventing such admissions: "Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in
that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained."

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

The informal system has been adopted in a few States of the USA. Some administrators established it without legal authorization and often without informing State officials that they were doing so. A number of other countries have amended their laws since 1959 to create an informal admission procedure.

In Costa Rica, the General Health Law adopted in 1973 has a Chapter on "Rights and Duties Relating to the Restoration of Personal Health". A general policy statement therein authorizes voluntary access to care, but also provides for compulsory treatment: "Mental patients and persons dependent on drugs or other substances, including alcoholics, may submit voluntarily to specialized outpatient or inpatient treatment provided by the health services; they must undergo such treatment whenever the competent authority deems it necessary to order such treatment, following the procedures and subject to the requirements laid down in pertinent regulations."

The definition of "voluntary admission" differs from country to country and the summaries for specific countries should be examined to identify these differences. In some countries, as noted earlier, application directly to a hospital by a relative for the admission of an adult patient, without court order, usually with no protest being made by the adult patient, is considered voluntary. In nearly all countries it is considered a voluntary admission when the parents or guardian of a child below the age of majority apply to an institution for a non-judicial admission. In both of these situations, the relative or parent/guardian can usually obtain the release of the patient on request. In the case of an adult, or when the admitted child reaches majority, these same laws generally allow the patient to be released on his own request. Since these patients are classified as "voluntary", the hospital has no power to hold them against their own wishes or the wishes of the relative or guardian. Placing power to hospitalize and discharge in the hands of relatives in this way is often
a part of the tradition and culture of the country supporting strong family responsibilities. The concept of “voluntariness” is further discussed in section 3.5.1.

Several important points emerge from our examination of voluntary admission procedures. Such admissions are widely available where there is no formal law. Where voluntary admission is infrequent, this is only rarely related to the law itself. In Japan it is a result of health insurance regulations. Voluntary admission often carries with it certain restrictions of rights, notably the possibility of delay in discharge following a patient’s request to leave hospital (this exists in several countries).

2.4.3 Involuntary hospitalization

This category of involuntary care covers those procedures which either authorize a commitment without limitation of time, or authorize commitments for specified periods with provision for repeated renewals. The involuntary procedures of this type are summarized in section 4.2.

The most dramatic change noted in the hospitalization procedures over the past 20 years comes under this category. It concerns the movement toward compulsory hospitalization on medical certification alone without prior judicial or administrative tribunal review. This form of hospitalization was strongly supported in both the WHO Expert Committee Report and the comparative legislative review published in 1955. At that time, there were 19 jurisdictions in this category among the 37 countries surveyed.

In 1975, however, we found 34 jurisdictions with at least one procedure for involuntary hospitalization on medical certification alone out of 43 countries in our survey. In 12 of the 34 jurisdictions, this non-judicial procedure is the only compulsory method of prolonged, or indefinite, commitment. It is our impression that in all jurisdictions where this method is available, it is the most heavily used procedure for such hospitalization. Both patients (and their families) and the provider groups avoid use of procedures which entail prior approval of admission by the courts. Where such a non-judicial, long-term procedure does not exist on the statute books, but there is a non-judicial emergency or temporary observational commitment procedure available, this method also tends to be utilized as a substitute to avoid the formalistic system of prior court review.

In the great majority of jurisdictions, the legislation requires a finding that the patient, owing to mental illness, constitutes a danger to himself or to others around him, or to the community at large. In 17 jurisdictions this type of “dangerousness” criterion was the exclusive ground for compulsory hospitalization. In the remainder, it was an alternative basis, usually accompanied by another criterion such as the person’s need for

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*a Almost all provisions for involuntary care refer to admission to and care within a hospital. An exception is provided in the Norwegian Law of 28 April 1961, Section 7 of which provides for “mental health care provided outside hospitals when the patient is cared for without his own consent”.

treatment, his refusal to accept it, or his inability to understand his need for it. Most of the legislation leaves the term “dangerous”, or equivalent words such as “harm”, undefined. Examples are as follows:

- Cyprus: patient of unsound mind and dangerous.
- Democratic Yemen: patient at large and dangerous.
- Malaysia: patient suspected of being dangerous.
- Peru: patient with dangerous tendencies.
- Switzerland (Geneva): patient's condition of obvious danger or neglect.

The laws of some countries are more specific concerning psychiatric condition. For example, Brazil authorizes compulsory hospitalization where the patient has suicidal tendencies or exhibits serious aggression toward others, or where the patient has a disordered social life and has committed immoral acts. In the USSR certain conditions are specifically excluded from consideration.

The two States of the USA included in the survey define “dangerousness” in terms of potential for harm to self or to others. The Indiana law has two classifications: one called “dangerous”, defined as “substantial risk he will harm himself or others”; and the other “gravely disordered”, defined as a mental patient who is “in danger of coming to harm because of inability to provide for his food, clothing, shelter, or other essential human needs”.

The Massachusetts law contains degrees of certainty of prediction of dangerousness in relation to the seriousness of the harm. A patient in Massachusetts can be committed involuntarily only if failure to hospitalize “would create a likelihood of serious harm by reason of mental illness”. The law defines “likelihood of serious harm” in detail (see section 4.2).

2.4.4 Observational hospitalization

The procedures classified as observational are summarized in section 4.3. The selection is somewhat arbitrary and procedures can be found to overlap in actual operation with those covered in the previous section and with the category of emergency care.

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

Nearly all of the procedures are involuntary. Many of them are available without prior court approval. Observational hospitalization is always limited in time. The general mode is 3 to 4 weeks at the end of
which time a decision must be made to transfer the patient to a regular, indefinite, or extended stay, or to release him.

The Malaysian legal procedures are unusually complex. We have listed three different procedures in this category because the law of Malaysia so classifies them, even though one of them is limited to three days. Another Malaysian procedure is listed under emergency hospitalization, even though it provides for seven days’ hospitalization with provision for renewal for an additional seven days.

It is our impression that observational hospitalizations are less frequently utilized at present than in former years. In a formal way, this is evident from the relatively small number of countries having such a provision in their current law. The summary of provisions contains legislation from only 12 jurisdictions. Such procedures are not included in the quite recent revisions of the law in the Canadian Provinces and the US States surveyed. The reason for this change in practice is quite clear. It is due to the greater availability of outpatient and consultation services in many countries where diagnostic services and early and effective treatment can be given in the community without the need to hospitalize the patient. Only where the large public mental hospital is the only available facility will there be a continuing need for 3-4 week observational periods for non-dangerous patients who do not need emergency confinement. General hospital psychiatric services are also absorbing a large percentage of this type of patient in nearly every country surveyed, either in outpatient or short inpatient stays. This practice was reported in the developing countries as well as in the industrial nations.

2.4.5 Emergency hospitalization

Whereas observational hospitalization has declined in importance, emergency hospitalization procedures still seem to be a significant and frequently used method of admission in nearly all countries. The emergency procedures of the countries surveyed are summarized in section 4.4. The key factor in these procedures is time. The patient is in need of immediate professional attention. He usually needs immediate treatment, supervision, and care, on account of a violent outburst, a suicide attempt, or other bizarre behaviour of sudden onset.

In those jurisdictions which normally require pre-hospitalization review by court, or the certification of the illness by two physicians, the use of the emergency procedure often dispenses with these requirements. However, many countries still require certification by one physician, even for acute emergencies. In many countries, the application itself can be made by a mental health officer or by a physician who has examined the patient. Our survey identified emergency provisions in 24 jurisdictions. One medical certificate for hospitalization was required in 15 of these jurisdictions.

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

In some countries, especially developing countries without formal legislative systems, there may be little opportunity on the part of hospital doctors to exercise medical discretion about admitting patients escorting to the hospital by the police. Improved legal systems with more modern procedures would strengthen the role of the admitting doctors to refuse to admit, or to refer elsewhere when inappropriate cases are brought to the facility by police or other governmental authorities.

The specified length of time of emergency admissions varied considerably among the countries surveyed. The most frequent period was three days. The longest was 21 days. In a few laws there was no specified time limitation. In some countries the French custom was followed of requiring reports to the Prefecture of Police or another independent officer during the 24 hours following hospitalization. The procedure in the USSR requires a report by a special panel of three psychiatrists within 24 hours of an emergency admission.

One of the most novel procedures was the recent adoption in Trinidad and Tobago of a procedure under which a person wandering at large on a highway or in any public place can be apprehended by a "mental health officer" and taken, with the aid of police if necessary, to a psychiatric hospital or ward for observation for 72 hours. Upon examination at the hospital within the observational period, the patient can be transferred by the hospital to an indefinite, involuntary status. These mental health officers are appointed by the Minister of Health and can be psychiatric social workers, mental nurses, District Health Visitors (i.e. public health nurses), or other nurses who have equivalent training and experience as District Health Nurses and at least six months' supervised experience in social work and in psychiatric nursing. Under the same new law, directors of public psychiatric hospitals, and all mental health officers are appointed as Justices of the Peace for all of Trinidad and Tobago, apparently so that they may issue orders for hospitalization under the law and to enable mental health officers to apprehend persons and to require the police to assist them in bringing the patient to hospital. Our correspondent indicates that the procedure is working well, though the police prefer being asked to assist rather than being ordered to do so. The mental health officers usually comply and only ask for police assistance when it is necessary to deal with an uncooperative patient. There are currently 15 such officers functioning in the five new mental health regions for a population of one million. It is planned to increase the number to 40 in the near future. The same law also contains a more
traditional "urgent admission" procedure, which requires medical certification.

2.4.6 Mentally ill offenders: the criminal law processes and the mentally ill offender

The criminal law and mentally ill offenders were outside the scope of our study. Most of the mental health codes which we examined had provisions on observational commitment of persons charged with crime. In some countries, such matters were taken care of in completely separate criminal codes. Many countries have separate institutions for the "criminally insane", usually under the supervision of the state penal authorities. Such institutions are rare in the developing countries. An exception is Sudan where in the past 25 years five special forensic psychiatric institutions have been established. With traditional family and community support breaking down, more disturbed patients, homeless persons, and vagrants are being handled in the jails and prisons of the developing world.

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

Some of the civil-law hospitalization procedures which were surveyed overlap with the criminal areas or provide for alternative methods of disposition of persons who could otherwise have been handled under the criminal law system. This was the case with the mental hospitalization of alcoholics and drug-dependent persons reported upon earlier in this report. It has also happened under laws such as the Mental Health Act of 1959 in England and Wales and laws modelled thereon which include "psychopaths" in the same classification as other "mentally disordered" patients. It is difficult to integrate this type of patient into the more modern psychiatric facilities with their open wards and doors and liberalized rules of operation. A Report of the World Federation for Mental Health in 1967 questioned the British approach: "Among the categories of mental disturbance provided for is 'psychopathic disorder'... This clause has the effect of bringing psychopathic behaviour within the scope of medical treatment and has raised the significant question of a medical type of institution for the treatment of chronic criminality. If moves are made in this direction they will undoubtedly result in the provision once again of some closed psychiatric hospitals for individuals who are there under some form of legal duress."28

The doubts expressed were quite prophetic. Among the most serious problems in the British mental health system at present is the handling of "psychopathic patients" both in the special closed hospitals and in the general mental hospitals. The classification is extremely difficult to define. In fact, the term "psychopath", as descriptive of
dangerous, acting-out patients who are not psychotic, has been abandoned in most countries other than England and Wales.

A recent Report in the United Kingdom recommends extensive reforms in the handling of mentally ill offenders. There is also considerable interest in this subject in many other regions of the world. The subject is dealt with in a paper on health aspects of avoidable maltreatment of prisoners and detainees prepared by WHO for the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders held in Geneva in 1975. The difficulties of drawing a clear distinction between criminality and mental disorder are stressed and the growing practice of “arranging” informal admission to psychiatric hospitals for offenders who accept to be received for observation and any necessary treatment is mentioned. The problems which have arisen as a result of preference of committal to psychiatric hospitals rather than prisons of offenders medically judged to be abnormal are discussed in the light of the evolution of the “open door” policy.

It must be admitted that in a penal setting the requirements of institutional security take priority, even in the handling and treatment of mentally ill offenders. Nevertheless, basic human rights apply to inmates of penal institutions as well as to patients in mental hospitals, whether open or closed institutions. Various specific applications of human rights to prisoners have been acknowledged in declarations and resolutions of the United Nations, the World Health Organization, and the World Medical Association.

2.4.7 Functions of mental health professionals in criminal and penal settings

When mental health professionals examine, on behalf of the courts, persons charged with criminal offences, they are acting as public agents. They may be offering opinions (as psychiatrists), or providing evaluations (such as psychological testing and social-work reports), on questions asked by the presiding judge in regard to such matters as competency to stand trial, criminal responsibility, mental status and intelligence, and potentiality for dangerous conduct.

Overlaps between the civil and criminal systems occur in many of these situations where the underlying question is one of disposition: whether the person charged should be channelled through the penal system or through health facilities. In the case of psychopathic disorders, the decision is not essentially medical. The legal systems of most nations deal with psychopaths in accordance with national cultural beliefs and public policy. In some nations, psychopaths may be committed to specialized mental health institutions. In others, they may be dealt with as criminal offenders and, after conviction of a specific offence, are sentenced to a fixed or indefinite term of imprisonment. The role of mental health personnel in relation to such persons should not differ whichever method is used. The relationship is essentially clinical and governed by the traditional standards of professional ethics. This is also true for mental
health personnel conducting clinical programmes for sexual deviants, drug-dependent persons, and alcoholics, where decisions on placement in penal or health-care settings are taken by penal or health authorities. Some of the problems facing professionals working in this area, which represents the interface between the health care and penal systems, have been outlined in the report of a recent WHO meeting on forensic psychiatry.31

2.5 Protective measures for patients

2.5.1 Court and administrative review

Throughout history, the independent system of the judiciary — official justice — has been the primary recourse of the individual to protect his rights, to redress wrongs against him, and to gain his liberty from unjust or improper imprisonment or detention. These traditions have been adopted in international documents on human rights. The basic principle appears in the Universal Declaration of Human Rights48 as follows:

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

The right of judicial recourse regarding personal liberty appears in the International Covenant on Civil and Political Rights:32

"Article 9. (1) Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law...

(4) Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."

Similar provisions can be found in the European Convention for the Protection of Human Rights and Fundamental Freedoms: 33

"Article 5. ... 4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful...

Article 6. 1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law...”.

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

The provisions of the international instruments concerning the right to a public hearing to protest against confinement are not as clear. They are open to interpretation and to different application, depending on the circumstances of the individual case. The most serious interpretative problem concerns when the hearing, or an opportunity for a hearing, must take place. Article 9(4) of the International Covenant on Civil and Political Rights and Article 5(4) of the European Convention deal with the matter of when the court, once the request is filed, must make its decision. In the former, it is to decide “without delay”, in the latter it is to be “decided speedily”. But the implication of the provisions is that the person has already been deprived of liberty before the request for court action is made. It seems reasonably clear that these instruments were concerned mainly with the serious problems of arbitrary arrest and imprisonment under sentence without trial. Such persons are in confinement and without opportunity to protest. Nevertheless, the most effective means of exercising the right of freedom from improper confinement and imprisonment is by public trial or hearing prior to confinement. The Constitution of the United States of America has been held to require a prior public hearing on the question of involuntary commitment to a mental hospital. The older commitment laws of the 19th century in Europe, which were adopted from about 1850 onward, generally followed this principle. There were, of course, exceptions to this requirement in situations of emergency, but the person was afforded the opportunity to appeal against his confinement very speedily; alternatively, the confinement itself was limited to 24 to 72 hours, within which time the hospital was required either to release the patient or to seek court action for a further confinement. The person’s opportunity to protest was, of course, to be exercised at this hearing. The laws of many countries, as indicated in the details of the relevant statutory provisions, currently adhere to this requirement. Among the jurisdictions surveyed, 13 provide for non-emergency commitment exclusively under prior court review and judicial order of detention (Cyprus, Democratic Yemen, Ghana, India, Iran, Iraq (under the current law and the draft law), Nigeria, Pakistan, Romania, Senegal, Tanzania, and the USA (Indiana and Massachusetts)).

As indicated earlier, compulsory hospitalization without prior court review is the most favoured system in nearly all other countries. Also, where the only method of indefinite commitment is by prior court order, the tendency is to over-utilize any available non-judicial alternative such as temporary observational and emergency procedures. At the end of these periods, a court hearing is generally required. However, some jurisdictions do allow a change of status of patients to take place, either without court approval, or without providing the patient with prior notice and an opportunity to request a hearing in court or before an administrative tribunal. In the USA, the courts have declared such practices to be unconstitutional deprivations of due process of law.
In countries providing for court review after commitment, the burden is usually upon the patient to request a hearing before a court or tribunal. The exercise of the opportunity to request a hearing is itself often restricted to once per year, or once during a renewal period of two years. Such restrictions on applications to review tribunals are contained in the Mental Health Act of 1959 in England and Wales and in the legislation of other countries using that Act as a model. The purpose of the restrictions is to avoid multiple appeals by severely paranoid patients. However, such restrictions and their application to all patients are open to question.

It has been reported that in England and Wales appeals to the review tribunals after non-judicial compulsory commitments are very infrequent (3.5% actual cases heard in 1971 of all first involuntary commitments) and further reviews in the courts are almost never sought. Court review is limited to matters of law; findings of fact are final before the Mental Health Review Tribunals.

In our questionnaire we asked about the influence of recent court decisions on the mental health legislation of the countries. There was no mention of such decisions in any country except the USA. The lack of mention of court decisions indicates that few patients are seeking court review of their commitment. Of course, cases may be heard by administrative tribunals and lower courts without appeals to upper courts. Substantive changes in law on constitutional-civil rights matters usually require decisions by the highest courts.

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

Press and other mass media coverage of mental illness and of commitment or hospitalization is often closely related to court cases and court hearings. Considerable coverage is often given to decisions of the courts and tribunals in releasing dangerous psychopaths who, after release, commit bizarre murders, rapes, and other crimes. Nevertheless, our correspondents in most countries, as indicated earlier in this report, were of the opinion that understanding of the mental health legislation by the press and other media was generally limited. The public probably receives a large part of its information concerning the country's mental health programmes from these sources. It is therefore not surprising that we found a correspondence between levels of understanding of the public and of the press.
2.5.2 Visitation boards and reporting laws

Among the earliest legal mechanisms adopted to provide public surveillance of the operation of public mental hospitals were the "visiting committees", "boards of control", and lunacy commissions. These official bodies were generally composed of leading citizens of unquestioned integrity and prestige. They were charged by law to "visit" the institutions, to hear grievances, and to make recommendations to the institutions and to the government concerning improvement of conditions.

At the time of our survey, 13 of the countries provided in their law for a visiting committee or similar independent body to conduct activities such as those mentioned above (Australia (South Australia and Victoria), Democratic Yemen, Egypt, Fiji, Ghana, India, Malaysia, Nigeria, Norway, Peru, Sudan, Switzerland (Geneva), and Uruguay). In England and Wales, where such mechanisms were first established, they were eliminated as a result of the 1959 Mental Health Act. In Scotland, however, a national-level surveillance board, called the Mental Welfare Commission, is still functioning, apparently quite effectively, according to the responses we received in our study.

Most of these laws require the institutions to make reports to the control boards or committees regarding their operation, often with specific information on each patient. The French and Senegalese laws require reports to be made to the Prefect of Police and the Public Prosecutors and empower these officials to make visits and inspections.

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

2.5.3 Periodic review and right to treatment

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

Under the earlier laws, hospitals were often required to report on the condition of their patients, sometimes periodically, to the boards of visitors on their attendance at the institutions, or in written documents sent to a central office. During the 19th century and well into the current century, these reports were perfunctory and of little utility. Most of the patients were handled as chronically ill and little more than custodial care was given. The reports evidently varied little, except in the event of the death or escape of a patient. Even when more "aggressive" treatment methods were adopted, the reporting systems had little effect.

It has only been in recent years that the legislatures have begun to re-examine the issue of periodic review and how such a method could be made more effective. It would seem clear that the first requirement would
be that an actual examination of the patient take place specifically for the purpose of the review. (Previously, administrators merely wrote notes on patients' progress, based on available evaluations in the records. As might be expected, the reports on many patients read: "No change since last report"). The next requirement would concern who was to perform the examination. As a minimum, one might expect that the examination should be conducted by a physician properly trained in psychiatry, or by a physician or other professional properly trained in mental retardation for the latter field. Such a requirement would present a problem in many institutions, since there are rarely enough professional staff qualified to conduct such examinations of every patient semi-annually or even annually.

Proposals to require effective periodic review were therefore usually seen to be unrealistic. Indeed such proposals exposed the major weaknesses of the entire mental "asylum" system: the critical shortage, or the virtual absence, of qualified personnel capable of taking full clinical responsibility for the management and evaluation of individual patients committed to the care of the institutions.

When legislative bodies or reform groups have sought effective periodic review, the institutional managers have countered by pointing out the cost of employing professional staff to conduct them. Not only were the funds difficult to procure from the same legislative assemblies which desired the reviews, but the professional personnel were rarely available in the country.

In recent years, however, this situation has been changing. Through better treatment and management techniques, the hospital patient population has declined in many countries and average length of stay per patient has been substantially reduced. This has made periodic review a more feasible proposition but, also, it is no longer as necessary. "Short-stay" patients, by definition, are not hospitalized long enough to be the subject of an annual or even a semi-annual review.

In the USA, another issue relating to the clinical progress of individual patients raised during the 1960s was that of the "right to treatment". It was argued that involuntary patients were hospitalized with the underlying assumption that, in a medical care institution, they would be "treated" for their mental disorder. If they were not being treated, the legal basis for their compulsory detention could be challenged.

The basic problem with the "right to treatment" criterion is one of enforcement. Logically, the only sanction a court has for failure to treat is to order discharge of the patient. However, if the patient is mentally sick and in need of treatment, this is hardly a remedy, unless community-based services can be assumed to be readily available. Also, if the patient is believed to be dangerous if at large, the court will be reluctant to release him, since protective detention is also a separate legal ground for involuntary detention despite the inadequacy of the treatment being given. In the past year, the United States Supreme Court reviewed its first right to treatment case and rendered a conservative opinion which endorsed the underlying need to provide treatment or to release the patient,
but did not deal with the issue of whether a dangerous patient must be discharged if not receiving adequate treatment.\textsuperscript{37, 38}

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

Despite these obstacles, courts in the USA have begun to enter into the professional areas and have issued detailed orders for treatment programmes and for institutional improvements in professional staff, maintenance, and facilities in both mental hospitals\textsuperscript{39} and institutions for the retarded.\textsuperscript{40} The efforts to establish periodic review have also been stimulated by the action of the United Nations in 1971 in adopting the Declaration on the Rights of Mentally Retarded Persons.\textsuperscript{20} The Declaration contains a provision requiring effective, professionally conducted, periodic review. The “right to treatment” has also been endorsed for all disabled persons, including the mentally ill and handicapped, in the Declaration on the Rights of Disabled Persons adopted by the United Nations General Assembly in 1976.\textsuperscript{21}

The concept of “right to treatment” in this United Nations Declaration has much wider implications than the use of the same term in recent court cases in the USA. In the latter case the right is seen as contingent upon involuntary commitment to hospital and hence it protects patients who might be involuntarily detained but receive no treatment. The UN Declaration, on the other hand, establishes the right as consequent upon disability. This derives from the affirmation of health as a human right, as implied both in the Universal Declaration of Human Rights and the Preamble to the WHO Constitution and declared even more forcefully in a resolution adopted by the Twenty-third World Health Assembly in 1970 (WHA23.41) which states that “the right to health is a fundamental right”. There can be no doubt that mental health is included in the concept of health as a human right. However, such a widely embracing right is even more difficult to enforce than the more narrow concept of “right to treatment”.\textsuperscript{22}

In our comparative legal survey, statutes requiring periodic review as an independent procedure were found in very few jurisdictions. The most common practical application of a periodic review which any
appreciable number of countries have adopted is attached to renewals of the commitment orders themselves. Where the original orders are for three months, or six months, a further clinical examination and report to the court or tribunal is required. After that, a clinical examination and report is required for each periodic renewal, usually at two-year intervals for chronic-care patients in an involuntary status. The more effective statutes specifically mention the requirement for a clinical examination by the responsible medical officer rather than merely requiring a request for further commitment by the hospital managers. These matters are dealt with in our summary of the legal provisions on involuntary procedures in section 4.2.

There are no statutes specifically requiring that the periodic review or renewal-application examination be done by independent, outside psychiatrists not on the hospital staff. The recent revision in Canada (Alberta) could impose such a requirement in that it applies the same requirement for a “two-therapist certification” to the six-month renewal procedure as that applied to initial commitments from the community. The law does not, however, go into detail as to who these “therapists” can be, so that two staff members of the hospital could perform the examination and make the certification. Provision is made for administrative regulations to define who may act as “therapists” under the law for certification purposes, but these regulations actually deal with authorizing psychologists and social workers to conduct initial commitment certifications rather than with procedures for in-hospital renewal examinations. (The Alberta law will be discussed later in this report in regard to new alternatives in the use of professional manpower.)

No country has moved very far in statutory enactments on an enforceable right to treatment. In the USA (Indiana), a special law on mental patients’ rights has been enacted which contains a general statement of policy on treatment, but no enforcement procedures. The statement is as follows: “A patient shall be entitled to reasonable living conditions, humane care and treatment, medical and psychiatric care and treatment in accordance with the standards accepted in medical practice.”

2.5.4 Rights of mental patients and mentally retarded residents

Very few of the mental health laws examined in this survey contained extensive provisions about patients’ rights. The older laws dating from the 19th century generally contained a provision, under the heading “offences”, which imposed a criminal penalty against hospital personnel who beat patients or sexually abuse female patients. They also frequently contained a provision requiring female patients to be escorted by a female attendant when transferred to another hospital. Most of the laws also regulated the use of mechanical restraints on patients and required that such actions be recorded in a special register which frequently had to be sent to the Board of Control or other independent supervisory body.
In some of the newer laws, the rights of mental patients and retarded residents to send and receive mail and to have pocket money are detailed, usually with restrictions which can be imposed by the hospital under prescribed conditions. The right of hospitalized patients and retarded residents to treatment or habilitation was analysed in the previous section; the correlative right to refuse treatment, or at least certain forms of treatment, has also been raised. Apparently, voluntary patients can refuse treatment, but the hospital could threaten to discharge them in the event of refusal to follow a given programme of therapy. Committed patients are, of course, under legal constraint. Where a committed patient is hospitalized on a court order, the latter often mentions treatment specifically and authorizes and protects the hospital when it uses coercive measures to treat the patient. Nevertheless, we found it to be common practice in many countries to seek the consent of a relative, and often of the patient also, when electroconvulsive therapy was to be applied, even for court-committed patients. Usually, the seeking of consent was an effort at protection against malpractice suits in the event of severe adverse reaction or fractures of bones during provoked seizures. The issue of refusal of psychiatric treatment has, perhaps, been raised more often in recent years concerning criminal offenders than for hospital patients. These matters have been examined in a number of European countries as well as in North America. Objections have been raised to the use of behaviour control measures and coercive drug treatment.

The most frequently mentioned problem concerning patients' rights reported by our respondents was the lack of adequate protection against exploitation of patient labour within the institutions. A substantial majority of the respondents felt that the laws of their countries were inadequate on this matter. We discovered only one jurisdiction with a special law addressed to this subject, namely Indiana. Some other countries do provide for payment (invariably very low) to patients for work in hospitals, subject to there being a special appropriation in the hospital budget. Confusion can be added to this matter when the institution insists that the work, even that of cleaning wards and washing clothes and bed linen, is part of medically ordered therapy and rehabilitation.

3. GUIDING PRINCIPLES AND ALTERNATIVE APPROACHES

3.1 Introduction

In order to make the results of the international survey of the greatest possible practical value in the mental health field, we have outlined in this section of the report some basic principles to be considered in improving legislation in this area. These proposed guiding principles are based upon the data we have gathered, upon an examination of the worldwide literature in the field, and upon discussions and correspondence with many people. They also reflect the discussions of a small multidisciplinary Working Group with members drawn from the fields of law,
sociology, psychology, psychiatry, and public health administration, which met in Cairo in June 1976 to consider the preliminary results of the survey. The guidelines put forward indicate a number of alternative approaches. Administrators, legislators, and others interested in legislative revision should therefore be able to apply the guidelines, in a way which meets the needs of their own country, to their own needs and available resources. We would reiterate the views expressed by Dr E. E. Krapf in 1959: "It would be a serious mistake if the case for an international approach were overstated... Certainly it is frequently possible to use in one part of the world solutions which have proved valuable in others. But precisely the international experience of the last 10 years has shown very clearly that there are limits to the possibility of comparing situations and copying solutions... The risk exists, of course, also in respect of mental health recommendations which are not in accordance with the value systems of the society in question. The simple transfer of solutions from one area to another is therefore often strongly contra-indicated." 42

Dr Krapf was not discussing mental health legislation, but his observations, based on his own international experience in the mental health field at WHO, can be applied fully to the legal field. For example, care must be taken in adapting complex hospitalization procedures and legal controls from industrial countries to the developing world where different patterns of mental health services are being planned and established. The law, if not enacted and interpreted in accordance with the actual programme plans, could force alterations in services and create barriers between the programmes and the people who need services.

3.2 Legislative systems

3.2.1 Basic statutory structure

A critical review of the entire mental health legislative programme of a nation should be greatly aided by first constructing a model of what a complete statutory system should contain in order to function properly. Therefore, in these pages we offer a basic statutory structure or model which can be followed in reviewing a nation's laws. In outline, the structure is as follows:

1. **Policy**
   Establishment of broad public policy and objectives in the mental health programme;

2. **Authority**
   Designation of proper authority for planning and carrying out the public policy and administering mental health programmes (along with other health programmes of a public nature);

3. **Budget**
   Providing the budgetary policy and continuing fiscal support for publicly conducted mental health programmes;
(4) Operations
Providing adequate structure and detail about the operation of mental health programmes to enable administrators to follow and to implement them, and building in accountability and evaluation processes;

(5) Research and training
Providing central planning (and financing to the extent determined) for basic, clinical, and applied research in mental health, and for the education and training of mental health personnel;

(6) Access to services
Providing for equitable, non-discriminatory access to mental health services;

(7) Protection of individuals
Providing protection by the law and through legal-judicial institutions (courts, tribunals, etc.) of the rights, welfare, property, and dignity of mentally disordered and retarded persons and their families;

(8) Minimum standards for mental health manpower and resources
Establishment of the policy for minimum standards (in such detail as deemed necessary and desirable) for mental health manpower and resources;

(9) Regulation of therapeutic drugs and other treatment methods
Establishment of the policy for regulation of the quality, supply, and distribution of therapeutic drugs in the mental health field, and for regulation of other methods of treatment;

(10) Delegation of regulatory powers
Delegation of authority, within statutory guidelines, to governmental agencies (such as public health authorities) to adopt administrative regulations, decrees, or other instruments, for further implementation of legislative policy, to apply technical detail to the programme, and to be able to adjust the content of the programme to changes in conditions in the field.

The above structure or model need not appear in integrated fashion within a single mental health law; the full scope may be distributed in various parts of the law of the country. It is important, however, to review each of the ten elements listed above to assure that all can be accounted for in the total legal system.

The basic statutory model set out above is intended to provide the full legal and governmental authority for the operation of a public mental health programme, whatever its particular scope in the country. Therefore, the first two items deal with the establishment of policy and objectives
in the programme and with the designation of authority to carry it out. The greatest weaknesses in this area, according to our survey, were a failure to integrate mental health into overall health policy and planning and lack of coordination among the various ministries or departments having responsibilities in the mental health field. Coordination was found particularly weak between educational, employment, social, medical, and psychological programmes with respect to mental retardation. As regards drug abuse, there was often direct conflict between law enforcement objectives and treatment-rehabilitation philosophies.

The next two items, 3 and 4, are essential to the execution of programmes, since they deal with budget and operations. More will be said in section 3.2.2 on the interrelationship of policy, planning, evaluation, and accountability.

Item 5, research and training, is a key factor in the long-range success of a mental health programme. Programme planning should be interrelated with the support of research and the development of future manpower. A major problem in this area is the fact that control over policy and operations in research and manpower development is rarely vested with mental health programme administrators. The planning and funding of higher education and professional training and scientific research are generally concentrated in ministries of education and in national science foundations or research councils. The academic and research communities have a much greater influence on policy and on individual training and research projects in the mental health field than the officials responsible for provision of mental health care. It is important, therefore, for the latter group to work closely with the education ministry and the scientific foundations or councils. Interlocking memberships on policy-making and grant-review boards are an important means of coordination and should be provided for in the law or regulations. An excellent model for this type of coordination can be found in the French science academies, the Ministry of Health, and the two national research organizations, the National Centre for Scientific Research (CNRS), and the National Institute of Health and Medical Research (INSERM). As part of this coordination effort, mental health programme administrators should make available to these other organizations their data on health conditions and their own plans for coping with the mental health problems of the country.

Items 6 and 7 are the core of the legislative structure as it deals with individuals. Item 6 concerns access to mental health services. Care must be taken to provide in this context for comprehensive services equitably distributed on a non-discriminatory basis. This concern must be noted, not only in regard to hospital admission procedures, but in eligibility requirements for mental health programme benefits under insurance schemes and in workmen's compensation schemes. In many parts of the world the main concern under this heading will be extension of mental health care to rural areas and deprived urban populations which have at present no access to modern methods of treatment.
Item 7, protection of individuals, is a pervasive matter. It involves a wide range of laws and reflects the attitude of society toward the mentally ill and mentally retarded. It is apt to appear earliest in the property law of the country whereby mentally disabled persons of all categories may be deprived of their possessions. Next, it may be expressed in a general alienation from society, expressed in the law by the person’s being deprived of all civil and political rights and privileges. It should be recalled that this movement was not supported in decades past solely by people who were ignorant of mental illness; it was advocated and practised by the staff physicians and managers of asylums. Only much later was this subject dominated by the commitment laws which were a part of reform movements against the evils of the asylum era. In contemporary times, the law should contain specific provisions protecting the mentally disabled and assuring the continuation of their rights except when curtailment in any way is proved to be warranted under due process of law.

Items 8 and 9 are very important parts of the regulatory system in the mental health field. They provide the policy and the articulated standards of the country for mental health manpower and resources, and for the use of therapeutic drugs, including the psychoactive drugs, being tested and marketed in the country, as well as other methods of treatment. Depending on the traditions of the country, some of these areas may be delegated to other public, semi-public, or private organizations. Improved laws in this area can encourage the more effective use of auxiliaries and other less elaborately trained mental health personnel. Therapeutic drug regulation programmes should be integrated in a single regulatory organization, but with consultation provided by the mental health programme administrators for the psychiatric field. In some federated countries, drug regulations may be largely a function of the subnational jurisdiction (as is the case in Switzerland). In others, as in Nigeria, it may be largely a federal concern because most drug products are imported.

The last item, delegation of regulatory powers, is an essential feature of an effective, modern legal structure for government programme operation. It provides for delegation of power and authority from the legislature (nationally or at the state or provincial level) to the ministries or departments of the executive branch. The statutory delegation should be clear and should contain standards to control operations by the administrative agencies mentioned. Often this control will be found to be expressed in specific pieces of legislation setting up particular programmes (such as a new drug abuse control programme) rather than in the enabling act which creates the agency or ministry itself. The enabling act for the broad-purpose ministry should be quite general in scope to allow for changes in focus and direction in the future.

There are distinct advantages in the use of regulations (or ministry circulars, statutory instruments, etc.) rather than constant resort back to the legislatures. In many countries, the enactment of formal legislation takes three to five years for anything of a serious nature. On the other hand, administrative regulations may be adopted with considerably less
delay. Procedures differ from country to country. In some, such as England and Wales, statutory instruments must be laid before Parliament for review, but the process is more expeditious than the enactment of a new law. In other countries, departmental or ministerial regulations or directives must be approved by another agency such as the ministry of justice. Approvals by such bodies can involve political considerations not of direct concern to the scientific or health agency and this may also cause delays.

At times, the adoption or amendment of ministerial directives or regulations may be the only practical way of achieving a change in programmes. This can occur during times of political or social emergency or strife when the legislative bodies may not be in session or may be limiting their deliberations. It may be futile under these conditions to prepare new draft legislation. New regulations may be the only realistic approach for several years.

In the mental health field, the use of ministerial directives can be highly advantageous. They are perhaps most frequently found in the more regulatory fields such as standard-setting for facilities and services and in the control of the testing and marketing of therapeutic drugs. They can also be useful in establishing the procedures for the admission of patients to, and their discharge from, mental health facilities. The tradition established in the 19th century of including all procedures in the statute book and allowing no deviation within the programmes for different institutions or patient groups was the result of distrust by the legislatures of the institutional managers. The justification for this distrust was clearly established by investigations and commissions of inquiry which exposed serious abuses in many countries. However, with modern open institutions, short-stay treatment programmes, and much less restraint of patients' liberties, the development of less restrictive statutory structures seems possible. Of course, the statutes would still contain all of the necessary provisions for the protection of the rights and dignity of the patients which could not be curtailed by ministry, agency, or institutional regulations. The types of regulatory differences which might be allowed by legislative delegation would be variations justified by different patient populations, by community programmes and community involvement, and different cultural and demographic patterns in various areas of the country.

Significant change may not require regulations of great length and complexity. For example, in one African country it was recently suggested that a large increase in facilities badly needed in the country for the care of mental patients could be accomplished with a quite simple change in the regulation which defined the term "mental hospital". Formerly, the definition had limited psychiatric care to that given in one large, custodial mental hospital. The change in definition allowed patients needing treatment for mental disorders to receive treatment in general hospitals. The advantage of making this change by regulation was that it could be accomplished in a simple manner by the Ministry of Health itself without recourse back to the legislature. To seek a new
policy on expansion of mental health facilities from the legislature could have taken years of effort, and might have failed entirely.

3.2.2 Providing for public accountability

One of the major themes in current management theory and practice is the development of formal means of requiring programme operators to be accountable for their actions. In the past, accountability has been applied mainly in areas of easily quantifiable achievement, such as numbers of sales of a product. In the health field, it has been displayed in the routine tabulation of patients seen and complaints answered. These data have been of little use as evaluations of quality or effectiveness of programmes. It is in the latter areas of accountability that mental health programmes have most often fallen short of established goals.

Concerns for accountability are essentially a part of overall planning and evaluation. The machinery of accountability must be built into the planning phases of programme development. A model for such a system in mental health legislation has been proposed by Dr Saleem Shah, who suggests that five basic questions be asked as follows:

1. What are the fundamental societal values to be protected, goals to be attained, or social harms to be avoided under the law?

2. How clearly have these objectives been articulated in the statutes and regulations in order to facilitate their implementation?

3. Have the necessary and appropriate resources to accomplish the objectives been allocated?

4. Have appropriate and effective provisions been made to monitor the programme and to evaluate it periodically in order to facilitate accountability?

5. Have appropriate sanctions been provided to encourage compliance and to discourage and punish noncompliance?

Question 5 above is of particular importance in legal and regulatory areas. For example, legal devices can be imposed in the area of hospitalization procedures to discourage long-term involuntary commitment. Community resources and short-term voluntary care can be made easier and more accessible. This has been the objective of so-called "informal admission" procedures for voluntary patients where the "paper work" has been reduced to a minimum. Use of alternatives can also be encouraged by making the application of the involuntary mechanisms more difficult, such as requiring documentation of the search for less restrictive means of dealing with the patient's problem. Of course, these legal mechanisms can only be applied when they conform to the realities of the country concerned. There must be a range of therapeutically acceptable alternatives for effective treatment of the mentally disordered. Otherwise, the mental health authorities will have no choice but to hospitalize patients needing such care and treatment.
3.2.3 Working with legislatures

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

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

3.2.4 The law as a rallying point and as public education

Resistance to change can be very great. At times, legislative bills and enactments can be used effectively to rally public and professional support for a new programme, or for a change in a programme. The more natural inclination of most mental health professionals is to avoid going to the legislatures and to seek to accomplish objectives without legal involvement or recognition. Often this is a wise choice. However, there will come a time when it is appropriate to press for a significant legal change to facilitate new programme strategies and to act as a signal to the public of new approaches. It is a fact of life in most countries that the legislatures control the bulk of all budget sources for mental health programmes. The legislatures also control basic policy. The press and the other mass media look to the legislatures as the source of significant change in government programmes and tend to give only limited coverage to administrative innovations. Mental health professionals and programme administrators need to be aware of these facts and to be willing to use the law and legislative initiative for improving mental health services. Otherwise, major change tends to be imposed from outside the mental health programmes themselves, forced upon the professionals who may actually have desired the change for years, but haven't moved to effect it through the legislative system.

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

Closely related to the above point is the significance of law in public education. The utility of law in this respect has been well known since ancient Roman times when the Legal Codes were the chief instrument of general public education. In the mental health field, we have seen legal changes in recent decades which have been primarily designed to educate the public and to change attitudes toward mental illness. Thus, the legislatures have abandoned terms such as “lunatic” and “insane asylum” and substituted less stigmatized terms. The trouble is, of course, that unless real change in programmes and services and in the rights of the mentally ill and retarded takes place, the new terms become stigmatized — and rightly so — just as the former designations were.

More effective public education and attitudinal change are accomplished by real change in the effects of the law — such as removing criminal penalties for alcoholism or drunkenness, or retaining the civil rights of committed patients. It is, of course, more difficult to convince the legislatures to make these substantive changes than merely to adopt new terminology.

3.3 Periodic evaluation of the law

We have argued that there is a relationship between mental health legislation, programme objectives, and public attitudes. The law is neither a static nor an isolated phenomenon and is dependent on a variety of societal factors. It cannot itself lay down moral standards or create human rights. It can, however, define, protect, and uphold such rights and standards. Furthermore, it has an important educational function.

An evolutionary approach to mental health law may therefore be necessary, with a progression of statutes or regulations matching (or, perhaps, more properly “leading”) the development of mental health services in a particular country. In any case, some further changes in the law are likely to be necessary even after a thoroughgoing assessment and modernization of the law. All legal systems make provision for changing statute law through amendments, repeal, and re-enactment; changes can also occur through administrative measures and through fresh interpretation of the law by the courts. It follows that a method of continuous evaluation of mental health legislation is appropriate, so that the need for change can be recognized and timely action taken.

3.3.1 Possible vehicles for the review mechanism

How should continuous evaluation be carried out? A number of possible mechanisms are considered below.

(a) Statutory commissions

In theory, it is the responsibility of the legislature itself to seek information which might indicate the need for statutory change. This may happen, in the field of mental health legislation, through the setting up
of commissions or standing committees or through debates. Perhaps the best known examples are the Royal Commissions in the United Kingdom convened in 1924-2627 and 1954-57.24 A major advantage of this procedure was the high prestige of these commissions and the public attention they attracted. A wide range of interests was represented and evidence could be presented by any interested party. The recommendations carried considerable weight. The recommendations of both commissions led to major statutory changes, which met with wide approval. The disadvantages of such commissions, particularly for regular review, are their expense, their cumbersomeness, and their procedural rigidity. In the case of the 1924-26 Royal Commission, the public hearings of the commission developed into court-like proceedings, with patients making detailed accusations of wrongful detention and ill-treatment. This brings us, in fact, to the central weakness of the time-limited commission (or similar body) as a review mechanism: its lack of control over information input. It must rely upon post hoc information, e.g. inviting evidence, calling witnesses, examining available documents, etc. It cannot decide in advance what information is needed to reach its conclusions nor can it set up a system to gather that information.

For these reasons, a commission of the legislature (or similar body) may be best able to carry out an occasional, broad review of mental health legislation, stimulating public awareness in the process and allowing seminal and progressive ideas to emerge. It is probably unrealistic, however, to expect such a body to carry out the detailed and ongoing monitoring and review necessary in a field as complex and specialized as mental health.

(b) Ministerial review

Responsibility for mental health care is usually vested in the health ministry, although in a number of countries services for the mentally retarded are either wholly or partly the responsibility of other ministries. It therefore appears reasonable that health ministries should be involved in the ongoing review of mental health legislation. It is difficult to see how this could be done in the absence of a section or unit concerned with mental health, and these have not been established in all countries. It is known that such mental health sections have often originated and applied pressure for legal changes in the past. The advantages of placing the responsibility for periodic review within health ministries are as follows: (i) the ministry is responsible for programme formulation and execution so that the review will be carried out in the context of overall programme goals; (ii) the time frame allows a longitudinal as well as a cross-sectional assessment of legislation; (iii) the ministry is likely to be in the best position for obtaining the information needed for the review.

There are, however, some disadvantages in assigning the review and monitoring as an internal function of the ministry. Firstly, there are clearly other sectors of government responsibility involved, for example, the police and the judiciary. Civil servants in one ministry
are likely to be wary of crossing ministerial lines in their recommendations. Secondly, if the review mechanism is completely in the hands of those responsible for programme implementation, objectivity in assessing services (and the role of legislation) may be difficult to achieve. Thirdly, it may be difficult for psychiatrists, who are likely to be in positions of authority in mental health sections of health ministries, to carry out the review on their own; they may lack drafting skills or legal knowledge. Fourthly, an internal review lacks visibility. Public interest is unlikely to be stimulated. Outside bodies and individuals who may wish to express their views may be frustrated.

In general terms, it appears that the health ministry should be part of, but not responsible for, the full scope of the review process. There is a natural tendency for ministries to prefer "manipulation" of existing law to the complex and time-consuming process of enacting new laws. In the case of mental health legislation, multi-sectoral involvement and potential controversy are likely to reinforce the natural conservatism of a government department.

(c) Professional groups and associations

Psychiatrists, psychiatric nurses, psychologists, social workers, and other professionals have a strong motivation to improve mental health laws, as our questionnaire responses revealed in many countries. Working under outdated or ineffective legislation is frustrating. These professional groups have first-hand knowledge of how the law operates and the effect it has on patients. Their views and expertise are clearly of great importance. Furthermore, in many countries, it has been groups of mental health professionals who have realized and publicized the need for introducing or changing mental health legislation. Many professional psychiatric associations have a standing committee on legislation, which does in fact carry out an ad hoc review function. Such associations are hampered, however, by lack of official support for review activities. Furthermore, there is an inevitable tendency to view the problem from the standpoint of the profession concerned and to resist what may be seen as "outside interference". There are historical examples of psychiatric associations resisting legal review mechanisms and under-estimating the role of other groups. This is not necessarily due to bad faith or self-interest, but stems from an understandable preoccupation with the role and contribution of their own professional group.

Mental health professionals must take part in the review of legislation; their expertise and experience is indispensable. Professional associations are useful channels for this involvement. It would probably be a mistake, however, to rely entirely on activity within these associations. The public would rightly expect an independent counter-balance.

(d) Lay associations

There has been a growing movement of lay associations concerned with mental health, since the early part of the century. The story of Clifford Beers, whose autobiographical book describes treatment in a large
mental hospital and the founding of the National Council for Mental Hygiene, is well known. Such associations now exist in many countries of the world, most being affiliated to the World Federation for Mental Health or, in the field of mental retardation, the International League of Societies for the Mentally Retarded. In some countries, these lay associations have a network of local branches which provide help and advice to mentally disordered people and their relatives. Legal and human rights matters are increasingly involved both in general and in individual cases. In their early development, there was a tendency for such associations to be quasi-professional, i.e. many influential members were in fact psychiatrists, social workers, or psychiatric nurses. Recently they have become increasingly independent and questioning of professional wisdoms. They naturally lobby strongly for the devotion of increased resources to mental health services.

In England and Wales, the National Association for Mental Health (a lay organization) has recently carried out and published a review of mental health legislation which has provoked a good deal of debate. In the field of mental retardation, lay associations have been active in sponsoring test cases to establish the rights of retarded people, particularly in the USA.

Such associations therefore seem to be in a good position to contribute to legislative review more than in the past. They are increasingly independent, they have direct involvement with individuals affected by mental health laws, and they are concerned with improving mental health care. Furthermore, they are usually able to call upon professional advice from both the psychiatric and the legal field. Possible weaknesses are: firstly, a lack of comprehensive information (difficult cases tend to be over-emphasized); secondly, a lack of involvement in programme planning and execution (and a lack of awareness of resource constraints); thirdly, their recommendations tend to be seen as special pleading for one group and may therefore be discounted; and, lastly, there is a risk that lay associations may be unduly influenced or taken over by small groups with extreme views.

(e) Academic institutions

Universities, legal institutes, and other academic bodies have a number of qualities which equip them for an effective review function. Their staff are relatively independent of government or professional pressures. They are in a position to adopt a multidisciplinary approach. Research workers are trained to gather and review critically relevant information. Staff are able to draw information from library sources and are likely to be aware of historical precedents and trends. They may also have strong international links and can make useful cross-national comparisons. An academic review is therefore likely to be broad-based, incisive, and unparochial. Nevertheless, academic institutions also have their limitations as an exclusive situs for periodic review of mental health legislation. Institutions specializing in legal medicine are relatively few, and their sphere of interest is much wider than mental health legislation.
alone. Fundamental research must, to some extent, reflect the interests of academic staff. Universities may also tend to be divorced from the realities of programme activities. The trend towards strengthening of links between universities and government services may decrease these limitations in the future. Partnerships in legislative drafting can be a fruitful aspect of university/government collaboration.

(f) Courts and tribunals

If the court system has to deal with a number of cases arising under existing mental health legislation, it may take on a review function. In legal arguments before the court, deficiencies or lack of clarity in the law may be exposed. In their written decisions, the judiciary may provide a commentary on the law and its application which makes the need for change clear. In the case of appeals and dissenting opinions, an illuminating dialogue may develop, providing a powerful analysis of the legal situation. The high reputation of the judiciary ensures that such opinions are not ignored. Such a process can, however, operate only if cases come to court and will be restricted to the issues raised by these cases. Much will depend on the interest and motivation of the judges concerned.

3.3.2 Towards a workable model

All of the mechanisms discussed above offer advantages and disadvantages in achieving an ongoing evaluation of mental health legislation. It may be useful to list the various advantageous factors identified in the different mechanisms: (i) public attention and prestige; (ii) time and resources for a careful review process, including longitudinal assessments; (iii) involvement of a range of professional groups with relevant expertise; (iv) availability of information and ability to plan necessary information collection; (v) lay participation; (vi) involvement in programme planning and execution; (vii) international links (governmental and non-governmental organizations, academic links, etc.); (viii) research capability. Should such a combination be sought in a single mechanism? Perhaps not — some of the characteristics may indeed be incompatible. Parallel activity by the different bodies may provide the most effective process, with cross fertilization of ideas, a two-way process of challenge and reaction, and stimulation of debate. This kind of multiple, independent reviewing seems to be evolving in some countries (Canada, the USA, the United Kingdom, Scandinavia, and elsewhere in Europe) but it requires a critical mass of highly trained manpower and a well-informed public. It is unlikely to emerge as a meaningful process in many developing countries in the near future. Furthermore, in countries with centrally planned economies and social services, such heterogeneous activities may be out of tune with usual practice. It could be useful, therefore, to suggest a single model which would have as many as possible of the characteristics listed above.
An interministerial standing advisory committee (ISAC) could provide such a model. Its chairman and members would be jointly appointed by those ministers with responsibility for health care, social and welfare services, the police, and the judiciary. The secretariat would be drawn from the health ministry (specifically from the mental health section). The committee would be informed directly of the national mental health policy and programme, would have access to the national health information system, and would be able to request the collection of additional data. The committee members would include: one or more members of the legislature; senior civil servants from the ministries involved; at least two lawyers and a judge; senior mental health professionals (including those representing professional associations); representatives of lay mental health associations; an academic; and one or more additional members. Total membership would not be more than 20. Such a committee need not meet as a total group more than once or twice annually. The aim would not be simply to provide a forum for discussion and exchange of views but to initiate and maintain a cycle in which mental health programme objectives were reviewed, the potential contribution (or negative effect) of existing legislation identified, and a series of detailed objectives for such legislation agreed upon. Information required to enable the committee to make an evaluation of the extent to which these objectives were achieved would be specified. Data on international trends could be provided by WHO. At a subsequent meeting, this information would be reviewed and if objectives were not being achieved, legal or administrative changes could be considered. Recommendations would be made directly to the government in a report which could receive wide publicity.

The suggested model is a hybrid; it might suffer from bureaucratic inertia and in any countries modifications would obviously be necessary. Some mechanism of this kind may, however, be the only way to ensure prestige, wide representation, relevant information input, necessary expertise, an adequate secretariat, and independent opinions. Obviously if such a committee was set up it could address the wider problems of coordination of mental health programmes at the national level.

3.3.3 The review process

We have described above a possible model of an interministerial standing advisory committee with wide representation and an effective secretariat which could provide the vehicle for ongoing review and monitoring of mental health legislation. It is assumed that, prior to instituting an ongoing review process, there will have been a comprehensive and careful assessment of existing legislation and that changes found to be necessary will have been carried out. In countries with no formal legal provisions for the mentally ill, a decision to adopt such legislation would have been taken. If it is decided not to attempt to link legislation with programme goals, an ongoing review process is not needed (although the decision should be reviewed from time to time). Such a decision may be taken in those countries with relatively little reliance on formal law
in the field of social action and in which formal mental health legislation might be exceptional and therefore undesirable.

In any comprehensive review of legislation leading to recommendations for immediate change, the possibility of further modifications in the future should also be considered. In some situations a policy of step-by-step development may be more effective than a radical legislative overhaul. Elsewhere, new measures would be regarded as experimental and requiring review after a specified period.

The first step in the ongoing review process would be to set and define the objectives of mental health legislation. These would be congruent with the overall objectives of the national mental health programme but would specify to which aspects of the national programme objectives legislation might contribute. Examples of such objectives might be: (a) to decrease the proportion of involuntary admissions to mental hospitals; (b) to promote community-based treatment of priority conditions; (c) to expedite access to treatment for patients living in remote rural areas; (d) to reduce the number of chronically hospitalized patients; (e) to provide early treatment for acutely disturbed mentally ill individuals; (f) to protect the public from potentially dangerous psychotic individuals; (g) to define responsibility for the development of mental health care; (h) to stimulate communities to participate in mental health programmes.

Such a list could be extended, but it would be realistic to limit the number of objectives in a country at any one time to those which reflect the most pressing needs. Wherever possible, objectives should be quantifiable and targets should be set for a 2-5 year period, e.g. to increase the proportion of voluntary admissions from 40% to 60% in a two-year period. Great care is needed in defining and quantifying objectives; for example, if a decrease in involuntary hospital admissions is defined as an objective and quantified in absolute numbers during a period in which hospital facilities are extended, a rise in the absolute number of involuntary admissions may coincide with a fall in the proportion of involuntary to voluntary (or informal) admissions. Similarly, the objectives of promoting community-based psychiatric treatment might be quantified in terms of the number of ambulatory clinic attendances, home visits, and other extramural patient/care-provider contacts. This may be misleading since the type of patient seen is not known. Large numbers of people with minor, self-limiting disorders may be seen while the seriously ill are not reached. Here, epidemiological data and skills are needed so that different patient groups can be defined and estimates of prevalence of certain disorders made. If, for example, working predictions of the number of acute psychiatric emergencies occurring over one year, the number of moderately-severely mentally retarded children, and the number of patients with schizophrenia can be made for a given community, targets for various kinds of patient care can be set.

In some instances, it will be difficult to quantify objectives precisely but indirect indicators can be used; for example, the objective of stimulating community participation in mental health care could be assessed
by the membership of mental health associations, by the number of
visitors to mental hospitals, or by the unemployment rate of discharged
patients (adjusted for overall changes in unemployment levels).

The second stage in the review process would be the collection of
information to assess the extent to which objectives are attained. This
should be done, as far as possible, as part of the national mental health
information system. Some additional data gathering may be necessary,
however, and this should where practicable be built into the existing
system. To give an example of a need for such additional data: if a stated
objective of legislation is to ensure rapid access to treatment of acutely
disturbed patients, the time between first contact with any social agency
and receiving treatment could be recorded on admission for all emergency
cases and included in monthly statistical returns. Data of this kind can
be analysed in three ways: (a) to see whether the targets set for the various
objectives have been reached or surpassed; (b) to observe changes over
time; and (c) to compare different geographical areas within the country
to determine whether some legal provisions are used disproportionately
in certain areas or adversely affect certain areas of the country.

The review committee would also need information about operational
aspects of the mental health legislation. 

Firstly, administrative measures taken to implement existing legis­
lation should be described by the relevant ministry. In some countries
there have been considerable delays in implementing newly enacted
legislation. The committee would examine the reasons for any such delays
and suggest how they may be overcome.

Secondly, information on changes in the organization and pattern of
general health services would be relevant. In many countries, radical
shifts in health service policy are being considered, e.g.: (a) placing
emphasis on extension and accessibility of health care through primary
health workers with relatively brief training working in close collaboration
with communities; (b) unification of services, in countries which at present
have both security and government-directed systems; (c) sectorization,
regionalization, and decentralization. Such changes alter the availability
of existing personnel, the responsibility for planning, and the extent of
community involvement, and lead to the employment of new kinds of
health personnel. They may call for changes in mental health legislation
or at least its administration. Policy changes relating specifically to mental
health care would be of particular importance; for example, the establish­
ment of psychiatric units in general hospitals, outpatient clinics in health
centres, or other extensions would be reported in detail to a review
committee so that the legal implications can be carefully considered.

Thirdly, the review committee should examine whether new methods
of treatment or approaches to mental health care mean that new, more
ambitious objectives can be set or, alternatively, that former unrealistic
or over-ambitious objectives should be modified. Information on technical
advances (e.g. new forms of drug therapy or behavioural treatments) and
training methods should therefore be available. It may be considered
that simpler, effective treatments make it possible to widen the range of
personnel actively involved in treatment. Advances in therapeutic methods may also call for additional legal provisions for control.

Fourthly, information concerning the protection of patients' rights should be sought. This is a difficult area in which to be objective but some quantitative data would be useful, e.g.: the number of letters dispatched by patients from hospital in a specified period; the rate of utilization of different commitment procedures (to establish whether "emergency provisions" are being overused to circumvent standard admission procedures which have more safeguards and are therefore more complex); and the number of patients using appeal procedures and the outcome of such appeals. If very few appeals have been filed, this may be because patients are unaware of or unable to use such procedures. If a very large number is recorded, this may indicate that the provisions are not being properly applied. Such quantitative data could be supplemented by more impressionistic material sought from a variety of sources, e.g. mental health associations, professional groups, and patients themselves.

Fifthly, an assessment of "public attitudes" concerning mental health would be highly useful. Clearly, there is no uniform set of "public attitudes", but some indications of attitudinal shifts, areas of concern, level of prejudice, fears, interests among the public, etc. may be discerned. Press and other media coverage of mental health issues could be reviewed. In some cases, there may be a place for a limited sociological study. The aim would be to establish: (a) whether the hoped-for educational function of the law is taking place; (b) whether there is a need for new legal provisions to control certain kinds of treatment or admission procedures to restore public confidence; (c) whether the climate of public opinion would be favourable to provisions which would lead to more patients being treated in the community.

The review committee, armed with this information, could pose a series of questions:

— Has the law performed as well as expected? If not, what modifications would allow the original objectives to be achieved?

— Have changes in the health care system or newly available methods of diagnosis or management created a need for new legal provisions?

— Is there public concern or anxiety which would justify additional legal controls or checks?

— Are patients' rights and interests adequately protected?

In answering these questions, value judgments must be applied and can be debated. The committee would, however, be expected to reach agreement and to formulate a series of recommendations concerning both legal and administrative provisions. In doing this, several practical issues would be important. The committee should take into account the cost of administering legislation, particularly in terms of manpower resources.
Review procedures, court hearings, and independent medical examinations use resources which could otherwise be applied to service provision. This is not meant to imply that basic principles can be compromised, but that realistic solutions should be sought reserving as far as possible the most highly trained personnel (both psychiatric and legal) for the tasks that only they can perform. Lay magistrates, traditional leaders, nurses, medical assistants, and others could also play an important part in the operation of the law. The practical problems of enacting new laws should also be considered. Many legislatures are grossly overloaded with business and serious delays in legislative programmes are common. Political instability, ministerial changes, and scarcity of legal draftsmen bring further delays. Frequent statutory changes are unlikely to be feasible. Simple amendments may be considered once every two to three years, but major change (e.g. a completely new law) could probably only be introduced once in 10-15 years. On the other hand, administrative provisions, as discussed earlier in this report, can be changed more readily (usually by a ministerial directive) and can lead to substantial improvements in the operation of the law. A minister is likely to feel more secure in making such changes if he has the support of such an independent review committee.

What is the potential role of WHO in such a review process? WHO could provide assistance in the methodology needed, for example the development of information systems, data analysis, and assessment of public attitudes. Information on new approaches to mental health care introduced in different countries could be provided and WHO could also provide information on legislative trends. The International Digest of Health Legislation is useful in this respect. If a number of countries indicate an interest in establishing a regular review process, it would be possible to establish cooperation between these countries and provide regular information not only on legislation itself but also on the way it operates and on the review mechanisms in use in different countries.

The international aspect of mental health legislation could then take on new meaning. Whereas in the past there has been a one-way, linear exchange, with one or two influential laws being used as a model for many countries, a collaborative network could be evolved so that each country could draw on the experience of many others.

3.4 Administrative structures

3.4.1 Integration with other health services

It has long been the policy of WHO to foster general integration of health services and thereby prevent costly and ineffective fragmentation of the efforts of health personnel working with scarce resources. This policy was most recently restated in relation to mental health services in developing countries.13

Such a policy can be carried out when the central authority for health affairs is concentrated in one ministry or department. It is also seen in the avoidance of delegating specific legal powers to separate
divisions or to *ex officio* administrators of separate programmes. Administrative regulations, rather than the law itself, may be used to distribute authority. Avoiding the setting up of administrative structures by law within the health department or ministry also enables periodic reorganization of services or personnel to take place without going back to the legislatures. Integration with general health services also encourages the development of local community mental health programmes in collaboration with public health clinics and the use of community personnel in mental health services.

Separation should also be avoided in areas other than administrative structure. When new methods of evaluation or regulation are developed, such as peer-review mechanisms for social insurance, they may apply to only one type of medical care. Mental illness is often excluded because it is perceived as "specialized" and inevitably chronic and thus too costly to deal with by means designed for handling acute illnesses. Administrators of such programmes are often unaware of the radical changes in treatment methods for mental disturbances and the change in mental patient populations to the point where the majority are now undergoing short-term care in most countries. When such separate handling of mental illness cases is allowed to continue, it reinforces the stigma of mental illness and its alienation from other health problems and treatment services.

3.4.2 Identification and management of mental health programmes

The above considerations must, however, be tempered by the realization that there is often a need to identify and provide for the consideration of mental health problems and priorities as such within the operation of general health programmes. As a matter of public administration and management, this effort at identification generally takes the form of suggesting that the responsibility for mental health activities be placed in a mental health division or unit within the health ministry. Experience has shown that unless this is done, mental health needs are not fully recognized, inappropriate responses are continued, and mental health is not properly considered within overall health planning. This is due to the fact that general public health professionals and administrators often have little or no background in mental health, whether through training or experience. Since mental health needs may not be readily apparent to them, they tend to assign very low priority to the field.

The Fourth Report (1955) of the WHO Expert Committee on Mental Health advocated establishment of a central authority for mental health in health ministries. In their 1960 assessment of accomplishments in mental health work since 1948, Krapf and Moser gave particular importance to the establishment of separate mental health divisions or sections at the national level. (It was the first subject covered in their data.) For ten of the 34 countries surveyed, information was received on the establishment of mental health divisions. In seven of the countries, the response was that no such division existed and none was contemplated. In its Sixteenth Report (1975), the WHO Expert Committee repeated the
earlier recommendation, and also recommended the formulation of a national policy in which the "contributions of health, education and welfare services should be specified and co-ordinated". In a number of countries, however, resources and trained manpower are so scarce that it may not be possible to establish such units in ministries, at least in the immediate future. Such considerations led the participants at a workshop held in Lusaka in September 1976 and organized jointly by WHO and the African Psychiatric Association to recommend as follows:

"1) National will and decision on policy

A pre-requisite for effective mental health action is an expression of national will and commitment to provide treatment and care for the mentally ill. This means a political decision leading to the statement of a mental health policy, recognizing the importance of the problem, underlying the community's responsibility to the mentally ill and defining the main principles and lines of action.

2) Planning

On the basis of [an] overall mental health policy statement, a detailed plan of action should be evolved. Whenever possible this should be an integral part of the national health plan. Priority conditions should be selected according to the criteria of prevalence, harmful consequences and availability of effective and cheap methods of management. In order to produce such a plan, to implement it and to evaluate the results of action, mental health expertise and advice must be regularly available in health ministries. The establishment of mental health departments within ministries is one way of achieving this, but in view of the serious shortage of mental health professionnals some countries may opt for alternative mechanisms such as a standing advisory committee. Since co-ordination with other ministries and educational institutions is needed, such an advisory committee should be interministerial and include representatives of other disciplines such as public health, sociology and law. Such a mechanism will be useful even where a mental health department exists. In many cases it may replace it.

3) Legislation

Outdated and inappropriate mental health laws exist in many African countries, usually dating from the colonial era. Countries should assess this legislation and, where necessary, enact new laws. These laws should reflect resources in the country and available manpower and should facilitate the implementation of the mental health policy.

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

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

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

3.4.3 Decentralization and community services

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

Under some of the 19th century laws creating Boards of Control and Visiting Committees with extensive powers, these groups were given the authority to discharge patients whom they determined to be improperly held. However, this authority was rarely exercised.

It is our impression that much of the modern legislation which vests these admission-discharge powers in the hospital managers has restated or followed the practice in the earlier laws dating back to the asylum era when these institutions functioned independently and often were not attached to any central ministry or other authority. The laws creating Boards of Control and Visiting Committees for each institution did not materially change this situation, since the boards exercised no regular management authority. Even when the mental institutions came under the authority of central ministries, the traditional concentration of management authority at the institutional level under the law was continued. This was justified by the great size and unwieldy nature of the mental hospitals, which in many countries were virtually the only sites of mental health care. The heads of the institutions often had more professional
Much existing mental health legislation reflects this state of affairs. Recent changes in the methods of treatment for mental illness, particularly drug therapy, have enabled a larger number of disturbed patients to be cared for in the community. At the beginning of this era, nearly all of the new psychiatric programmes were extensions of the large mental hospitals into the community through outpatient services located in the grounds of the hospitals. Later, clinics were established outside hospital precincts in the communities, but still as units under the supervision of the hospital. For this reason, the legal structure was not changed and one could discover no reference to community services in the law. Also, since most of the patients receiving outpatient care were not committed, they were not identified or processed through legal procedures. This lack of official recognition has had its effects in other aspects of programme review. Even in the developed countries of Europe, it has been reported that few countries have developed outpatient statistics which would provide even simple data. A Working Group Report from the European Region, commenting on the same lack of data, called it a "hangover" from the days of custodial care in institutions. Most significantly, it was said in this Report that:

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

Both the law and the mental health programme structures have as yet failed in many countries to recognize or to cope with the new system of delivery of mental health care. It is not an "either-or" choice between hospitals and community care. Both will continue to be needed. Efforts in a few industrialized countries to move in revolutionary fashion to community services and to close most of the large hospitals are now being re-examined in the face of unfortunate incidents in which numbers of patients were thrust into the communities without adequate services or facilities being available for them. The centre of gravity of services is shifting away from the mental hospital towards general health services and the community in many industrialized countries. The developing countries are trying, with some clear successes, to avoid overconcentration on large-hospital programmes as the core of their mental health services. Nevertheless, the law of most countries of the world, as indicated earlier in our survey, does not reflect the change to community-based mental health care. In the drafting of new mental health legislative codes, we would expect this change to be considered. It has two different types of concern: (1) impact upon management and planning of mental health services; and (2) impact upon the selection of treatment methods for individual patients. Both of these matters have legal implications. In regard to the first, there is a need to consider where policy-making authority should rest for programme development and management. In regard
to the second, there is a need to consider establishing legal requirements to place priority upon the least restrictive types of psychiatric care which are community-based.

Nations can make a variety of choices concerning these issues. The important thing is that they be considered carefully. Otherwise, the new codes will continue the past concentration on inpatient care, perhaps reflecting new concepts of the rights of inpatients, but without realizing that the best way to protect all patients is to afford them a variety of treatment methods suitable to their needs.

The establishment by law of specific, formal programmes of community-based services can provide the rallying points and public educational efforts described earlier in this section. Public interest is aroused when the programme is itself based upon identifiable communities of particular size to which the services are especially geared, as under the "sectorization plan" in France and the "community mental health centers program" in the USA. In the latter, the adoption of special legislation for such programmes in the various States inevitably brought with it a very substantial infusion of new funds from the legislatures, often with matching contributions from local governments and voluntary agencies.

3.4.4 Preventive programmes

All psychological stress cannot be prevented, and probably should not be, since some stress is a necessary ingredient for normal psychosocial development. Nevertheless, there are clear goals in prevention which can be identified and which have legal implications. A great number of them concern child development and protection. Immunization programmes are necessary to prevent infectious diseases which can lead to mental disability. Prenatal care programmes are also very important, along with improved nutritional programmes, for pregnant women and for children in the early years. In the developing countries, the above are undoubtedly the most important wide-scale preventive efforts against mental illness and disability in later years. Legal issues are of great importance in child custody, adoption, and foster care and the psychosocial needs of children should be given priority in framing laws in this field. Programmes to combat child abuse have both primary and secondary significance since a history of violence in childhood is often associated with criminal and violent conduct in the adult years.

In the prevention of brain damage and impaired mental functions, automobile and other accident prevention is of great importance in both the developing and the developed countries. It is clear that energetic legal efforts can help to control road accidents and work-related injuries.

3.5 Access to treatment

3.5.1 The principle of voluntariness

There is no doubt that there is a major trend in mental health care throughout the world toward voluntary care. This is most evident both in community-based and in inpatient care.
Voluntary care can be encouraged by four means: (1) making the mental health services effective and attractive to patients; (2) making methods of admission to voluntary care easily accessible and without economic barriers not applicable to involuntary care; (3) making discharge of voluntary patients easy and prompt on the request of the patient; and (4) making involuntary admissions more difficult to obtain, or requiring that they be justified as necessary.

The first method is certainly the most effective and has been proved so in country after country. The second and third are also very important. In most jurisdictions, there has been an effort to make access to psychiatric care as similar as possible to any other type of health care. This is the case for community outpatient care and, in most instances, for inpatient care in the psychiatric wards of general hospitals. For inpatient care in mental hospitals, the transition has not been so simple. The most well-known effort to achieve easy access similar to that for general hospital care was in the English-Welsh legislation of 1959 and its "informal admission" provision. As noted earlier, however, some restrictions on the discharge of such patients remain and patients' status may be changed to involuntary. Some countries have not included this restriction. In the USA, the idea of "informal admission" was first greeted with great favour, but an unrestricted voluntary admission procedure has not gained ground in the past 10 years. In 1961, six States had laws requiring immediate release on request of the patient. In 1971, there were only two more States added to this list from among the 50 States. The other States imposed a restriction allowing the hospital to retain the patient and requiring the patient to give from 48 to 72 hours' notice of intent to leave. In many of the States, as in the 1959 Act of England and Wales, the status of the patient could be changed to involuntary without waiting for a request for discharge from the patient. Where such a power exists, the patient might be transferred to an involuntary status because of refusal to follow hospital rules or to take particular medication. On account of this situation, voluntary admission in the United States has been branded as "an unacknowledged practice of medical fraud" by an American psychiatrist, Dr Thomas Szasz. The conditional release system has been defended by two other leading authorities in American psychiatry as a "highly desirable alternative to involuntary commitment".

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

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

The last of the four methods of encouraging an increase in voluntary admission is more indirect. It would make involuntary admissions more difficult to achieve. Such a system will be discussed later, particularly with regard to requiring the application of “least restrictive methods of treatment”. Specifically, the law can require that the opportunity be offered to any patient brought to the hospital on an emergency basis, or other involuntary basis, to elect to enter voluntarily. Such a method has been adopted in the Massachusetts law in the USA. However, this latter provision could be criticized as forcing upon the patient the selection of voluntary status when he or she actually wants no treatment at all, or at least a wider choice including outpatient care. Essentially, this is the dilemma of voluntariness. A very strict interpretation will cut down the use of practically any voluntary method of inpatient care. Searching the motives of patients for seeking any kind of psychiatric treatment can be difficult, and unrewarding, in terms of free and unencumbered choice. Is a man who seeks psychiatric help acting freely if he says his wife has threatened to leave him if he does not go and seek help? Is a patient voluntary if his employer has very strongly suggested that he undergo treatment? Is a patient seeking help voluntarily when he knows he is facing criminal charges for his behaviour? It would be impractical, both legally and therapeutically, to take these into consideration in classifying patients as involuntary. Nearly all patients of all types are reluctant to seek treatment for either physical or mental problems. They are precipitated to do so by all sorts of social, economic, and familial pressures, some realistic, some imaginary. The key questions for the clinician are, first, whether the person needs treatment; and, second, whether he will cooperate in the suggested treatment programme. The underlying motives of the person in seeking the treatment are secondary to these two imperatives. When a patient appears voluntarily at a mental health facility and asks for treatment, including hospitalization, these two areas should be explored. As part of the exploration of the patient’s willingness to cooperate in treatment and to remain in the facility long enough to benefit from care and treatment, the underlying pressures which moved the patient to seek help may be revealed. Some patients may not reveal them at initial interviews, but may bring them up at later sessions when they are confident of not being rejected.
pressures mentioned in this paragraph, i.e. family rejection, employer suggestions, and threats of prosecution, are commonly unearthed in treatment programmes. In nearly all instances, they are revealed as confidential communications to the therapists. If the persons responsible for treatment programmes were forced by law to disclose these matters, there would be little, if any, benefit to the patient.

The draft Introductory Guidelines prepared by WHO in 1973 (mentioned in section 2.1) contained a provision for non-protesting access to treatment for “some persons, whether enfeebled, aged, demented, mentally infirm or retarded”. It was suggested that this method be classified as “voluntary”, except that some responsible person should be consulted “as if he were guardian”, particularly concerning continuation of treatment or release of the patient. As a matter of law, most countries would classify the “non-protesting” procedure suggested in the Introductory Guidelines as involuntary. The legal weakness in the suggestion is that all of the types of patients mentioned are probably mentally incompetent adults. They could not exercise judgement on their own behalf and would require court orders for hospitalization, or would have to be under guardianship allowing the guardian to hospitalize them. The concept of the “non-protesting” patient being a special, in-between category applies legally only when the person is in full possession of his faculties and can be assumed to accept hospitalization because, given the opportunity to protest, he or she does not exercise it and quietly and passively goes through the routine of admission. These conditions must exist in order to be able to assume reasonably that the person wishes treatment, though does not choose to seek it actively. These conditions cannot be presumed to exist in the mentally incompetent adult. It is on the same basis that some jurisdictions are questioning the “voluntariness” of commitments of minor children to mental hospitals and schools for the retarded by their parents or legal guardians.

The above discussion is not intended to make legally impossible the hospitalization of mentally incompetent adults or of children by their legal guardians or parents respectively. However, it does mean that these procedures should be recognized as involuntary on the patient’s part and requiring legal safeguards to prevent improper use. An important method of protecting the welfare of the incompetent person or child is through a court-appointed, independent investigator or advocate of the person’s interest. This responsibility could be placed upon a child-welfare agency, or social service organization, or on a child-advocacy group, if such bodies are functioning in the country. In most cases, the guardian or parent will welcome the intervention of this representative, if it is offered and conducted in a cooperative, non-threatening manner with full realization of the difficulties and frustrations a guardian or parent often has with an enfeebled, troubled adult, or a disturbed child.

3.5.2 Evaluation of treatment: periodic review

The theme of accountability has been strongly presented in this report. To provide accountability in clinical care, there must be a system
of evaluation of the results achieved by treatment. Where patients are handled in short-term care, the problem of evaluation does not come up in a legal sense. Post-audits and patient-record reviews may be done by the programme in order to evaluate performance, as in other medical systems. For longer-term psychiatric care, however, periodic evaluation takes on a legal character. First, the review itself can be established by law or regulation. Second, the evaluation may include determinations of legal issues (such as the competency of the individual, especially if he or she has been under guardianship, or has lost civil rights as a result of hospitalization) or estimates of the "dangerousness" of the patient if released.

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

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

3.5.3 Involuntary care: specific limits of time

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

The most salutary innovation in the involuntary procedures in the past 20 years would seem to be the greater application of limited-stay provisions requiring hospitals themselves to seek and to justify extensions of the period. At their longest, two-year renewals for more chronic patients are provided, thus establishing a periodic review every two years.
The initial hospitalization periods were found to range from 30 to 90 days. If other jurisdictions are considering using this system, we suggest that it be instituted only after a thorough and comprehensive analysis of average-stay figures for all types of patients, review of manpower demands, examination of community-based alternative plans for treatment, and development of future clinical-care objectives for each type of facility where involuntary patients are to be handled.

3.5.4 Emergency care procedures

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

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

Many of the newer revisions of the hospitalization laws have shortened the emergency hospitalization period to 24 or 48 hours. Serious doubts have been expressed about the psychiatric advisability of these statutes. They have been advocated by civil rights groups as a means of limiting the confinement period to the barest minimum. Experience has shown, however, that the statutes can have the opposite effect when the initial observation period is brief (1-3 days). The reporting time is very often too short to allow for any new evaluation of the patient, particularly if he was under medication either before or after admission. Also, the patient will still tend to be in the midst of the crisis of admission during 24 hours or so and will not be able to evaluate his own situation and decide on further care, on voluntary admission, etc. The result is that the hospital is most likely to adopt a practice of automatically reporting and asking for a further commitment order on all such patients. If the next renewal period is an extended one, usually three to six months, or even indefinite, the patient certainly has not gained by this procedure.

Some countries have adopted longer temporary admission periods of between 7 and 14 days. Further inquiry and research should be conducted to determine the optimum temporary periods to serve the best interests of acutely ill mental patients.
3.5.5 Release and aftercare problems

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

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

Community aftercare of mental patients can be greatly encouraged by effective legislation and operational programmes of guardianship and foster care. Under these methods, the patient has personal supervision and support, but also is enabled to function in the community, either at home or in a work setting. Such programmes are found in the Scandinavian countries and in the United Kingdom, for example. The detailed legal provisions in the USSR for guardianship and foster care have already been mentioned. There, foster care is intended to supplement treatment and to help patients to work again, as on the collective farms. The requirements for a foster-care programme are set out in detail in formal agreements between the psychiatric facility responsible for regular visits
to the patient on the one hand and the family, individual, or collective farm responsible for foster placement on the other hand.

The guardianship and foster-care legislation examined in this survey seemed to function primarily on a voluntary basis and with non-dangerous patients. For involuntary care, the major procedure in most countries for community supervision operates only for criminal offenders placed on probation and required, as a condition of probation, to receive mental health care and treatment.

3.5.6 Therapeutic psychiatric drugs; legal controls

The development of improved mental health services in the community and the more widespread use of auxiliary personnel from general public health programmes in mental health work depends a great deal on the availability of therapeutic psychiatric drugs and the legal authorization of personnel (after proper training) to prescribe and/or dispense such drugs in local clinics. The subject of legal control of therapeutic drugs was not covered in this survey. The laws in this field are complex and are currently undergoing considerable change, especially in view of the many countries ratifying the Vienna Convention on Psychotropic Substances, which came into effect on 16 August 1976.

3.5.7 Mental health manpower; legal controls

Closely associated with the above subject is the matter of training and certification of mental health professional personnel and auxiliary manpower. Fully qualified psychiatrists clearly cannot provide all of the services needed in mental health programmes. The integration of mental health programmes into general health programmes will demand an extension of training to a much wider group than the current "psychiatric teams" of highly trained psychiatrists, clinical psychologists, and psychiatric nurses and social workers.

The law in a number of the countries surveyed grants special certification to psychiatrists. This is a traditional practice in the countries of Continental Europe. Some countries also certify clinical psychologists. Furthermore, the laws of all but two of the jurisdictions studied limit hospitalization-certification authority to physicians.

The 1972 law in Alberta (Canada) provides for certification by what is called a "therapist", who is specially licensed as such by a newly created board. The law does not indicate what groups can be licensed, but it is expected that physicians, psychologists, and psychiatrically trained social workers will be included among the approved licensees. Under the hospitalization law, each involuntary admission (and some discharges) must be certified by two "therapists", one of whom must be a physician. The other is expected to be a therapist drawn from the other professions. Thus, the newly authorized therapist never acts alone in certifying a patient for hospitalization.

The other country with a novel procedure is Trinidad and Tobago, where the 1975 Act created and defined the category of "mental health
officer" with specific legal powers. The provision is described in detail in section 2.4.5. Its importance in manpower development is that it authorizes workers from different backgrounds to enter this new category and stipulates the training and experience required. It can therefore be expected to stimulate mental health training and closer working relationships between different categories of personnel.

3.6 Human rights in mental health

3.6.1 Forms and labels; rights of various groups

It has in the past been considered a sign of progress in the mental health legislation of a country when the terms describing mental disorder were changed in keeping with modern psychiatric usage. Much attention was given to these changes in the 1955 WHO comparative legal survey. It is important to note, however, that changes in definitions and terminology do not automatically lead to a change in programme.

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

In legal philosophy, the above matters are called "formalism", or a concentration on form to the exclusion of substance. The dialecticism of formalism is also shown in its opposite — the attention to lack of form. This was also displayed in the 1959 English-Welsh Act where the voluntary admission system, with its substantive requirements, was abolished and an "informal" admission procedure substituted. However, the very important substantive powers to detain the patient and to change his status to involuntary were retained in a later provision of the law. Substantive demands of security clearly won out over the more superficial and cosmetic changes in language.

Mere changes in terminology and even in definitions, especially when the latter are quite vague, accomplish very little. If the conditions of the programme do not change, the new terms soon become as stigmatized as the old. Because this fact is not realized, there is a tendency in mental health programmes to feel that all mental health terms carry stigma by their very association with the field. An interesting example is the reform legislation referred to earlier in Alberta. It was decided to discard any
reference to either voluntary or informal admission and to cover only involuntary care. The Director of Mental Health Services for the Province described this move as follows: "The category of 'voluntary patient' has been dropped with the intention of removing an unintentional stigma". Later in the same paper it was stated that the goal of the 1972 bill was to place mental health legislation in its "rightful place within overall health and welfare laws" and to avoid the current "legislative schism" which, it was said, "may be the result of the ongoing stigma attached not only to the mentally ill but also to those professionals who administer to them". When it was pointed out that the absence of any reference to voluntary care might result in all patients being forced to undergo court-ordered commitments, the Alberta legislation was changed to include a voluntary admission procedure.

In a discussion of terminology for the mentally retarded, the WHO Expert Committee on Mental Health indicated, in its Fifteenth Report (1968), that there were four methods of classification: (i) legal and administrative; (ii) etiological; (iii) psychological; and (iv) clinico-psychological. The only type of classification criticized was the first, which was said to be most likely to lead automatically to a decision as to what action, if any, should be taken. The Expert Committee at that time cautioned against the temptation to "favour" certain special groups, like the retarded, by the enactment of special laws. It was pointed out that special laws could lead to over-protection and discrimination. Therefore, it was suggested that whatever services and facilities were open to other citizens should be open to the retarded on the same basis. The placement of retarded persons under guardianship, with consequent loss of legal competency, should be avoided where possible.

There has been a great deal of objection to "labelling" individuals as retarded, or delinquent, or genetically predetermined to be more likely to become criminal. These classifications have been attacked as self-fulfilling prophesies which can greatly damage the individual and which are very difficult to remove at a later time. Yet, these objections seem at times to scientists and clinicians to be efforts at avoiding any unpleasant diagnosis or classification, however careful the usage and limited its application. The key problems here are the use to which the diagnostic label or classification is put, and the confidence-level of its application. Mental health classifications are particularly vulnerable on both counts. They can have devastating effects and yet can be of relatively low reliability. The general public tends to see most diagnostic labels of mental disorder as implying chronic disability. There is enough reality in that assumption to make it difficult to persuade even well-educated lay people to make distinctions and to acknowledge that many mentally ill people recover and can lead normal lives. Much of the latter problem can be dealt with legally by keeping medical, psychological, and psychiatric patient records as confidential as possible and limiting the use of such records to the facilities concerned. In some countries, this suggestion is difficult to accomplish, since centralized records are maintained. There are recognized advantages to centralized records, particularly in smaller
countries without extensive movement and migration in the population, but there can be personal disadvantages, particularly in the mental health field, which should be considered and guarded against in these systems.

3.6.2 Least restrictive alternatives

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

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

It should be pointed out that the application of least drastic alternatives is a common principle of all medical treatment, not merely the mental health field. Thus, radical surgery is avoided where more conservative measures are available and have not been tried. Similarly, the encouragement of simple forms of treatment and care and the discouragement of long-term commitment should be the hallmark of all effective mental health services.

3.6.3 The right to treatment

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

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

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

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

It would seem that the best approach to ensuring an effective right to treatment is to move toward the overall improvement of both inpatient and outpatient services, in hospitals and in the larger community. As suggested earlier, the periodic review at specified intervals attached to discharge provisions is the most effective means of evaluation and accountability for hospital personnel in charge of clinical management of patients.

3.6.4 The right to refuse treatment

The other side of the coin to the above discussion is the right to refuse treatment. This matter was dealt with earlier in regard to the mentally ill offender. It was also covered in the questionnaire survey to the extent of its application to the requirement of obtaining patient consent for certain therapeutic procedures. It is also a part of the concept of voluntariness discussed earlier.

There is some dilemma here for clinical personnel. On the one hand, they favour the handling of all patients as voluntary, in the same way as other hospital patients. On the other hand, they prefer to have their clinical recommendations carried out for the benefit of patients. Where the patient makes what seems an "unreasonable" objection, the clinician may try to use pressure and various techniques to "impose" the treatment. This happens in many treatment situations in all areas of medicine. If the treatment has beneficial results, the patient and his family usually thank the doctor for being assertive. However, in most areas of medicine, the attending physician is limited in the means he can use. He can threaten to leave the case, he can enlist relatives to persuade the patient, and he can predict very dire physical consequences in the event of refusal of
treatment. He can rarely do more. In mental health, however, the tools to impose treatment are much more readily available. In most countries, involuntary commitment carries with it the authority to require treatment. In a formal sense, it is often said in the law that the patient becomes a “ward” of the hospital. In court-commitment orders, the specific language of the judge’s directive generally includes the phrase that the patient is committed for care and treatment. The implication is very clearly that the patient, being unable to decide such matters for himself, has been ordered by the judge to submit to treatment and the hospital has been charged with the responsibility of providing that treatment. This is, after all, the underlying legal justification for the “right to treatment” movement in the law.

Despite this legal basis for treatment without a patient’s consent, it is usual in many countries to seek patient consent, or consent of legal representatives, for some forms of treatment for committed patients. Examples are electroconvulsive treatment and psychosurgical procedures. The former, although known to be safe and effective in appropriate cases, still arouses anxiety and misgivings in the public, probably because this form of therapy has been overused at times. In the latter instance, the risk of post-operative sequelae has led to regulations requiring a review by an independent panel prior to surgery in some jurisdictions and, in the case of the USSR, outright banning of psychosurgery.

Questions have been raised as to whether voluntary mental patients can be forced to accept the treatment offered. None of the statutes surveyed dealt directly with this issue. As a matter of logic, it would seem that voluntary patients can refuse any treatment, since they can leave the institution at any time. In order to require treatment, the institution would be forced to have the patient transferred to involuntary status. In many jurisdictions, the hospital could not do this without also proving that the patient would be dangerous to himself or others if released to the community. A mere refusal to accept suggested treatment would not, in these jurisdictions, be enough to warrant a change in status.

3.6.5 Civil rights, mental illness, and the general law

As indicated in the survey, the trend of the law in most countries is toward preserving the rights of the mentally ill, mentally retarded, and other categories of persons suffering from mental disorders, such as alcoholics and drug-dependent persons. This is part of the civil rights movement, according to which any deprivation of rights must be fully and individually justified. The presumption must always be applied that the individual is legally competent and entitled to the rights and privileges — and obligations — of all other citizens.

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

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

3.6.6 The use of advocates or patients’ representatives

The protection of patients’ rights requires more than a legal enactment, as has been pointed out frequently in this report. One of the newer innovations in this respect is the placement of advocates or patients’ representatives in mental health programmes to advise patients of their rights and to represent their interests in certain situations. These advocates can be lawyers, but they need not be. Lawyers are best utilized for involvement with tribunals and courts, but other types of personnel, such as specially trained social workers, nurses, or community members, can function very effectively as advocates.

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

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

One simpler way to ensure the protection of patients’ rights is to follow the principle of the openness of mental institutions. They should
be open to patients' representatives of course, to their family and friends, and also to any interested visitors. This free access is likely to promote a flow of information and discussions in the press. In England, for example, the National Association for Mental Health is often responsible for placing challenging articles in the newspapers.

An example of a law which could severely limit access to information and the publication of reports and commentaries on conditions in mental health facilities was enacted in 1976 in South Africa. South Africa was not covered in the comparative review, but this statute should be mentioned here. It prohibits the publication of sketches, photographs, or "false" information on mental patients and mental institutions by any person who is not a member of the Newspaper Press Union of South Africa, unless he is expressly authorized to do so by the Secretary for Health. It is not difficult to foresee how information not favourable to the public authority could be labelled as "false". In such circumstances there can be little objective information on the real condition of mental patients or an open discussion of patients' rights. The books "A Mind that Found Itself" by Clifford Beers and "The Experiences of an Asylum Doctor" by Montagu Lomax revealed the true conditions of asylums in the United States and England early this century and activated a previously apathetic public. Both would have been difficult or impossible to publish under current South African law.

3.6.8 The search for knowledge: experimental approaches and the rights of subjects

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

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

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

Within communities, even in the most sophisticated of societies with high levels of public education, there is a lingering fear that the mentally ill are dangerous, or potentially dangerous, to others, despite the fact that reliable research indicates that in some countries the mentally ill and the retarded have rates of crime and violence equal to or lower than the general population. There has been an increase in the incidence of violence in some parts of the world. Mental health personnel are expected to treat the mentally disturbed and at the same time to protect the community against the actions of some of the mentally ill. At times, this double obligation is difficult to fulfill, especially with the imperfect predictive tools of psychiatry.

The trend of the law in the countries surveyed was seen to be toward the requirement of a finding of potential danger to self or others in order legally to justify involuntary commitment. There was also an effort in some countries to encourage the release of patients who have formerly committed violent acts, but now seem to be significantly improved in their mental health. In order to provide encouragement to personnel to recommend release of such patients, however, immunity statutes have been enacted as protection against later lawsuits. These laws help, of course, but no clinician wants later to find that patients recommended for release have brutally killed innocent people, or committed other violence, or acted violently against themselves. The press and other media usually criticize the action despite the legal immunity. The situation is inherent in mental health treatment; it cannot be avoided without retreat to the days of the remote asylums. Decisions on release of all types of patients must be made. Yet, the public's fears must be reckoned with, just as their support must be sought for positive progress in the treatment of mental illness. More studies of violence and the means of treatment and rehabilitation are needed in all societies. Failures in this area can lead to legally imposed restrictions and the use of restraint and involuntary treatment methods which workers in the mental health field would deplore. It is in the interest of the entire field of mental health to deal more effectively with the problems of violence in our communities and to encourage communities and community leaders to cope with the problem with humane and well thought out methods.

3.7 Mental health law in developing countries

3.7.1 The challenge

It has been made clear in the preceding sections that there are some constraints and considerations in providing mental health care which apply particularly to the developing countries. In these countries, as elsewhere, mental disorders constitute a serious public health problem, but there are other urgent health problems in the fields of nutrition, infectious diseases, and sanitation and consequently the resources available for the control of mental disorders are very limited. For example, in a survey
carried out in 23 African countries during 1975 it was found that in over two-thirds there were fewer than two psychiatrists per million population and that in half the countries there was no provision for training psychiatric nurses. As well as having meagre resources, many developing countries are handicapped by a history of separate development of mental health services, usually in the form of a large, centralized mental hospital, providing an institutional response almost totally inappropriate to the rural/agrarian communities which form the major part of the developing countries' populations. The "asylum concept" emerged in the industrial nations of Northern Europe and North America during the last century, largely in response to the needs of the urban poor; in many instances it was simply transferred by colonial administrations as an instrument for the control of the more obvious and socially unacceptable manifestations of mental illness in the main towns by providing custodial care. This "given" system of care, now seen as both inadequate and inappropriate, was linked in many cases to laws introduced by the colonial authorities and based on those in force in the metropolitan countries. For example, the 1890 Lunacy Act (England and Wales) was used as the model for legislation in many parts of the former British Empire. Ironically, although this Act has been superseded by two major enactments in England and Wales, its derivatives remain in force today in a number of developing countries formerly under British rule.

Developing countries are seeking ways to provide health care for their widely dispersed, poor, rural populations. Solutions are emerging which emphasize community participation and the use of health auxiliaries with a simplified training for meeting basic health needs. Most existing mental health laws, with their emphasis on hospitalization procedures (inevitably leading to treatment in distant mental hospitals) and the role of highly trained personnel for certification and review, are in polar opposition to this trend. It is therefore not surprising that there are often serious delays in bringing patients for treatment and that rehabilitation is difficult or even impossible. Furthermore, the existence of large numbers of "chronic", institutionalized patients who have lost all contact with their homes is a major problem delaying implementation of effective mental health programmes in the developing countries.

A specific example will serve to illustrate some of the points made above. In Tanzania the effort to provide health care for the whole population (of which only 6-7% live in urban areas) is closely linked to the overall sociopolitical policy which emphasizes rural development and local contribution as instruments of liberation and socioeconomic development. The 1969-74 Health Plan was "directed above all towards development of preventive and rural health services...". Medical assistants, rural medical aides, and health auxiliaries are being used to increase coverage and utilization of primary health services. At the time of independence, the only way of managing acutely disturbed mentally ill individuals was to confine them in a local prison, where patients could be detained for up to two months. A single, central mental hospital existed, but patients admitted there frequently lost contact with their
families. Over the years the number of chronically hospitalized patients gradually rose, thus confirming the general belief that patients, once admitted, rarely left. The existing mental health legislation in Tanzania is based on ordinances from the colonial era dating from 1937, with minor revisions in 1941, 1946, and 1958. The law deals mainly with "custody of persons of unsound mind", prescribing a court procedure for deciding whether a person should be detained in a mental hospital. The court may authorize detention in "suitable custody" prior to such a decision for a period of up to 60 days. There are also detailed provisions dealing with the "management and administration of the estates of criminal lunatics and persons of unsound mind".

Even with this restricted legal framework, it has been possible to develop some decentralized mental health services in Tanzania. Regional psychiatric units have been set up in five of the country's 20 regions, with experienced assistant medical officers providing much of the care. This has proved an effective way of extending coverage, notwithstanding the fact that at the time of writing only three psychiatrists were working in Tanzania. Only 20-30% of admissions to such units are on a voluntary basis, however. Plans for future developments involve further decentralization with mental health care being provided at the health centre level and more responsibility being assigned to the community and family. For these reasons "a large-scale revision" of the law is seen as necessary with less emphasis on committal procedures and more on community care and rehabilitation. This experience indicates that progress can be made even under "out of date" laws but that, at some stage in the development of community-based mental health services, new laws will be necessary. This provides an opportunity for using law in promoting such services as well as in regulating admissions, guardianship, and the administration of mental hospitals.

Mental disorders secondary to infectious illness and other organic pathology are relatively common in the developing countries. This means that there is an urgent need for rapid diagnosis and availability of treatment for those who develop mental symptoms such as confusion or excitement. Existing mental health laws in many instances do not recognize this need. Similarly, the lack of specialist services has meant that many patients with neurological disorders, particularly epilepsy, are drawn into the institutional system of mental health care, although they could be adequately treated in the community. Lack of treatment facilities also leads to the development of particularly florid forms of mental illness and to the appearance of numbers of untreated "vagrant" psychotics. It is usually these problems as opposed to the whole range of mental disorders which command public attention and the concern of the authorities. A common reaction is to provide more institutional care rather than to prevent such problems arising by making early treatment available.

The developing countries therefore face a situation in which:

(a) mental disorders constitute a serious health problem, for which limited resources are available;
(b) present responses, usually centralized, separate institutions, are inappropriate;

(c) mental health laws are out of step with the trend to extend health care through the use of alternative, cheaper approaches, less reliant on highly trained professional staff;

(d) organically-based mental disorders are common but the consequences of this are not properly reflected in legal provisions;

(e) public concern is unduly concentrated on the highly visible problems of florid illness and vagrant psychotics, both largely the result of the failure to provide prompt treatment in the community.

3.7.2 Strategy and planning

Breaking out of the impasse described above requires first a new strategy and second a mechanism to implement the newly conceived programmes. Here we can see the potential role of the law. Legislation can be changed from a restricted set of regulations concerned with institutional care into a stimulus for new kinds of mental health care. The report of the WHO Expert Committee on Organization of Mental Health Services in Developing Countries 13 has indicated what steps should be taken to bring presently available methods for the control of mental disorders to the mass of the population in such countries. These steps are summarized below together with the legal implications.

(a) Decentralization. This implies reducing the reliance on large, central mental hospitals. The patient population of such hospitals can be reduced by increasing the scope of outpatient treatment, by providing alternative forms of inpatient treatment (see below), by reducing the average length of stay for new patients, and by vigorous efforts to rehabilitate institutionalized, long-stay patients.

The main legal implications of decentralization are that treatment of the mentally ill should not be limited by law to mental hospitals and that the staff available at general hospitals should be able to carry out the various admission procedures. Early discharge and rehabilitation efforts can be facilitated by flexible and easily administered conditions for discharge and by providing for support and supervision of patients in the community a range of staff including, where appropriate, community nurses, social workers, and health auxiliaries.

(b) Integration. The main emphasis in developing mental health services should be on integration with general health services. Facilities for treating the mentally ill should be available in general hospitals, either in the form of a psychiatric unit or by admitting the mentally ill to general wards. Outpatient services should also be provided at general hospitals.

Wherever necessary, therefore, general hospitals should be legally designated as places for the treatment of the mentally ill and it may be
helpful to require that inpatient and outpatient treatment is available in each state, province, or region of the country. Authority for emergency admission should be within the competence and responsibility of staff normally working in general hospitals. A rigorous legal distinction between mentally ill patients and others should be avoided in view of the needs of patients with acute psychiatric symptoms having an organic basis. It may be possible to foster links between mental hospitals and general hospitals by legal and administrative provisions increasing the exchange of staff and assigning extramural responsibilities to staff in mental hospitals.

(c) **Extension of care.** The structural changes implied by "decentralization" and integration will have little impact unless they are linked to real extension of mental health care to those communities which are now beyond their reach. This means shifting attention and resources to rural communities and to deprived urban sectors such as peri-urban slum areas. To do this existing staff in peripheral health services would have to take on new tasks in mental health care. Such tasks would have to be circumscribed, limited, and directed towards clearly defined priority conditions.

Here the law could be used as a stimulant and rallying point. A clear statement in law to the effect that certain types of care are to be available to the community (e.g. management of acutely disturbed patients, follow-up of chronic psychotic patients, etc.) and specifying the responsibility for providing such care (e.g. health centres) could be decisive in promoting new approaches. Legislation should also take full account of the whole range of health staff working in the peripheral health services who should be involved in mental health care, including the most simply trained workers. It may also be helpful to specify the role of the police, village chiefs, and other community agents in providing care. Legislation should lay down that the mentally ill should not be neglected or maltreated in the community and should make it clear who is responsible for ensuring this (i.e. for enforcing the legal provisions).

In many countries traditional healers of various kinds (herbalists, Ayurvedic practitioners, religious healers, etc.) provide treatment and care for the mentally ill. Often they perform a socially valuable task, all the more so since their patients may have difficulty in receiving modern medical treatment of any kind. In other cases healers use harmful and potentially dangerous methods and many even deliberately mislead and deceive patients and their relatives. Generalizations are of little value in this field and health planners should at least be aware of the potential offered by traditional medicine. It follows that legislation should be sensitively framed in this area. Laws forbidding traditional healers to treat the mentally ill would in most cases be unwise and impracticable. General provisions concerning maltreatment and neglect of patients would usually be sufficient to control unscrupulous healers. In some countries it may be possible to frame regulations which would increase the contribution of healers to the care and rehabilitation of the mentally ill and would stimulate collaboration between healers and modern health services.
(d) Mental health policy and planning. The new strategies outlined above can be employed only if the necessary political decision is taken leading to the definition of a mental health policy and to provisions within the national health plan. This can be done only if the necessary expertise is available to health ministries, in the form of a mental health department or advisory committee. Legal provision should exist for this and can also indicate the need for coordination with other ministries (e.g. justice, education, and social welfare) in the administration of mental health services. The law can also lay down the main lines of the mental health policy itself, indicating the various responsibilities for its implementation.

3.7.3 Criteria for legal provisions

Mental health laws cannot be assessed or drafted in isolation. As countries move towards integrated and more widely available services, the role of law will change. Precise legal provisions will have to take into account the pattern of health services in the country, the type of health manpower available, the existing police services, and the court system. Legislation adopted uncritically from other countries is likely to be inappropriate and ineffective.

Section 3.2.1 on "basic statutory structure" provides a check-list of essential issues that should be addressed by the law and that can be applied to all countries. It may be helpful to have some criteria by which legal provisions can be assessed with particular reference to developing countries. Such a list is given below. It should be read in close conjunction with the "basic statutory structure" items.

(a) "Negative" criteria (i.e. what the law should not do)

(i) it should not impede desired change, e.g. by restricting the places in which mentally ill patients can receive treatment, by making discharge of patients (or temporary "trial" discharge) difficult to arrange, or by limiting the contribution of any potential helping agency such as the police or social welfare agencies.

(ii) it should not require an undue level of resources or staff time in its operation. Complex certification procedures may waste the time of scarce trained personnel and that of the courts, while offering little or no protection of patients' rights, if patients are unable to understand the proceedings properly.

(iii) it should not impair helpful responses to mental illness which already exist in the community. With the involvement of families and traditional healers, many patients may be able to remain in the community if they receive some treatment from modern health services. Such pragmatic solutions should not be interfered with by too rigid legal requirements concerning the nature and conditions of treatment.

(iv) it should not create a completely separate mental health service. Legal requirements for administratively separate services (hospitals,
clinics, etc.) will make integration into general health services difficult if not impossible.

(v) it should not create or reinforce negative attitudes towards the mentally ill. The importance of nomenclature has probably been overstressed. However, it is desirable to move away from old-fashioned and stigmatizing terms such as "lunacy", aliéné, etc. On the other hand, fashions change and the word "asylum" seems to be acquiring more of a "helping and caring" connotation than previously. Conversely, "psychopath", which was previously a technical term (however poorly defined), is entering into commoner usage as a pejorative and fear-engendering term.

Much more important than nomenclature in this respect is the content of legal provisions. A concentration on dangerousness, public nuisance, and vagrancy in the texts of laws reinforces the negative image of the mentally ill. Such provisions should therefore be carefully balanced by sections on access to treatment, aftercare, rehabilitation, and community involvement.

(b) "Positive" criteria (i.e. what the law should do)

(i) it should closely reflect the overall direction and approach of the national policy.

(ii) it should exploit available manpower. Specific reference to various categories of health workers can stimulate their contribution, e.g. in detecting mental illness, bringing patients to treatment, and providing care and support in the community. Training can also be stimulated by defining clear but realistic training criteria for various tasks ("mental health officer" can, for example, be used as a generic term covering several categories such as nurses, medical assistants, and social workers, and specifying the experience and training needed to qualify in each category).

(iii) it should require treatment for priority conditions to be available in all parts of the country. Such a provision would help to ensure an equitable distribution of resources. It should refer explicitly to the needs of underserved groups.

(iv) it should stimulate intersectoral involvement. A legal requirement is needed to ensure that educational and social welfare services and the police are fully responsive to the needs of the mentally disordered. This is particularly important for mentally retarded people and those with problems related to alcohol abuse or drug dependence. Involvement of representatives of these services and also of lay mental health associations on tribunals, review panels, etc. can be required by law and would help to stimulate contacts.

(v) protection of civil rights should be independent of educational status, residence, etc. Since many people in developing countries cannot read or write, it is important that provisions protecting
patients' rights, allowing for appeals, laying down review procedures, etc. should, to the greatest extent possible, be fully explained to such people and not be so complex as to prevent easy use. Similarly, people living in remote areas should be able to raise legal issues in local courts concerning mentally ill relatives.

3.7.4 Enactment of mental health law

One factor frequently overlooked by those who have not been directly involved in bringing about legal changes, is the complexity of the process and the time involved. Legal drafting is highly skilled work and there may be long delays in receiving help and advice from the government departments. The process of consultation with ministries, police, lay associations, professional groups, and magistrates is essential but slow. Legislative processes themselves may also be delayed by political crises, government changes, etc. In many developing countries these factors have combined to prevent changes in the law for many years. One possible approach to overcome these delays is to include provisions for the mentally ill in general public health laws (as, for example, in Costa Rica and Sudan), thereby avoiding the need for a separate act and reinforcing the integration of mental health into public health programmes.

4. SUMMARIES OF LEGAL PROVISIONS

In this section will be found the results of the comparative survey of legislation covering legal provisions for access to various forms of care. The material is organized in four categories: voluntary access to care, involuntary hospitalization, emergency hospitalization, and observational hospitalization. For each category the countries surveyed are listed alphabetically (those federal countries in which information from two jurisdictions was obtained are listed under the name of the country with the name of the relevant state, province, or canton indicated in brackets). In the case of the countries with "informal systems", this is indicated by a note after the name of the country in brackets. Information for each country (or jurisdiction) is presented in a standard format using a series of headings. In this way comparisons can be readily made between different countries and jurisdictions. When necessary an explanatory note has also been included. The reader can therefore obtain a general view of the different provisions under one or other category by reading through the whole of that category. In order to focus on one particular aspect, for example "discharge procedures" under "involuntary hospitalization", the reader can refer to the relevant heading under each country.

It should be stressed that this information is presented primarily for comparative purposes. The reader should not take the information as an authoritative and comprehensive statement of the legal provisions in
any one country. For this, reference should be made to the national authorities concerned.

The legal citations on which these summaries are based will be found at the end of the report.

4.1 Voluntary access to care

**Australia (South Australia)**

*Note: Act contains provision similar to Mental Health Act of 1959 in England and Wales establishing policy of "informal admission".*

1. **Application:** Request signed by patient if over 16 years; request signed by parents (or guardian) where patient is under 16.
2. **Medical Certification:** Required.
3. **Other Formalities of Admission:** Medical examination by hospital staff required within 24 hours of admission. Notification of admission to Director General within 48 hours of admission.
4. **Discharge Procedure(s):** On request of patient, but patient must provide 72 hours' written notice to hospital of intention to leave.
5. **Change of Status:** Patient may be transferred to involuntary status during voluntary hospitalization and during 72-hour period mentioned above prior to voluntary departure.

**Australia (Victoria)**

1. **Application:** (Same as South Australia).
2. **Medical Certification:** Required.
3. **Other Formalities of Admission:** Notification to the Chief Medical Officer within 72 hours of admission.
4. **Discharge Procedure(s):** (a) On request of the patient, but patient must provide 3 days' written notice to hospital of intention to leave.
   (b) On order of Superintendent or Chief Medical Officer.
   (c) Patient may be granted temporary leave of absence for up to 3 months by Superintendent.
5. **Change of Status:** (Same as South Australia).

**Bahrain (informal system)**

No details of the procedure for voluntary access available.

**Benin (informal system)**

1. **Application:** The patient's family makes application to hospital, or brings patient to the hospital, and requests admission.
2. **Medical Certification:** Not required. Hospital staff determines need for admission.
3. **Other Formalities of Admission:** At the time of admission, the hospital seeks the agreement of the family to the course of treatment determined for the patient.
4. **Discharge Procedure(s):** Informal arrangements with family for patient to return home.
5. Change of Status: No provisions.

_Brazil_

2. Medical Certification: Required; by one physician.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): At will of patient.
5. Change of Status: No information.

_Canada (Alberta)_

1. Application: There are two procedures, as follows:
   (a) Any person may be admitted as “informal patient” in accordance with the rules of the mental health facility.
   (b) Any person 16 years of age or older may, if capable of expressing his own wishes, be admitted as “informal patient” despite objection of parents or guardian.
2. Medical Certification: Not required.
3. Other Formalities of Admission: Admission of “informal patients” must be in accordance with the rules of the mental health facility.
4. Discharge Procedure(s): At request of patient on written notice to hospital. Also, the superintendent of the mental health facility must discharge “informal patient” upon medical certification to that effect by two “therapists”. (See hospitalization procedures under 4.2.)
5. Change of Status: “Informal patient” may be changed to “formal patient” (involuntary) at any time during hospitalization upon medical certification by two therapists on same grounds as for involuntary care. (See involuntary hospitalization procedures under 4.2.)

_Canada (British Columbia)_

1. Application: By patient if 16 years of age or older, by parents if patient under 16 years. The director of the facility may not admit voluntary patient (or any category) unless suitable accommodation is available for care, treatment, and maintenance of the patient.
2. Medical Certification: By physician. Director must be satisfied with medical certification of patient as suitable for voluntary care.
3. Other Formalities of Admission: Application for admission includes consent to electroconvulsive treatment.
4. Discharge Procedure(s): Within 72 hours of receipt of application by patient (or parent for child under 16), facility director must discharge.
5. Change of Status: No provisions for change of status to involuntary patient while in hospital.

_Costa Rica_

Note: The procedures described herein are taken from the provisions of the General Health Law of 1973. Further regulation of mental hospitals is contained in administrative regulations.

1. Application: By patient.
2. **Medical Certification**: None required.
3. **Other Formalities of Admission**: None.
4. **Discharge Procedure(s)**: Patients may leave in accordance with "patient regulatory provisions", either on the basis of a medical discharge or an application for discharge submitted by the patient or members of his family, provided that discharge of the person concerned will not entail a hazard to the health or life of the patient or of third parties.
5. **Change of Status**: No provisions.

**Cyprus**

*Note*: The Mental Patients Law of 1931 does not provide for voluntary admission to psychiatric hospitals. Mental patients are, however, admitted on a voluntary basis to the Psychiatric Wing of Nicosia General Hospital where virtually all patients are voluntary. Only neurotic and mildly psychotic patients are treated.

**Democratic Yemen**

1. **Application**: Request by patient or family in writing to hospital superintendent.
2. **Medical Certification**: Not required.
3. **Other Formalities of Admission**: Consent of the patient's family is required for voluntary admission of a patient. Consent of two official visitors also required.
4. **Discharge Procedure(s)**: On request of patient, within 24 hours of notice to leave.
5. **Change of Status**: No provisions.

**Denmark**

1. **Application**: By patient.
2. **Medical Certification**: By general practitioner, another doctor, or (in the case of re-admission) by doctor on the staff of the mental hospital.
3. **Other Formalities of Admission**: None.
4. **Discharge Procedure(s)**: At will of patient.
5. **Change of Status**: No provisions.

**Egypt**

*Note*: Currently it is reported that nearly all mental patients are admitted voluntarily to Egyptian mental health facilities except those patients who enter through the criminal process.

1. **Application**: Written application by patient or guardian (including parents).
2. **Medical Certification**: Not required.
3. **Other Formalities of Admission**: Hospital must make written report of admission of patient within 48 hours to national-level Board of Control, including description of mental condition of patient.
4. **Discharge Procedure(s)**: On request in writing of patient.
5. **Change of Status**: When condition of voluntary patient so requires, can transfer to involuntary status by following requirements for involuntary hospitalization. (See description under 4.2.)
**Ethiopia (informal system)**

*Note:* Ethiopia currently has no formal laws in the field. A draft law on mental hospitals and patients has been prepared and is under consideration. At present, 25-30% of patients are admitted voluntarily.

1. **Application:** Draft law would authorize admission of patient 18 years of age or older on own request; for patient under 18 years, admission would be authorized on request of parents or guardian.
2. **Medical Certification:** Not required.
3. **Other Formalities of Admission:** Not specified.
4. **Discharge Procedure(s):** No information available.
5. **Change of Status:** No information available.

**Fiji**

*Note:* Though procedure exists for voluntary admission, very few (2%) currently are classified as fully voluntary patients.

1. **Application:** Written request by patient 18 years of age or older; by parents or guardian for patient under 18.
2. **Medical Certification:** None required before admission; examination is conducted by hospital staff following admission.
3. **Other Formalities of Admission:** Superintendent of mental hospital must send written notice of admission of patient to national-level Board of Visitors.
4. **Discharge Procedure(s):** On request of patient on 72 hours' written notice of intention to leave.
5. **Change of Status:** Not specified, but 72-hour period may be used to allow hospital superintendent to apply for involuntary hospitalization. (See under 4.2.)

**France**

*Note:* The formal Law (30 June 1838) contains no provision for voluntary admission and none has been added in subsequent years. Nevertheless, voluntary patients are admitted to "open" or "free" services of the mental health facilities. Regulations on "sectorization" of the hospitals adopted by the Ministry of Health in the 1960s and 1970s recognize the voluntary-patient category.

1. **Application:** By patient; admission under "sectorization" is to open service of hospital serving patients from patient's own community. Outpatient services are arranged on same basis.
2. **Medical Certification:** Not required.
3. **Other Formalities of Admission:** Not specified.
4. **Discharge Procedure(s):** On request of patient even when against medical advice. No provisions for detaining patient.
5. **Change of Status:** No provisions.

**Ghana**

*Note:* The current law dates from 1888 and is generally considered obsolete. A Draft Mental Health Act of 1971 has not yet been implemented. Both laws are described below.
Lunatic Asylums Ordinance of 1888

1. Application: Though no legal provision for such admissions is contained in the Ordinance, voluntary patients are currently admitted on an informal basis on their own application in writing.
2. Medical Certification: Not required.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): 72 hours' notice is usually required (although not specified in the text) from voluntary patients before release is allowed by the hospital superintendent.
5. Change of Status: No provisions.

Draft Mental Health Act of 1971

1. Application: Authorized in law; by patient in writing.
2. Medical Certification: Required; one medical practitioner.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): (a) on request of patient within 72 hours of giving notice;
   (b) by Chief Administrator of the mental health facility; or
   (c) on written application with 72 hours' notice by relative or other person (friend of patient).
5. Change of Status: No provisions.

India

Note: The current law is the Lunacy Act of 1912.

1. Application: By patient.
2. Medical Certification: Not required.
3. Other Formalities of Admission: Consent of two members of Board of Visitors required.
4. Discharge Procedure(s): At request of patient on 24 hours' written notice.
5. Change of Status: No provisions.

Iran (informal system)

Note: Currently 90-100% of all patients in mental health facilities are reported to be voluntary.

1. Application: Informal; by patient or family; free access to care is provided for all.
2. Medical Certification: Not required.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): On request of patient.
5. Change of Status: No provisions.

Iraq (informal system)

Note: The current system is informal. A draft mental health law is under consideration. Provisions from both are cited below. At present, nearly all patients are voluntary.
1. **Application**: Patients are admitted informally at present. Under the draft law, written application would be required of patients 18 years of age or over and from parents or guardian of a patient under 18 years.

2. **Medical Certification**: None is required currently. Under the draft law, one medical certificate would be required to refer a patient for voluntary care.

3. **Other Formalities of Admission**: None.

4. **Discharge Procedure(s)**: Currently, and under the draft law, discharge can be obtained at the request of a patient or of the parent or guardian for a child.

5. **Change of Status**: No provisions.

**Japan**

*Note*: The proportion of voluntary admissions is relatively low (20%), due in part to regulations concerning insurance benefits. Voluntary admissions are primarily to private facilities. There are no provisions in the Mental Health Act of 1950 for voluntary admission. However, voluntary admission is allowed under the Medical Treatment Act. (See discussion under 2.4.2.)

**Jordan (informal system)**

1. **Application**: Informal; request by the patient or family.

2. **Medical Certification**: Not required.

3. **Other Formalities of Admission**: None.

4. **Discharge Procedure(s)**: Informal.

5. **Change of Status**: No provisions.

**Kuwait (informal system)**

*Note*: At present nearly all (95%) admissions to mental health facilities are voluntary.

1. **Application**: Application is made by the patient or family.

2. **Medical Certification**: See under 3 below.

3. **Other Formalities of Admission**: Patients are usually admitted on agreement between health authorities and police authorities where patient cooperates to receive care and treatment. Patients are required to give signed consent for treatment.

4. **Discharge Procedure(s)**: At request of patient or family, even when against medical advice. Trial discharge for temporary periods may also be arranged when patient's condition has improved.

5. **Change of Status**: No provisions.

**Lesotho**

*Note*: Currently 90% of all patients in mental health facilities are on voluntary or informal status.

1. **Application**: There are two procedures:
   (a) Informal procedure, no formalities, application by patient.
   (b) More formal procedure where application is made by patient or family.
2. **Medical Certification:**
   (a) None required.
   (b) One medical certification.

3. **Other Formalities of Admission:**
   (a) None.
   (b) The family (or relative) must accept responsibility for the patient in hospital and after discharge, if allowed.

4. **Discharge Procedure(s):** On request by the patient or the family (or relative) after giving 7 day's notice of intention to leave.

5. **Change of Status:** During the seven days, the Medical Officer at the hospital may institute proceedings for involuntary hospitalization. (See under 4.2.)

**Malaysia**

*Note:* Though there is a legal provision for voluntary admission in the Mental Disorder Ordinance of 1952 (Section 39), our correspondent reported a voluntary admission rate of only 5-10% in 1975.

1. **Application:** Request signed by the patient.
2. **Medical Certification:** Not required.
3. **Other Formalities of Admission:** None.
4. **Discharge Procedure(s):** At will of patient on 7 days' written notice of intention to leave.
5. **Change of Status:** Board of Visitors may petition a magistrate to commit patient to involuntary status.

**Nigeria**

*Note:* The Lunacy Law of 1916 contains no provision for voluntary admission. Nevertheless, our correspondents report that patients are treated voluntarily at the psychiatry departments of teaching hospitals.

**Norway**

1. **Application:** By patient himself in writing.
2. **Medical Certification:** Medical certification from the patient's general practitioner is required. The patient is usually referred to the mental health facility by a general practitioner.
3. **Other Formalities of Admission:** The clinical decision to admit the patient remains with the superintendent of the mental health facility.
4. **Discharge Procedure(s):** On request of the patient within 21 days after giving written notice of intent to leave.
5. **Change of Status:** No provisions.

**Pakistan**

*Note:* The basic law is the Lunacy Act of 1912, variously amended in later years. Our correspondent reports that there are very few voluntary admissions to mental hospitals operated by the federal and provincial governments.
to which the law applies. No formal application is required for admission of voluntary patients to general hospitals.

1. Application: By the patient.
2. Medical Certification: None required.
3. Other Formalities of Admission: Admission must have the consent of two members of the Board of Visitors.
4. Discharge Procedure(s): On request of patient with 24 hours' written notice.
5. Change of Status: No provisions.

Poland

2. Medical Certification: Medical examination is conducted by outpatient physician at the mental hospital, or by other physicians, or by those responsible for admissions at the hospital.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): On request of patient. A medical certificate of sufficient health recovery to warrant discharge is required from the head of the hospital or the treating physician.
5. Change of Status: No provisions.

Peru

2. Medical Certification: Not required.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): At the will of the patient.
5. Change of Status: No provisions.

Qatar (informal system)

1. Application: On request of the patient or of a relative on his or her behalf.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): None; on determination of head of facility.
5. Change of Status: No provisions.

Romania

Note: Under various ordinances and decrees, patients have free access to care and treatment and to voluntary admission. It is reported that the great majority of patients in psychiatric hospitals are admitted voluntarily.

1. Application: Informal application by patient or family.
2. Medical Certification: Not required.
3. Other Formalities of Admission: None.
4. Discharge Procedure(s): Informally provided.
5. Change of Status: No provisions.
Rwanda (informal system)

Note: There are no formal provisions on mental hospital admissions. Our correspondent reports that approximately 90% of all patients are admitted voluntarily.

Saudi Arabia (informal system)

Note: The current system of mental hospitalization is entirely informal. Nearly all patients are admitted voluntarily to mental hospitals on request of their families who remain responsible for them. They may be released on request of the family members who sought their admission. In 1975, a draft law was prepared and is currently under consideration. The following description relates to the provisions of the latter text.

1. **Application**: On request of the patient or of the person responsible for him, the patient may volunteer to enter a mental hospital for treatment.
2. **Medical Certification**: None required.
3. **Other Formalities of Admission**: The director of the hospital must agree to receive any voluntary patient.
4. **Discharge Procedure(s)**: None specified; provisions for release of committed patients would seem to apply. (See under 4.2.)
5. **Change of Status**: No provisions.

Senegal

1. **Application**: On request of patient.
2. **Medical Certification**: Conducted at hospital with psychiatric diagnosis justifying voluntary treatment.
3. **Other Formalities of Admission**: Patient may be treated on outpatient basis with monthly visits of the patient to the mental health clinic or facility.
4. **Discharge Procedure(s)**: Discharge is at the will of the patient. The law allows hospital stay only for such period as is necessary for treatment and periodic evaluations of progress.
5. **Change of Status**: When the patient is of outpatient status and fails to cooperate in following the treatment plan, he can be brought back to the mental health facility for medical examination and any necessary treatment.

Sudan

Note: Under the new mental health text (Chapter 13 of the Public Health Law of 1975), provision is made only for involuntary detention to special security hospitals of mentally ill persons who are found dangerous to themselves or to others. (See under 4.2.) Nevertheless, our correspondent indicates that all patients in other psychiatric hospitals are admitted voluntarily on an informal basis.

Switzerland (Basel-Stadt)

1. **Application**: On written or oral request of the patient.
2. **Medical Certification**: Not required.
3. **Other Formalities of Admission**: None.
4. **Discharge Procedure(s):** Discharge is by determination of the superintendent after receiving advice of Psychiatric Commission. (Same procedure as for involuntary patients.)

5. **Change of Status:** No provisions.

**Switzerland (Geneva)**

1. **Application:** On written application of the patient evidencing his consent.
2. **Medical Certification:** By one physician.
3. **Other Formalities of Admission:** All voluntary admissions must be reported immediately to the Canton’s Board of Psychiatric Surveillance.
4. **Discharge Procedure(s):** Patients may be discharged at their will unless they are dangerous to themselves or others.
5. **Change of Status:** If, during his stay or on request for discharge, a patient is found to be dangerous to himself or others, the Board of Psychiatric Surveillance may change the patient's status to involuntary hospitalization. The hospital is required to make a report to the Board immediately in order to request such a change of status.

**Syrian Arab Republic**

*Note:* The current law contains no provision for voluntary admission and no voluntary patients are accepted in the public mental hospitals of the country. There is, however, a provision for commitment by the "guardian" of a patient similar to procedures considered voluntary in some other countries. (See description under 4.2.)

**Thailand (informal system)**

1. **Application:** Request for admission by patient or by relative or guardian on his behalf. The relative or guardian must consent to hospitalization when the patient makes the request for admission.
2. **Medical Certification:** Not specified.
3. **Other Formalities of Admission:** None.
4. **Discharge Procedure(s):** Not specified.
5. **Change of Status:** No provisions.

**Tanzania**

1. **Application:** By request of the patient if 16 years of age or over; by request of parent or guardian if patient is under 16 years of age.
2. **Medical Certification:** None required by patients 16 years or over; medical certification from one physician required for patients under 16 years of age.
3. **Other Formalities of Admission:** None.
4. **Discharge Procedure(s):** At the request of the patient or the parent or guardian of patients under 16 years of age with written notice at least 7 days in advance of time requested for discharge.
5. **Change of Status:** No provisions.

**Trinidad and Tobago**

1. **Application:** Request in writing by patient if 18 years of age or over; by parents or guardian for children under 18.
2. **Medical Certification:** The patient must be examined and found suitable for admission by duly authorized medical practitioner or by the director of the psychiatric facility.

3. **Other Formalities of Admission:** None.

4. **Discharge Procedure(s):** Hospital director may discharge at any time. Patient may also be discharged on request after giving 7 days' notice of intention to leave hospital. (See also under 5 below.)

5. **Change of Status:** Hospital director can refuse discharge and keep patient in hospital if patient is still mentally ill and in need of further care and treatment. Patient may appeal refusal to discharge to Mental Health Review Tribunal. (See description under 4.2.)

*Union of Soviet Socialist Republics*

*Note:* The information presented here is based on the Fundamental Principles of the Health Legislation of the Union of Soviet Socialist Republics and the Union Republics of 1 June 1970 and other laws and regulations in force at present. Voluntary access to care is provided for in the Regulations on psychiatric hospitals and neuropsychiatric dispensaries. About 96-99% of patients enter psychiatric hospitals voluntarily.

1. **Application:** Patients are referred for voluntary admission to psychiatric facilities by district psychiatrists, or by duty psychiatrists on the emergency care service of the psychiatric facility. In their absence, patients can be referred for voluntary admission by doctors at polyclinics or general hospitals. Also, persons seeking psychiatric treatment may be sent, with their consent, to a psychiatric facility by doctors at dispensaries or hospitals if there are medical/psychiatric indications for such care and treatment. In addition, where a patient's mental condition is acutely impaired, he may be sent for voluntary inpatient care to a psychiatric hospital with the agreement of his relatives as an emergency care measure.

2. **Medical Certification:** Most patients are referred by district psychiatrists in local districts, or from dispensaries or general hospitals as indicated above.

3. **Other Formalities of Admission:** If newly admitted patients show no signs of mental disorder, or if their placement in a psychiatric hospital serves no real purpose, the duty physician must refuse to accept them. In doubtful cases, a panel can be appointed by the chief physician or his deputy for medical matters to decide whether to admit the patient. In all cases of refusal to admit, the refusal is recorded in a special register and the referring medical facility is notified of the action.

4. **Discharge Procedure(s):** The status of voluntary mental patients is the same as that of patients in general hospitals for the treatment of physical illness as regards matters of treatment and discharge at will, except when the mental condition changes, as in excitation, etc., and temporary restriction of the voluntary mental patient may be required.

5. **Change of Status:** See under 4 above.

*Foster Care:* A system of voluntary foster care has been established in the USSR. Patients in compulsory treatment cannot be transferred to foster care. The head of a family, an individual, or the management of a collective farm can conclude an agreement for the foster care of mental patients with a neuropsychiatric or psychiatric hospital. The agreement can be terminated by either
side on one month's notice. Where the patient requires hospitalization, or where he improves to such a point that he can be removed from foster care, the agreement on that patient may be terminated immediately, though notification to the other party is required. The medical follow-up and treatment of foster-care patients is carried out by the psychiatric facility through regular visits to the patient. Patients are placed in foster care by a foster-care panel at the psychiatric facility. The panel consists of the chief medical officer as chairman, the physician in charge of foster care, and the patient's attending physician. The purpose of foster care for adult and child patients is to complement the treatment given at the psychiatric facility by placing them with a family or a working community (a collective farm) under conditions enabling them to be treated effectively and to regain their fitness to work.

United Kingdom (England and Wales)

1. **Application:** Informal admission on request of patient or of parents or guardian of children under 16 years of age. No written application may be required under informal procedure. A non-protesting patient may be admitted if accompanied by relatives or friends acting on his behalf.
2. **Medical Certification:** Not required.
3. **Other Formalities of Admission:** None.
4. **Discharge Procedure(s):** At will of patient, see under 5 below.
5. **Change of Status:** The medical officer responsible for the treatment of the patient may at any time apply for a change of status of an informal patient to formal, involuntary status; and, on a request for discharge, may detain an informal patient for 72 hours while making an application for formal involuntary hospitalization. (See procedure described under 4.2. Also see patient's right of appeal to Mental Health Review Tribunal provided therein.)

United States of America (Indiana)

1. **Application:** On request of the patient if 18 years of age or over, or of parents or guardian if the patient is under 18 years of age.
2. **Medical Certification:** Not required.
3. **Other Formalities of Admission:** None.
4. **Discharge Procedure(s):** Superintendent of mental hospital may discharge at any time if hospitalization is no longer necessary or advisable. Patient or parent or guardian of patient under 18 years may request discharge which must be granted within 5 days.
5. **Change of Status:** Within the 5 days specified under 4, the superintendent may petition the court for involuntary hospitalization.

United States of America (Massachusetts)

1. **Application:** On request of patient if 16 years of age or over, or of parents or guardian if the patient is under 16 years of age. The law also provides for amplification of admission procedures for the mentally ill and for the mentally retarded by departmental regulations. Such regulations have been adopted in considerable detail under this provision. There are separate regulations for mental hospitals and for schools for the retarded.
2. **Medical Certification:** Not required.
3. Other Formalities of Admission: None provided in law, but departmental regulations are extensive.

4. Discharge Procedure(s): On request of patient if 16 years of age or over, or of parents or guardian if the patient is under 16 years of age. The superintendent of the mental health facility may, at admission or at any time thereafter, require that a voluntary patient provide 72 hours' written notice of an intention to leave the facility. During such period, the superintendent may petition the court to order the involuntary hospitalization of the patient. (see provisions described under 4.2.)

5. Change of Status: See previous section.

**Uruguay**

1. Application: On request of the patient or the patient's representative.

2. Medical Certification: Examination conducted by the admitting medical officer of the mental hospital.

3. Other Formalities of Admission: None.

4. Discharge Procedure(s): At will of patient.

5. Change of Status: The status of a voluntary patient may be changed to involuntary commitment by application of the hospital to a judge or to the General Supervisory Board. (See description under 4.2.)

**Yemen Arab Republic (informal system)**

1. Application: Informal admission procedure by request of patient or family. Admission determined by head of psychiatric facility.

2. Medical Certification: Not required.

3. Other Formalities of Admission: None.

4. Discharge Procedure(s): Determination by head of psychiatric facility.

5. Change of Status: No provisions.

4.2 Involuntary hospitalization

**Australia (South Australia)**

1. Grounds: There are four procedures, as follows:
   
   (a) General provision: person believed to be “mentally defective” and without sufficient means of support or found wandering at large or under circumstances that denote purpose of committing some offence against the law.
   
   (b) Persons neglected: person believed to be “mentally defective” and not under proper care and control or cruelly neglected by any person having or assuming his care and charge.
   
   (c) Inquisition: person found “mentally defective” by inquisition or other proceedings in court.
   
   (d) Temporary commitment: where one or two justices find it advisable to remand a patient.

   “Mentally defective” means: (i) a person who is mentally ill and who, owing to his mental condition, requires oversight, care, or control for his own good or in the public interest and who, owing to mental disorder of the mind or mental
infirmity arising from age or the decay of his faculties, is incapable of managing himself or his affairs; or (ii) an intellectually retarded person.

2. Application:
   (a) General provision: by complaint on oath before a justice, or on the initiative of a police officer or one justice, or on the request of "some person".
   (b) Persons neglected: by complaint on oath by a police officer, or on initiative of two justices.
   (c) Inquisition: request by committee appointed by the court, or on request by some person.
   (d) Temporary commitment: Statement of one or two justices.

3. Decision-Making Authority:
   (a) General provision: order of a justice.
   (b) Persons neglected: order of two justices.
   (c) Inquisition: committee appointed by court.
   (d) Temporary commitment: not stated.

4. Medical Certification:
   (a) General provision: one physician, except where petition is filed by "one person" in which case certificates of two physicians are required.
   (b) Persons neglected: one physician.
   (c) Inquisition: not required.
   (d) Temporary commitment: two physicians.

5. Length of Stay: Indefinite on all but temporary commitment which is by a 30-day order which can be prolonged, after medical examination, for a period not exceeding six months.

6. Appeal: Appeal to court against wrongful detention.

7. Periodic Review: Every six months during first three years of detention, once each subsequent year, conducted by superintendent of mental health facility or by a medical practitioner.

8. Discharge Procedure(s): On written request of the person who signed admission request, or who made last payment for patient's care, or family of patient, with the consent of the Director of Mental Health Services.

   On the decision of the Director of Mental Health Services on his own authority.

   On the issuance of a certificate by an Official Visitor to the facility, or the superintendent of the facility.

   On delivery of the patient to the care and control of a relative or friend.

   On information by a judge if the patient is wrongfully detained.

Australia (Victoria)

1. Grounds: There are two procedures, as follows:
   (a) General provision: any person considered mentally ill.
   (b) Persons at large: person mentally ill found without sufficient means of support, or wandering at large, or found in circumstances showing intention of committing a crime, or not under proper care and control, or cruelly treated or neglected.
2. **Application:**
   (a) General provision: request of some person.
   (b) Persons at large: information by medical officer or other person, on the initiative of a justice.

3. **Decision-Making Authority:** By order of two justices (for both procedures).

4. **Medical Certification:**
   (a) General provision: two medical certificates; recommendation of a medical practitioner for observational period of six months.
   (b) Persons at large: two medical certificates.

5. **Length of Stay:**
   (a) General provision: indefinite.
   (b) Persons at large: indefinite.

6. **Appeal:** By patient to Chief Medical Officer for reconsideration of case.

7. **Periodic Review:** Each patient must be examined at least once each year with a report on the results of the examination being made to the Chief Medical Officer.

8. **Discharge Procedure(s):** On request of the person who signed the admission request.
   - By order of the superintendent of the mental hospital.
   - By order of the Chief Medical Officer.
   - Upon recommendation of the Visitors to the mental hospital.
   - On delivery of the patient to the care and control of a relative or friend.
   - By a judge.

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**Bahrain (informal system)**

1. **Grounds:** Not stated.
2. **Application:** Police escort patient to hospital; court order is sometimes required.
3. **Decision-Making Authority:** Local court.
4. **Medical Certification:** Not required.
5. **Length of Stay:** Indefinite.
6. **Appeal:** No specific provision.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** Clinical decision of hospital.

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**Benin (informal system)**

1. **Grounds:** Aggressive behaviour dangerous to the public safety, or criminal offence.
2. **Application:** Police order; administrative health officer recommendation.
3. **Decision-Making Authority:** Local court where criminal offence charged.
4. **Medical Certification:** Not required.
5. **Length of Stay:** Indefinite.
6. **Appeal:** No specific provision.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** At patient's request with medical authorization.
THE LAW AND MENTAL HEALTH

Brazil

1. **Grounds:** Where the patient exhibits suicidal tendencies, or threatens serious aggression towards another person, or exhibits behaviour evidencing a troubled social life or immoral actions.

2. **Application:** By the spouse or relative of the patient, the superintendent of a hospital psychiatric outpatient department, a welfare board, the representative of the patient, or an interested party.

3. **Decision-Making Authority:** Police authorities, confirmed by the local court.

4. **Medical Certification:** One physician.

5. **Length of Stay:** Indefinite.

6. **Appeal:** No specific provision.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** By order of the hospital director or superintendent.
   On request of the person who applied for the commitment and approved by the director or superintendent.

Canada (Alberta)

1. **Grounds:** Suffering from "mental disorder" and in a condition presenting a danger to himself and others. "Mental disorder" means lack of reason or lack of control of behaviour.

2. **Application:** None specified; the admission certificate of the two "therapists", described under 4, serves as application for commitment.

3. **Decision-Making Authority:** The two therapists as below. No court review.
   If a person should refuse to submit to an examination by the therapists, a court-ordered examination by the therapists is provided after apprehension by a police officer.

4. **Medical Certification:** Separate examinations and certification by two therapists, one of whom must be a physician. The certificate must show the facts upon which the therapist's opinion is based, distinguishing those facts observed by him from those communicated to him by others.
   "Therapist" means any person who is the holder of a licence as a therapist issued by the licensing board. *(Note: It is expected that psychologists, psychiatric social workers, and psychiatric nurses will be included in the group.)*

5. **Length of Stay:** One month of hospitalization and treatment is authorized on the basis of the original two-therapist certification. A two-month renewal can be authorized after a further two-therapist certification in the same manner. After this period, a renewal for six months is authorized upon another two-therapist certification and for further six-month periods with no stated limit. *(Note: The statute does not require that the re-certifications be conducted by the same therapists who performed the original certification. Apparently, later certifications could be conducted by hospital staff if licensed as therapists.)*

6. **Appeal:**
   (a) After hospitalization, a "formal patient" (i.e. involuntary patient) may submit an appeal to have the admission or renewal certificate "terminated".
Only one appeal is allowed by the patient in any commitment period. The Minister of Health and Social Development or the director of the mental health facility may appeal on behalf of patient at any time. (Note: The latter procedure would seem necessary due to the fact that the director has no power to discharge a patient.)

(b) Appeal Panel: the law sets up an appeal review panel system. Each panel is composed of two therapists (one of whom is a physician) and a solicitor. No panel member may be a member of the staff of the mental health facility in which the appealing patient is hospitalized at the time of the appeal. No therapist who is treating or has treated the patient may be appointed.

(c) Panel Procedure: the proceedings of the panel must be in private except by permission of the Minister or on recommendation of the chairman of the panel. The appellant may be present at the hearing, but if in the opinion of the panel there would be an adverse effect on the appellant's health, he may be excluded. If he is excluded, the panel must appoint a person to act on his behalf if he does not already have a representative.

(d) Appeal to Court: the appellant may appeal the decision of the panel to the Supreme Court within one month of the date of the decision.

7. Periodic Review: See “Length of Stay”.

8. Discharge Procedure(s): The facility director is to "terminate the certificates" (of admission) where he is directed to do so by an order of the Supreme Court (after an appeal), or on the decision of a review panel to terminate, or where he receives a "certificate of discharge" signed by two therapists, one of whom is a physician, to the effect that the patient is no longer in need of "observation, care, treatment, control and detention" in the facility.

Where an admission certificate runs its course of time and is not renewed, the "formal patient" is to be discharged.

Canada (British Columbia)

1. Grounds: A "mentally disordered person" who (according to required medical certification) requires treatment in a mental health facility and requires care, supervision, and control in a facility for his own protection or welfare or for the protection of others.

"Mentally disordered person" means a mentally retarded or mentally ill person. "Mentally retarded person" means a person who (a) has a condition of arrested or incomplete development of the mind, whether arising from inherent causes or induced by disease or injury, that is of a nature or degree requiring or which is susceptible to medical treatment or other special care or training, and (b) who requires care, supervision, and control for his protection or welfare or for the protection of others.

"Mentally ill person" means a person suffering from a disorder of the mind that (a) seriously impairs his ability to react appropriately to his environment or to associate with others, and (b) requires medical treatment or makes care, supervision, and control of the person necessary for his protection or welfare or for the protection of others.

2. Application: By a near relative, a person who has knowledge of him, any police officer, or anyone who has reason to believe he is mentally disordered.

3. Decision-Making Authority: Director of the mental health facility upon receipt of written application from person as indicated above accompanied by medical
certification. The director can refuse admission if suitable accommodation is not available for the patient.

4. **Medical Certification**: Two physicians. (One of the physicians may be on the staff of the mental health facility to which admission is being sought).

5. **Length of Stay**: One year, renewal authorized for one year, then for additional two-year periods after examination of the patient and determination by the director of the facility.

6. **Appeal**: The patient, or near relative, or anyone on his behalf may appeal to a judge in chambers prior to his hospitalization or within three months after his commitment to order that his admission be prohibited or that he be discharged.

   The patient may also apply for a writ of *habeas corpus* or other prerogative writ to challenge his hospitalization.

   The patient or anyone on his behalf may also, at any time after the expiration of 30 days from admission, appeal to a special panel set up at the hospital for a "hearing" on the commitment. The patient must be given at least two days' notice of the hearing. The panel is composed of three persons: a chairman appointed by the Minister of Health Services and Hospital Insurance, a physician on the staff of the facility, and a person, other than a family member, who is appointed by the patient. Where the patient does not appoint anyone, the director may appoint any person, who in the opinion of the director, has "knowledge of the circumstances of the patient".

7. **Periodic Review**: See "Length of Stay".

8. **Discharge Procedure(s)**: The director of the facility may discharge involuntary patients at any time.

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**Costa Rica**

*Note*: The law described herein is the General Health Law of 1973 which contains general provisions on the hospitalization of mental patients, and which authorizes further regulations to provide greater detail.

1. **Grounds**: Treatment deemed necessary by competent authority.

2. **Application**: To director of establishment authorized to detain mental patients by the Ministry of Health.

3. **Decision-Making Authority**: Director of establishment.

4. **Medical Certification**: All involuntary commitments must be reported by the director of the mental health facility to the Supreme Court of Justice.

5. **Length of Stay**: Not specified.

6. **Appeal**: No specific provision.

7. **Periodic review**: Not required.

8. **Discharge Procedure(s)**: Any involuntary patient may be discharged by the director of the facility on his own determination or on application for discharge by the patient or his family.

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**Cyprus**

1. **Grounds**: Person who is mentally afflicted and a proper subject of confinement.

2. **Application**: On information under oath to the court.
3. **Decision-Making Authority:** A district court after inquiry based on information by informant (as above) who has good cause to suspect or believe that a person is mentally afflicted.

4. **Medical Certification:** By court-appointed medical practitioner as result of above inquiry.

5. **Length of Stay:** Indefinite.

6. **Appeal:** By or on behalf of the patient, from the district court's order to the Supreme Court under same conditions as if the patient had been convicted of a criminal offence.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** Apparently, the medical superintendent of the facility can discharge a court-committed patient with notice to the court. Furthermore, the Director of Medical Services (of Cyprus) may order the discharge of any mental patient from any mental hospital, whether the patient is recovered or not, and may allow any mental patient to be absent on parole for any period as he thinks fit.

**Democratic Yemen**

1. **Grounds:** There are three procedures, as follows:
   - (a) Lunacy: allegation of lunacy.
   - (b) Persons at large or neglected: person believed to be a lunatic and found wandering at large, dangerous or not under proper care and control, or cruelly neglected.
   - (c) Incompetent: person alleged to be a lunatic, of unsound mind, and incapable of managing himself or his affairs.

2. **Application:**
   - (a) Lunacy: spouse or nearest relative, or other person.
   - (b) Persons at large or neglected: arrest by police or report to police by informant.
   - (c) Incompetent: relative or administrator of estate of person, or by government pleader.

3. **Decision-Making Authority:**
   - (a) Lunacy: magistrate.
   - (b) Persons at large or neglected: magistrate.
   - (c) Incompetent: court order after inquisition.

4. **Medical Certification:**
   - (a) Lunacy: two physicians.
   - (b) Persons at large or neglected: one physician.
   - (c) Incompetent: none required.

5. **Length of Stay:** Indefinite.

6. **Appeal:** In cases of incompetency, a court order can be sought to declare the patient recovered to competency and to remove the patient from hospital.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** For all classifications, discharge may be obtained by order of three members of Board of Visitors of the facility, or on application
of person who applied for commitment, unless the patient is dangerous or unfit to be at large. The patient may also be delivered to the care and custody of a relative or friend.

**Denmark**

1. **Grounds:** Person dangerous to himself or his environment, or hospitalization necessary to ensure adequate treatment.
2. **Application:** By spouse, relative, social commission, or police.
3. **Medical Certification:** One physician. This must be supported by a further certificate of the local Medical Officer of Health in cases of involuntary hospitalization (to ensure adequate treatment).
4. **Decision-Making Authority:** In all cases of involuntary hospitalization, a guardian must be appointed, his duty being to ensure that the patient is not detained longer than necessary.
5. **Length of Stay:** Indefinite, but specified that stay is to be no longer than necessary.
6. **Appeal:** An appeal against involuntary hospitalization may be made to the Minister of Justice. Further appeal may be lodged in the courts.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** The patient may be discharged on order of the superintendent of the hospital.

**Egypt**

1. **Grounds:** Mentally disordered person dangerous to himself or others, or to the public safety.
2. **Application:** The usual procedure is by written application by relative or guardian. On arrest by police, the application can be made by a public prosecutor or by a medical officer.
3. **Decision-Making Authority:** The hospital must notify the Board of Control of each admission and within 30 days the Board must confirm the detention or discharge the patient.
4. **Medical Certification:** Two medical certificates are required, unless the patient is committed on arrest by police in which case one medical certificate is required.
5. **Length of Stay:** One year after confirmation by Board of Control; renewals upon medical report to the Board of Control for one year, then for two years, then for three years and subsequent five-year periods.
6. **Appeal:** No specific provision.
7. **Periodic Review:** See under 5.
8. **Discharge Procedure(s):** The hospital director may discharge a patient on his order or on application of a relative of the patient. The Board of Control may also order discharge of a patient at any time. Discharge is automatic at the end of each period of detention if the Board of Control has not acted. Any involuntary patient may, after improvement, be transferred to voluntary status.

**Ethiopia (informal system)**

*Note:* Current law is informal. Under a draft act now under consideration, a court order would be necessary for involuntary hospitalization. Appeal
against a court order would be authorized similar to criminal-law appeals. Discharge of patients would be allowed on the basis of clinical determination by the hospital director. A refusal to discharge a patient on the request of a patient's family could be appealed to the local court.

**Fiji**

1. **Grounds:** Two procedures are provided:
   
   (a) Persons at large or neglected: person suspected of being of unsound mind and found wandering at large, or is dangerous to himself or others, or is not under proper care and control, or is cruelly treated or neglected by relatives or persons having care or charge of person.
   
   (b) Incompetent: person alleged to be of unsound mind and incapable of managing himself or his affairs.

2. **Application:**
   
   (a) Person at large or neglected: on information to a magistrate under oath, or on application to the hospital by a relative or person having care or control of the person.
   
   (b) Incompetent: by any public service officer or by a relative.

3. **Decision-Making Authority:**
   
   (a) Person at large or neglected: magistrate.
   
   (b) Incompetent: upon inquiry by the Supreme Court which can declare the person incompetent and order hospitalization.

4. **Medical Certification:**
   
   (a) By one medical practitioner. If absent, detention is possible for up to 7 days provided certificate is issued within that period.
   
   (b) By two medical practitioners. Reception is possible with one certificate providing a second certificate is furnished within 7 days of admission.

5. **Length of Stay:** Indefinite.

6. **Appeal:** Supreme Court can order that detained person be brought for examination upon information on oath. Discharge is ordered if detained person appears to be of sound mind.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** Discharge may be ordered by two members of the Committee of Visitors.

**France**

1. **Grounds:** There are two systems:
   
   (a) Voluntary commitment ("placement volontaire"): on the basis of need for treatment and detention in mental hospital.
   
   (b) Official commitment ("placement d'office"): on the basis of the patient's potential danger to the public order and the safety of other persons.

2. **Application:**
   
   (a) Voluntary commitment: Written application to the mental hospital by the spouse, a relative, or friend.
   
   (b) Official commitment: by order of the local prefecture of police.
THE LAW AND MENTAL HEALTH

3. Decision-Making Authority:
   (a) Voluntary commitment: the hospital must send an admission report to the prefecture of police within 24 hours. The prefecture of police must in turn notify the public prosecutor of the admission.
   (b) Official commitment: the hospital must notify the public prosecutor and the patient's family within 24 hours.

4. Medical Certification:
   (a) Voluntary commitment: one medical certificate.
   (b) Official commitment: not required, but often obtained in practice.

5. Length of Stay: Indefinite.

6. Appeal: To competent court of the region in which the hospital is located.

7. Periodic Review:
   (a) Voluntary commitment: a further medical certification is required within two weeks of admission.
   (b) Official commitment: semi-annual reports of progress to the prefecture of police are required. The prefecture must decide in each case whether the report warrants prolongation of detention or discharge of the patient.

8. Discharge Procedure(s):
   (a) Voluntary commitment: the patient may be discharged on order of the hospital under a medical certificate of recovery, or on request of the family or person who requested the placement, or on request of the prefecture of police.
   (b) Official commitment: on order of the prefecture of police upon medical advice, or after reviewing semi-annual report of hospital.

Ghana

Note: As in regard to voluntary care, two laws will be described. The older law is considered "obsolete", but the Draft Act of 1971 has not yet been implemented.

Lunatic Asylums Ordinance of 1888

1. Grounds: Good cause to suspect person is a lunatic and proper subject for confinement in a lunatic asylum.

2. Application: Information before a magistrate under oath by any informant.


5. Length of Stay: Indefinite.

6. Appeal: To court (no specific provision).

7. Periodic Review: Not required.

8. Discharge Procedure(s): The patient may be discharged on order of a magistrate after written request for discharge, whether or not recovered, if relatives or friends provide care and prevent him from injuring himself or others. The patient may also be ordered discharged by the Director of Medical Services.
Draft Mental Health Act of 1971

1. **Grounds:** Where it is found expedient for the welfare of the person believed suffering from mental illness, or for the public safety.

2. **Application:** Same as previous law.

3. **Decision-Making Authority:** Same as previous law.

4. **Medical Certification:** Two physicians, one of whom must be experienced in psychiatry.

5. **Length of Stay:** The magistrate may order temporary hospitalization (for up to six months) or prolonged treatment and hospitalization (for up to 18 months), as the magistrate thinks fit. An order for prolonged treatment may be renewed from time to time before the expiration of the current term.

6. **Appeal:** An application may be made by the patient or person on his behalf to a Mental Health Review Tribunal to review the conditions of detention, requesting discharge, or requesting any other appropriate action.

Review Tribunal: the Mental Health Review Tribunal for Ghana is composed of five members: a legal practitioner, who acts as chairman; one person with qualifications in psychiatry; one other medically qualified member; and two other persons appointed by the Minister of Health. The Tribunal, after inquiry, may make appropriate recommendations to the Minister. The Tribunal may, however, on its own order, direct that a patient be discharged, notwithstanding the previous order of a magistrate if the Tribunal is satisfied that the patient is not suffering from mental illness or any other mental disorder, that detention is not necessary in the interest of the patient's health or safety or the protection of others, and that the patient, if released, would not be likely to act in a manner dangerous to himself or others.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** See discharge by the Tribunal; otherwise same as previous law.

**India**

**Note:** The law differs slightly in the two jurisdictions (Punjab and Uttar Pradesh), as pointed out below, but both are based upon the Lunacy Act of 1912.

1. **Grounds:** There are three procedures, as follows:
   
   (a) Lunacy: allegation of lunacy.
   
   (b) Persons at large or neglected: person alleged to be a lunatic and found wandering at large, or dangerous, or not under proper care and control, or cruelly treated or neglected.
   
   (c) Incompetent: person alleged to be a lunatic and of unsound mind and incapable of managing himself or his affairs.

2. **Application:**
   
   (a) Lunacy: application of spouse, relative, or other person.
   
   (b) Persons at large or neglected: arrest by police officer or report to police by informant.
   
   (c) Incompetent: application by relative or by the Advocate-General.

3. **Decision-Making Authority:**
   
   (a) Lunacy: magistrate.
(b) Persons at large or neglected: magistrate.
(c) Incompetent: court order after inquisition.

4. Medical Certification:
(a) Lunacy: two physicians.
(b) Persons at large or neglected: one physician.
(c) Incompetent: not required.

5. Length of Stay: Indefinite.

6. Appeal:
  Punjab: An appeal is provided for any involuntary patient (after hospitalization) to the hospital's Board of Visitors, which may forward the appeal to a local court or to the Director of Health Services of Punjab.
  Uttar Pradesh: An appeal is provided for all involuntary patients to the local criminal court or to the magistrate's court.

7. Periodic Review: Not required.

8. Discharge Procedure(s): Discharge may be ordered by the Board of Visitors of the hospital, by the head of the hospital, and upon application of the person who petitioned for the hospitalization. The patient may also be delivered to the care and custody of a relative or friend.

   In case of incompetency, a court order, after an inquisition, can be obtained to declare a patient recovered to competency and to remove the patient from hospital.

   Iran (informal system)

1. Grounds: When patient presents danger to himself or others.
5. Length of Stay: Patient can be admitted on medical certificate and remain for up to three weeks before a magistrate's order is obtained. After magistrate's order is issued, the commitment is usually indefinite.
6. Appeal: The patient or his family can appeal any irregularities in procedure to the government's ombudsman. The patient or his family may also appeal a refusal to discharge the patient to a judge of the Supreme Court.
7. Periodic Review: Not required.
8. Discharge Procedure(s): The patient can be discharged on request of his family.

   Iraq (informal system)

Note: The current system is informal. A draft mental health law is under consideration. Procedures under both systems are described briefly below. At present, the involuntary procedure is very rarely used for hospitalization of patients.

Informal System
1. Grounds: Unwilling or aggressive patient.
2. Application: Written application by patient's family to police or to magistrate.
3. **Decision-Making Authority:** Police or magistrate, but with permission of religious court for non-Muslims.

4. **Medical Certification:** Not specified.

5. **Length of Stay:** Indefinite.

6. **Appeal:** Not specified.

7. **Periodic review:** Not specified.

8. **Discharge Procedure(s):** A patient may be discharged by attending physician, or on request of the patient or a relative who will assume responsibility for his care and treatment.

**Draft Act**

1. **Grounds:** Suspicious or immoral behaviour, danger to the health or life of others, or neglect or exposure to material injury of patient himself.

2. **Application:** There are two rather similar procedures, as follows:
   (a) Court order: application to court on information received from police, civil authorities, or patient's family.
   (b) Magistrate's order: report by police officer or official responsible for public order.

3. **Decision-Making Authority:** As indicated above.

4. **Medical Certification:** A report from a medical committee is required for a court order. For the magistrate's order, the committee report or an examination by another physician is specified.

5. **Length of Stay:**
   (a) Court order: not to exceed four months.
   (b) Magistrate's order: not to exceed six months, but extension for period not exceeding three months is allowed on further medical recommendation.

6. **Appeal:** An appeal or request for discharge may be made to the court or to the magistrate after a refusal by the hospital to release the patient. Also, the patient can appeal a refusal by the hospital to release him to the Council for the Protection of the Mentally Afflicted.

7. **Periodic Review:** See 5(b) above.

8. **Discharge Procedure(s):** A request for discharge (for non-violent patients) can also be made to the Minister of Health by the Director General of Medical Services of Iraq.

**Japan**

1. **Grounds:** There are two procedures, as follows:
   (a) Compulsory hospitalization: person who, owing to mental disorder, is liable to injure himself or others.
   (b) Involuntary hospitalization: where treatment on involuntary basis is necessary for adequate care and treatment of a mentally disordered person.

2. **Application:**
   (a) Compulsory hospitalization: application to the Governor of Prefecture by a police officer or any person discovering the person. Application may be made by the head of the mental health facility where the person has escaped or been discharged previously from the facility.
   (b) Involuntary hospitalization: application to the head of the mental health facility by a person responsible for the care of the person, or someone else with the consent of the person responsible for his care.
3. **Decision-Making Authority:**
   
   (a) Compulsory hospitalization: Governor of Prefecture.
   
   (b) Involuntary hospitalization: head of the mental health facility.

4. **Medical Certification:**
   
   (a) Compulsory hospitalization: medical examination by two or more medical examiners for mental health.
   
   (b) Involuntary hospitalization: one physician.

5. **Length of Stay:** Not specified.

6. **Appeal:** For both procedures, an appeal can be made to the Governor of Prefecture for discharge of a patient. The appeal, or request for discharge, can be made by the patient, the person responsible for his care, or by the head of the facility. The Prefecture may require an opinion by the head of the facility or a medical examination by two or more medical examiners for mental health.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** See 6 above.

*Jordan (informal system)*

1. **Grounds:** Not specified.
2. **Application:** Police officer or relatives of the patient; arrest and transport to the police court when necessary.
3. **Decision-Making Authority:** Local police court.
4. **Medical Certification:** Not required.
5. **Length of Stay:** Indefinite.
6. **Appeal:** No specific provision.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** On request of the patient or his family if the patient is no longer dangerous to himself or the community.

*Kuwait (informal system)*

1. **Grounds:** Disturbance to the community or public nuisance.
2. **Application:** Police officer or family of the patient.
3. **Decision-Making Authority:** Discretion of the hospital to admit, with right of appeal to local court in the case of detention of a dangerous person against his will.
4. **Medical Certification:** Usually obtained from a psychiatrist or other physician asked to examine the person.
5. **Length of Stay:** Indefinite.
6. **Appeal:** See 3 above.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** The patient may be discharged back into the hands of the local police after a medical report. Where the patient is hospitalized on application of his family, he or his family may request discharge, even against medical advice, and the hospital must grant it if the family assumes responsibility for the patient.
Lesotho

1. **Grounds:** Allegation that the patient is suffering from mental disorder, and it is found expedient in the interests of the patient or for the protection of other persons.

2. **Application:** Responsible relative.

3. **Decision-Making Authority:** Authorization (approval) of the Permanent Secretary of Health.

4. **Medical Certification:** By Medical Officer in charge of mental hospital, within 14 days of admission. At that time, the Medical Officer may discharge the patient or order further hospital care.

5. **Length of Stay:** One year after Medical Officer's certification. Hospitalization is renewable yearly after examination by Medical Officer within two months of date of renewal.

6. **Appeal:** The patient or a responsible relative may appeal to the Mental Health Review Tribunal (M.H.R.T.) against a wrongful detention or in respect of other complaints. The usual practice is for a request to be made to the Medical Officer for discharge of the patient. If the discharge is denied, the patient or relative may appeal to the M.H.R.T. within 28 days of the refusal of discharge. The M.H.R.T. consists of two legal members, two medical members, and two other persons, all appointed by the Chief Justice of Lesotho. A panel of the Tribunal to hear a case consists of one of each group, with the legal member acting as chairman.

7. **Periodic Review:** See 5 above.

8. **Discharge Procedure(s):** A patient may be discharged by order of the responsible medical officer in charge of the case (M.O.) or by order of the Permanent Secretary of Health. A patient may be discharged on the request of the responsible relative of the patient, approved by the M.O.

Malaysia

1. **Grounds:** Person found to be of unsound mind and incapable of managing his affairs.

2. **Application:** Application to the local court for an inquiry, filed by any relative. For patients on temporary hospitalization orders (14 days or 90 days), the hospital's Visiting Committee members may petition a magistrate for an indefinite order of detention.

3. **Decision-Making Authority:** Local court.

4. **Medical Certification:** Not required.

5. **Length of Stay:** Indefinite.

6. **Appeal:** No specific provision.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** By order of Visiting Committee.

Nigeria

1. **Grounds:** Person suspected of being a lunatic and a proper subject for confinement.

2. **Application:** Information on oath by an informant.
3. **Decision-Making Authority:** Magistrate.

4. **Medical Certification:** One physician.

5. **Length of Stay:** Not exceeding 28 days in the case of a Magistrate's Court order, during which time a patient may be formally certified or adjudged "insane" and held indefinitely.

6. **Appeal:** Patients may appeal for discharge or on other grounds of complaint to the Visiting Committee of the mental hospital.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** Magistrate's order issued on the basis of a Certificate of Sanity made by either the superintendent of the mental hospital or by two medical practitioners.

**Norway**

1. **Grounds:** Where hospitalization may be beneficial to the mental patient and where it is necessary for the public order, or to prevent serious danger to the life or health of others.

2. **Application:** Nearest relative or public authority.

3. **Decision-Making Authority:** Medical Superintendent of the psychiatric facility. The superintendent must notify the Control Commission immediately after admission of an involuntary patient. The express agreement of the patient's nearest relative to the admission is usually obtained. If it is not obtained, the grounds for admission are strictly applied; that is, there must be a need for involuntary detention to prevent serious harm to the patient. In such cases, the application for involuntary detention is usually filed by the local authority.

4. **Medical Certification:** Not required.

5. **Length of Stay:** Indefinite.

6. **Appeal:** By patient, relatives, or public authorities to the Control Commission, requesting discharge or concerning other complaints regarding treatment. The patient or his family may also appeal to the Control Commission against a proposal by the hospital for a patient's discharge.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** The medical superintendent may discharge an involuntary patient when conditions for detention are no longer present. The patient may also be discharged on the request of the patient himself or his nearest relative. (Note appeal to the Control Commission mentioned above.)

**Pakistan**

*Note:* The procedures for involuntary hospitalization are essentially the same as for India, which were described earlier, under the Lunacy Act of 1912. Also see similar provisions on involuntary procedure for Democratic Yemen and Fiji.

1. **Grounds:** There are three procedures, as follows:
   
   (a) Lunacy: allegation of lunacy.
   
   (b) Persons at large or neglected: person alleged to be a lunatic and found wandering at large, or dangerous, or not under proper care and control, or cruelly treated or neglected.
(c) Incompetent: person alleged to be a lunatic and of unsound mind and incapable of managing himself or his affairs.

2. **Application:**
   
   (a) Lunacy: application of spouse, relative, or other person.
   
   (b) Persons at large or neglected: arrest by police officer or report to police by informant.
   
   (c) Incompetent: application by relative or by the Advocate-General.

3. **Decision-Making Authority:**
   
   (a) Lunacy: magistrate.
   
   (b) Persons at large or neglected: magistrate.
   
   (c) Incompetent: court order after inquisition.

4. **Medical Certification:**
   
   (a) Lunacy: two physicians.
   
   (b) Persons at large or neglected: one physician.
   
   (c) Incompetent: not required.

5. **Length of Stay:** Indefinite.

6. **Appeal:** An appeal is provided for all involuntary patients to the local criminal court or to the magistrate's court.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** Discharge may be ordered by the Board of Visitors of the hospital, by the head of the hospital, and upon application of the person who petitioned for the hospitalization. The patient may also be delivered to the care and custody of a relative or friend.

   In case of incompetency, a court order, after an inquisition, can be obtained to declare a patient recovered to competency and to remove the patient from hospital.

**Peru**

1. **Grounds:** There are two procedures, as follows:
   
   (a) General application: mental patient who is a danger to himself or others.
   
   (b) Court-ordered commitment: mentally ill person who, due to his dangerous tendencies, should be placed under control.

2. **Application:**
   
   (a) General: by the patient; by his relative or legal representative; by police authorities; or by any other person provided that documented evidence is produced that the patient is dangerous, neglected, or badly treated.
   
   (b) Court-ordered commitment: not specified.

3. **Decision-Making Authority:**
   
   (a) General: head of mental hospital admitting patient.
   
   (b) Court-ordered commitment: local court.

4. **Medical Certification:**
   
   (a) General: one physician.
   
   (b) Court-ordered commitment: none specified.
5. **Length of Stay:** Indefinite.

6. **Appeal:** Appeal against refusal to discharge may be filed with Mental Health Council.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** By medical superintendent on his own discretion when there is no longer any need for detention.

**Poland**

1. **Grounds:** There are two procedures, as follows:
   
   (a) General application: a mental patient who is found to be dangerous to himself or to society.
   
   (b) Court-ordered commitment: persons who are suspected of mental disorder and have committed a criminal offence.

2. **Application:**
   
   (a) General: by family member, guardian, or the patient's physician.
   
   (b) Court-ordered commitment: by the President of the local court or the public prosecutor of the district where the patient lives.

3. **Decision-Making Authority:**
   
   (a) General: by head of admitting mental hospital.
   
   (b) Court-ordered commitment: local court.

4. **Medical Certification:**
   
   General: not required.

   Court-ordered commitment: one physician.

5. **Length of Stay:**
   
   (a) General: determined by head of hospital.
   
   (b) Court-ordered commitment: not specified, but usually indicated as indefinite in court order.

6. **Appeal:** See 8 below.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):**
   
   (a) General: on request of the person who made the application, the head of the hospital may discharge the patient subject to a medical certificate at the hospital that his health is adequate for him to be discharged.
   
   (b) Court-ordered commitment: the head of the hospital may discharge such a patient on his own discretion. The patient may also be discharged on the request of the public prosecutor subject to a medical certificate at the hospital that his health is adequate for him to be discharged.

**Qatar (Informal system)**

1. **Grounds:** The family of the patient has difficulty in coping with the patient and his mental illness or disorder.

2. **Application:** The family of the patient seeks the help of the local police to control the patient and transport him to the mental hospital.
3. **Decision-Making Authority:** The head of the mental hospital or other medical facility admitting the patient must make the decision, but the consent of the family and the patient must be assured.  
4. **Medical Certification:** Not required.  
5. **Length of Stay:** Indefinite.  
6. **Appeal:** No specific provision.  
7. **Periodic Review:** Not required.  
8. **Discharge Procedure(s):** Not specified; generally on request of patient and family, with the family's agreement to care for the patient.

**Romania**

1. **Grounds:** Persons who are mentally disordered and who are liable to endanger their own life, health, or bodily integrity or that of others, and are liable to commit at any time other serious crimes covered by the Penal Code, or who are repeatedly and seriously disturbing the normal living or working conditions of other persons because of their behaviour.  
2. **Application:** Public prosecutor, on information supplied to him or on his own authority.  
3. **Decision-Making Authority:** Local people's court.  
4. **Medical Certification:** One physician. There can be a provisional detention at the mental hospital pending the decision by the people's court. During the provisional detention, the patient must be examined by the medical board and its opinion on the mental condition of the patient must be communicated to the public prosecutor within five days of the admission.  
5. **Length of Stay:** Indefinite.  
6. **Appeal:** From decision of local people's court to higher courts in accordance with Code of Civil Procedure.  
7. **Periodic Review:** Every six months, conducted by medical board of the hospital.  
8. **Discharge Procedure(s):** During a provisional detention, the patient may be discharged on recommendation of the medical board, by the public prosecutor, or by the local people's court. After an order of indefinite detention, the patient may be discharged by order of the local people's court on the basis of a petition made to the court by the public prosecutor, the patient, his family, or the medical board of the hospital.

**Rwanda (informal system)**

*Note:* Only those mental patients who are charged with a crime, or have committed a disturbance, or are considered dangerous by their families, are hospitalized involuntarily. They are usually committed by judicial order after being apprehended by the local police. Admission and discharge are handled informally by the hospital superintendent.

**Saudi Arabia (informal system)**

*Note:* As noted earlier, the current system is entirely informal. A draft law published in 1975 is under consideration. An outline of the methods of involuntary hospitalization, which are very rarely utilized at present, is provided below for both the current system and the draft law.
**Informal System**

1. **Grounds:** Not specified.
2. **Application:** A dangerous patient may be brought to the hospital by the police or may be referred to the hospital by a psychiatric clinic in a Province. A patient may also be referred by other administrative authorities in the government.
3. **Decision-Making Authority:** See 2 above.
4. **Medical Certification:** Not required.
5. **Length of Stay:** Indefinite.
6. **Appeal:** The patient may request his own discharge by appealing to the hospital and undergoing a medical examination by a psychiatric specialist.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** A patient may be discharged by the head of the hospital on the request of the patient's sponsor or family after a medical examination by a psychiatric specialist. Patients may also be discharged through the mass release by the hospital of recovered patients.

**Draft Law**

1. **Grounds:** The nature of the mental disease of the patient is such as to be prejudicial to security or order, or to arouse concern for the safety of the patient or others.
2. **Application:** Patient's family.
3. **Decision-Making Authority:** Order of the Minister of Health or his deputy or representative.
4. **Medical Certification:** Two physicians (one physician when two are not available).
5. **Length of Stay:** Indefinite.
6. **Appeal:** No specific provision.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** When the patient's care is completed or he has improved so as not to come under the grounds stated above for involuntary commitment, the director of the hospital must send a registered letter to the person who committed him, or to the person responsible for him, or to another person designated by the patient, asking him to call at the hospital within 10 days to take delivery of the patient. If this request is not followed after the 10 days, the patient is released by administrative action of the hospital.

**Senegal**

1. **Grounds:** If a mental patient has committed a criminal offence, if his behaviour is dangerous to himself or the public safety, or if he refuses to be treated.
2. **Application:** Written request to the Prefect of Police.
3. **Decision-Making Authority:** Local court, based upon facts presented and conscientiousness of the Prefect of Police in making his report.
4. **Medical Certification:** One physician.
5. **Length of Stay:** Indefinite under court order. Pending court determination, a dangerous patient may be detained for not more than 14 days in a special infirmary in the specialized closed institution for such patients.

6. **Appeal:** See 8 below.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** The hospital director may discharge the patient or treat him voluntarily when the condition of the patient allows. A request for discharge may be made to the local court by the public prosecutor or by any interested person on the patient's behalf.

### Sudan

**Note:** The recent law (Public Health Law of 1975, Section 13) provides only for involuntary hospitalization of dangerous mentally ill persons in specialized provincial forensic hospitals. The procedure for such hospitalization is described below. All mental patients in general hospitals and psychiatric institutions are treated informally on a voluntary basis.

1. **Grounds:** Mentally disturbed person felt to be dangerous to himself or others.

2. **Application:** Not specified.

3. **Decision-Making Authority:** The Mental Health Board of the Province. Confinement and treatment is provided in each Province in a closed forensic hospital.

4. **Medical Certification:** Recommendation to the Mental Health Board by a responsible psychiatrist. After hospitalization, the psychiatrist must make monthly reports to the Board on the condition of the patient.

5. **Length of Stay:** Indefinite.

6. **Appeal:** The patient may appeal against his detention to a provincial judge within one month of his hospitalization.

7. **Periodic Review:** See 4 above.

8. **Discharge Procedure(s):** Not specified; action by Mental Health Board on recommendation of responsible psychiatrist in monthly reports seems most likely procedure.

### Switzerland (Basel-Stadt)

1. **Grounds:** Mentally disordered person who is a danger to public security, order, or morals, or to himself, and who is in need of care, supervision, and treatment.

2. **Application:** By a relative, legal representative (for children or incompetents), a physician transferring a patient with the consent of relatives, or a director of an institution for person under his care.

3. **Decision-Making Authority:** Where the patient refuses hospitalization, the patient must be examined by a "judicial doctor" who must consent to the hospitalization as necessary. Where guardianship of the patient is sought, a court order is required. The court application must be accompanied by one medical certificate.

4. **Medical Certification:** See 3 above.

5. **Length of Stay:** Indefinite.
6. **Appeal:** There are a variety of procedures available to patients to appeal against their detention after hospitalization, including application to the Cantonal psychiatric commission, the Governmental Council, and the administrative court.

7. **Periodic Review:** Not required.

8. **Discharge Procedure(s):** The superintendent may discharge an involuntary patient with the advice of the psychiatric commission, which must answer a request by the superintendent within 14 days.

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**Switzerland (Geneva)**

1. **Grounds:** In situations of obvious danger to or neglect of the patient.
2. **Application:** By a relative, legal representative, police authority, or the Board of Psychiatric Surveillance.
3. **Decision-Making Authority:** Health Department.
4. **Medical Certification:** One physician.
5. **Length of Stay:** Indefinite.
6. **Appeal:** The patient or other responsible person may appeal at any time for discharge or in respect of any complaint about treatment to the Board of Psychiatric Surveillance. Also, the patient may file an appeal with a competent administrative court for review of his detention.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** A patient may be discharged on the clinical decision of the medical officer of the hospital. The patient may also be discharged on a conditional basis by the Board of Psychiatric Surveillance.

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**Syrian Arab Republic**

1. **Grounds:** There are two procedures, as follows:
   (a) General application: when a mental patient constitutes a danger to himself or to others.
   (b) Security police referral: persons considered dangerous to the general public, or who have disturbed the peace.
2. **Application:**
   (a) General: written application by guardian of the patient, or a written application from judicial or executive authorities.
   (b) Security police referral: request to hospital by public security authorities.
3. **Decision-Making Authority:** Hospital director.
4. **Medical Certification:** One physician. A further medical examination is required in the hospital within 7 days of admission to determine whether patient's condition warrants confinement or release.
5. **Length of Stay:** Indefinite.
6. **Appeal:** No specific provision.
7. **Periodic Review:** Not required.
8. **Discharge Procedure(s):** The hospital director may release a patient upon recovery or cessation of justification for confinement. Also, the director may release a patient upon the request of the guardian of the patient if the guardian agrees to take responsibility for the patient.
Tanzania

1. **Grounds**: Where there is reason to believe that a person is of unsound mind and not under proper care and control, or is being cruelly treated or neglected, or is dangerous, or is found wandering at large.

2. **Application**: Petition to court by a police officer.

3. **Decision-Making Authority**: Local court.

4. **Medical Certification**: One physician.

5. **Length of Stay**: Indefinite.

6. **Appeal**: The Permanent Commission of Inquiry can appeal confinement to the High Court on behalf of a patient.

7. **Periodic Review**: Not required.

8. **Discharge Procedure(s)**: A patient may be discharged on the request of a relative or friend, who must take delivery of the patient and care for him. The Visiting Committee of the hospital may also discharge a patient. Also, a court order for discharge may be obtained on the request of any interested person.

Thailand (informal system)

1. **Grounds**: Not specified.

2. **Application**: Relatives of the patient, a police officer, or a local judge or magistrate.

3. **Decision-Making Authority**: The hospital medical officer makes the decision to admit except when the patient is sent to the hospital on a court order.

4. **Medical Certification**: One physician.

5. **Length of Stay**: Indefinite.

6. **Appeal**: No specific provision.

7. **Periodic Review**: Not required.

8. **Discharge Procedure(s)**: Not specified.

Trinidad and Tobago

*Note*: The psychiatric hospital director, every duly authorized medical officer, and every mental health officer is an [*ex officio*](https://en.wikipedia.org/wiki/Ex_officio) Justice of the Peace in and for the whole of Trinidad and Tobago. (*Note*: This provision was enacted in order to allow these officials to call upon police assistance in detaining and transporting persons believed to be mentally ill.)

1. **Grounds**: There are three procedures, as follows:

   (a) **Medically recommended**: any person unable or unwilling to express himself as being in need of treatment.

   (b) **Court-ordered commitment**: where the person is considered by the hospital director to be mentally ill and in need of care and treatment.

   (c) **Mental health officer application**: person found wandering at large on a highway or in any public place and whom (by reason of his appearance, conduct, or conversation) a mental health officer has reason to believe is mentally ill and in need of care and treatment in a psychiatric hospital or ward.
2. **Application:**

(a) Medically recommended: by a relative or friend.

(b) Court-ordered commitment: not specified.

(c) Mental health officer: application by "mental health officer". The Minister of Health may designate the following as mental health officers: (a) psychiatric social workers; (b) registered mental nurses with at least six months' supervised experience in social work; (c) district health visitors with at least six months' supervised experience in social work and psychiatric nursing; and (d) other nurses with equivalent training and experience as district health visitors and with at least six months' supervised experience in social work and psychiatric nursing.

3. **Decision-Making Authority:**

(a) Medically recommended: the psychiatric hospital director or a duly authorized medical officer.

(b) Court-ordered commitment: the psychiatric hospital director (only) may admit a patient on order of a judge or magistrate.

(c) Mental health officer: the psychiatric hospital director or a duly authorized medical officer may admit a patient on application of a mental health officer.

4. **Medical Certification:**

(a) Medically recommended: two medical practitioners, one of whom must be a Government Medical Officer.

(b) Court-ordered commitment: the psychiatric hospital director (only) must, as soon as practicable after admission, make or cause to be made such examination of the patient as he deems necessary for determining whether or not the person is mentally ill and in need of care and treatment and within 14 days of the admission submit a report in writing to the court relative to the mental condition of the person. On receipt of the report, the court may either rescind the order or make another order authorizing the director "to admit" the person for such further care and treatment as the director may consider necessary.

(c) Mental health officer: the psychiatric hospital director or a duly authorized medical officer must, as soon as practicable after admission, make or cause to be made such examination as he may deem necessary for determining whether or not the person is in need of care and treatment. The latter examination must be conducted within 72 hours of the admission and the patient must be released within that time unless the person is found in need of further care and treatment, in which case he is placed on the same footing as a medically recommended patient. Because of this provision, this form of admission could be classified as temporary observational or emergency admission.

5. **Length of Stay:** Indefinite. (Examination within 72 hours required for mental health officer's application.)

6. **Appeal:** Involuntary patients, or their relatives or friends, except those on court-ordered commitments, may make application to a Mental Health Review Tribunal (M.H.R.T.) for discharge at any time after hospitalization. The patient, or his relative or friend, may be allowed to attend any meeting of a M.H.R.T. where the application is heard. A M.H.R.T. consists of the
following: (a) a judge of the High Court appointed by the Governor-General on advice of the Chief Justice; (b) the psychiatric hospital director; and (c) a suitably qualified person, other than an employee of the Ministry of Health or Ministry of National Security, who is appointed by the Governor-General on the advice of the Trinidad and Tobago Association for Mental Health.

7. **Periodic Review:** The Psychiatric Hospital Tribunal (described below) must review each “medically recommended patient” not less than once each year, and review each “court-ordered commitment” every six months. (The yearly periodic review also applies to “mental health officer application patients” held beyond 72 hours.) The Psychiatric Hospital Tribunal consists of the following: the Chief Medical Officer of the hospital; the Chief Magistrate; and three medical practitioners appointed by the Minister of Health. The Chief Medical Officer and the Chief Magistrate each have two alternates (appointed by the Minister on the recommendation of the Chief Medical Officer and Chief Magistrate, respectively), who may act for the members at any meeting of the Tribunal.

8. **Discharge Procedure(s):** Any “medically recommended patient” may be discharged at any time by the psychiatric hospital director, or the duly authorized medical officer, when it is “in the interest of the patient to discharge him”, or when the patient is not in need of further care and treatment in a hospital or psychiatric ward. For court-ordered commitment, the psychiatric hospital director must, when he is satisfied that the patient is no longer in need of care and treatment, report this “fact” to the court which must “forthwith rescind the order”.

**Union of Soviet Socialist Republics**

*Note:* Compulsory treatment is provided in accordance with Section 36 of the Fundamental Principles of the Health Legislation of the Union of Soviet Socialist Republics and the Union Republics of 1 June 1970, which reads: “In order to protect the health of the population, the health agencies shall be required to take special measures for the prevention and treatment of diseases which constitute a danger to the patient’s associates (tuberculosis, mental illness, venereal diseases, leprosy, chronic alcoholism, and drug dependence) as well as quarantinable diseases... The procedures and conditions governing the compulsory treatment and compulsory hospitalization of persons suffering from the afore-mentioned diseases may be laid down by national and Union Republic legislation.”

The Regulations on psychiatric hospitals provide for “immediate hospitalization” according to criteria described below. The provisions are included here, although they also serve the purpose of “emergency hospitalization”. Special provisions relating to emergencies are described under 4.3 below.

1. **Grounds:** Whenever there is clearly a danger to the patient or to those around him.

   The indication for hospitalization is that the patient constitutes a public danger because his condition is marked by the following pathological features:

   (1) aberrant behaviour in consequence of an acute psychotic condition (psychomotor overactivity with a tendency towards aggressive acts; hallucinations, delirium, a psychological automatism syndrome, disturbed consciousness syndromes, pathological impulsiveness, or severe dysphoria);
(2) systematized delusion syndromes if they form the basis for behaviour
dangerous to the public;

(3) hypochondriacal delusional states giving rise to an abnormal, aggressive
attitude of the patient to specific persons, organizations, or institutions;

(4) depressive states when accompanied by active suicidal tendencies;

(5) manic and hypomanic conditions leading to a breach of the peace or
aggressive manifestations towards other persons;

(6) acute psychotic conditions in psychopathic personalities, oligophrenics,
and patients with residual manifestations of organic cerebral lesions accom­
panied by excitation, aggression, and other actions dangerous to the patient
or to other persons.

Conditions of simple, even if severe, alcoholic intoxication or of intoxic­
ation due to other narcotic substances, apart from acute toxic psychoses and
psychotic variants of abstinence syndromes, are not indications for immediate
admission to psychiatric hospitals. Affective reactions and antisocial forms
of behaviour by persons not suffering from mental disease but only evincing
such mental anomalies as psychopathic traits of character, neurotic reactions,
mild sequelae of cranial damage, and so on cannot be used as indications
for hospitalization.

In cases where behaviour dangerous to the public suggests the presence
of a mental disturbance but said disturbance is not a manifest one, the
person concerned cannot be subjected to immediate hospitalization.

Such persons, detained in connexion with behaviour dangerous to the
public by the authorities responsible for maintaining law and order, should
be sent for expert psychiatric examination in accordance with the rules laid
down by the legislation on criminal procedure.

2. Application: Public health authorities can order the immediate hospitalization
of a patient without the agreement of the patient's relatives, guardians, or
other persons close to him on the grounds described above.

The Regulations on psychiatric hospitals lay down that, if newly admitted
patients show no signs of mental disorder or if their commitment in a
psychiatric hospital serves no real purpose, the duty physician must refuse
to accept them. In doubtful cases, the decision as to whether to accept a
patient or not is taken by a panel appointed by the chief physician or his
deputy for medical matters. Every case of refusal of admission is recorded
by the duty physician in a special book and the establishment that referred
the patient is subsequently notified.

3. Decision-Making Authority: See 2 and 3 above and 4 below.

4. Medical Certification: Patients must be examined within 24 hours by a special
panel of three psychiatrists; the panel considers whether hospitalization was
correct and whether a further stay in hospital is necessary. The result of
the examination is recorded in the patient's case history over the signatures
of the panel members.

If one of the doctors does not agree to further hospitalization, he can
append his personal opinion in writing in the notes. The patient's next-of-
kin must be informed of the patient's hospitalization within 24 hours of the
examination by the panel.

5. Length of Stay: Up to 1 month and thereafter by extensions of up to 1 month
on re-examination by panel of three psychiatrists.
6. **Appeal:** Governed by Soviet administrative law and by the Decree of 12 April 1968 of the Presidium of the Supreme Soviet of the USSR entitled "Procedures for considering proposals, applications, and complaints by citizens". This Decree emphasizes that it is the duty of directors of establishments and officials to receive proposals, applications, and complaints by citizens and that these must be considered within one month, except in cases where further study is needed. Proposals and applications are sent to the bodies and persons to whose immediate sphere of competence decisions regarding the matter in question belong.

Complaints are sent to bodies and persons at a level one step higher than the bodies and persons complained about.

If a proposal, application, or complaint has gone to a body whose terms of reference do not cover the settlement of the questions raised, it must be sent within the five-day period laid down by the law to the correct recipient, and the person who made the said proposal, application, or complaint must be so informed. He must also be informed of any decisions reached.

In the cases envisaged above, applications and complaints by citizens may be sent to a city or rayon people's court for the attention of the public prosecutor.

Section 14 of Chapter II of the Regulations on surveillance by the Public Prosecutor's Office in the USSR, adopted by Decree of the Presidium of the Supreme Soviet of the USSR on 24 May 1955, states that it is the duty of the Public Prosecutor to receive and consider applications and complaints by citizens regarding infringements of the law, check such applications and complaints within the time-limits laid down by the law, and take measures to restore infringed rights and defend the lawful interests of citizens.

Article 126 of the Criminal Code of the Russian Socialist Federated Soviet Republic lays down punishment for unlawful deprivation of liberty. In the Commentary on the Criminal Code of the Russian Socialist Federated Soviet Republic (published by Juridiceskaja Literatura, Moscow, 1971), the following explanations are given with reference to Article 126:

(a) Unlawful deprivation of liberty consists in hindering a person illegally from freely choosing his place of stay or keeping him in a place or in premises in any place against his will.

(b) Unlawful deprivation of liberty may be effected by physical or mental pressure (e.g. the victim... is placed in a hospital for the mentally ill). These provisions of the law give the right to every citizen who is forcibly placed in a psychiatric hospital to bring a criminal action according to the established procedure against the persons who have carried out the hospitalization.

7. **Periodic Review:** All compulsory care patients must be re-examined at least once a month by a panel of three psychiatrists to determine the need for further hospitalization.

8. **Discharge Procedure(s):** If the patient's mental condition improves or the clinical pattern of his illness changes in such a way as to remove any danger to the public, the psychiatric panel must state in writing that the patient can be discharged. Depending on their mental condition such patients are discharged into the care of relatives or guardians, whose agreement must be obtained.

Before the patient is discharged, the administration of the psychiatric institution must ensure that appropriate social and living conditions are going to be provided for him.
If a patient who is to be discharged from hospital on medical grounds is in a condition where he cannot be left alone and he has no permanent domicile or family responsible for looking after him, he may only be discharged from hospital after guardianship has been arranged for him.

The competent neuropsychiatric dispensary is informed of the patient's discharge in good time by the hospital; such patients must be on the dispensary's special register and where necessary undergo regular treatment.

If a discharged patient is in a condition where he cannot care for himself and has no permanent domicile or family responsible for him, he may only be discharged after guardianship has been arranged for him. The provisions concerning the responsibilities of guardians of mentally ill and incompetent persons are very detailed in the USSR.

United Kingdom (England and Wales)

1. **Grounds:** For general involuntary hospitalization, under Section 26 of the 1959 Act, the patient must be found to be suffering from a "mental disorder", being (1) "mental illness" or "severe subnormality" in a patient of any age; or (2) "psychopathic disorder" or "subnormality" in any patient under 21 years, and that said disorder warrants detention for medical treatment, and that it is "necessary" in the interests of the patient's health or safety or for the protection of other persons that the patient should be so detained in a mental hospital.

"Mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind.

"Severe subnormality" means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.

"Subnormality" means a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

"Psychopathic disorder" means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment.

Nothing in the [definition] shall be construed as implying that a person is suffering from a "mental disorder", or any form thereof, by reason only of promiscuity or other immoral conduct.

(The Act does not define the term "mental illness").

2. **Application:** Nearest relative or mental health officer (social worker).

3. **Decision-Making Authority:** Hospital manager.

4. **Medical Certification:** Two medical certificates, one from a medical practitioner with special experience in treatment of mental disorder and approved for such purposes by the Secretary of State. Unless this physician knows the patient, the other should have previous acquaintance with the patient. Both physicians have to specify whether the patient is to be admitted on account
of mental illness, severe subnormality, subnormality, or psychopathic disorder, and to state the clinical basis of their opinion and the reasons why compulsory admission is necessary.

5. **Length of Stay:** One year; renewable at hospital for one year; then renewable for two-year intervals. For psychopathic disorders and subnormality, the patient must be released on reaching 25 years of age.

6. **Appeal:** The patient or someone on his behalf may apply to a Mental Health Review Tribunal (M.H.R.T.) for the Region in which the hospital (or nursing home) is located within six months of his admission requesting discharge; he may appeal to a M.H.R.T. once during each subsequent renewal period.

   If a patient who is suffering from a psychopathic disorder or subnormality is not released before the age of 25, he or his nearest relative can appeal to a M.H.R.T. within 28 days of reaching that age.

   If the nearest relative requests the discharge of the patient and this is refused by the hospital, the relative can appeal to a M.H.R.T. within 28 days of receiving notice of the refusal to discharge.

   If the patient's diagnostic category under the Act is changed by the hospital, he or the nearest relative can appeal against the reclassification to a M.H.R.T. within 28 days of receiving notice of the reclassification.

   If a patient is transferred from guardianship into hospital, he may apply to a M.H.R.T. within six months of his admission to the hospital.

   A writ of *habeas corpus* can also be filed with an appropriate court petitioning for review of the legality of the detention. It is reported, however, that the court would only act if it can be established that there has been a legal error or improper procedure which appears on the face of the admission papers themselves or in the opinions or recommendations of the committing parties or medical practitioners.

   A M.H.R.T. must be appointed for each of the 15 Regional Health Authorities in the National Health Service. The composition of the tribunals is not set out in the Act but is dealt with in the First Schedule to regulations made under the Act. Each tribunal consists of one or more persons drawn from each of three groups of members, as follows: (a) legal members as appointed by the Lord Chancellor; (b) medical-practitioner members as appointed by the Lord Chancellor after consultation with the Health Minister; and (c) lay members having experience in administration, or social service, or such other qualifications or experience as the Lord Chancellor considers suitable. The medical member must conduct a mental examination of the appealing patient prior to the hearing on his case. The legal member presides at the hearing. There are detailed Rules of Procedure for the conduct of proceedings of the tribunals.

   The decisions of a M.H.R.T. are final on the facts of the case, including the determination of the mental condition of the patient and his need for detention. Decisions can, however, be appealed to the higher courts on matters of law. (Such appeals have been very uncommon.)

7. **Periodic Review:** See 5 above.

8. **Discharge Procedure(s):** The hospital manager or the responsible medical officer (R.M.O.) of the patient can discharge an involuntary patient at any time. The nearest relative can request the discharge of such a patient at any time with 72 hours' notice to the hospital. Within the 72-hour period, the R.M.O. may refuse the discharge by certifying to the hospital manager that the patient would be likely to act in a manner dangerous to himself
or others if released. The nearest relative can appeal against the refusal to a M.H.R.T., as indicated above.

United States of America (Indiana)

1. **Grounds:** A "mentally ill person" who is "gravely disabled" or "dangerous". "Mental illness" means a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behaviour and impairs the person's ability to function. For the purposes of the Act, "mental illness" may include, but shall not be limited to, any mental retardation, epilepsy, alcoholism, or addiction to narcotics or dangerous drugs.

   "Gravely disabled" means a condition in which a person as a result of mental illness is in danger of coming to harm because of his inability to provide for his food, clothing, shelter, or other essential human needs.

   "Dangerous" means a condition in which a person as a result of mental illness presents a substantial risk that he will harm himself or others.

   There are two procedures, as follows:

   (a) Temporary commitment: grounds as above.

   (b) Indefinite commitment: person who appears to be suffering from a chronic mental illness and reasonably expected to require custody, care, and treatment for a period exceeding 90 days.

2. **Application:**

   (a) Temporary commitment: upon request of the superintendent of a hospital for a voluntary patient who requests and is refused release; by order of court having jurisdiction of the person; or by a written petition to a local court by a health officer, police officer, a friend, relative, spouse, or guardian of the person, or the superintendent of the hospital.

   (b) Indefinite commitment: by a written petition to a local court as above (same petitioners).

3. **Decision-Making Authority:** Local court. However, the superintendent of the mental health facility must be satisfied that adequate space and treatment staff appropriate to the needs of the patient are available.

4. **Medical Certification:**

   (a) Temporary commitment: one physician's certificate. The court may also appoint a physician to examine the person and report on his findings prior to a hearing on the petition.

   (b) Indefinite commitment: one physician's certificate.

5. **Length of Stay:**

   (a) Temporary commitment: court order cannot exceed 90 days. The superintendent may request the court to grant a renewal of the temporary commitment for another 90-day period. The court must hold a hearing on the renewal. At the end of the renewal period, the superintendent may request the court to grant an indefinite commitment under the procedures for such commitments. The court must also, in the original commitment, require the superintendent, or the attending physician of the patient, to file with the court a treatment plan for the patient within 15 days of the admission.

   (b) Indefinite commitment: The order of commitment is indefinite, but see "Periodic Review".
6. Appeal: No specific provision.

7. Periodic Review:
   (a) Temporary commitment: not provided, but period is automatically limited as described above.
   (b) Indefinite commitment: the superintendent, or the attending physician of the patient, must file at least annually, or oftener if ordered by the court, a report to the court on the mental condition of the patient and on the existence of the grounds for commitment as stated above, or whether the patient may be cared for under a guardianship. Upon receipt of the report, the court is to order the commitment continued, or terminate the commitment and discharge the patient. The court may, in order to make provision for the patient's continued care, appoint a guardian. If the court orders a further commitment, the patient may appeal to the court for a hearing. Only one such hearing may be requested in any year, unless the court determines that good cause exists for an additional review.

8. Discharge Procedure(s): The superintendent, or the attending physician of the patient, may discharge either class of patients at any time during their hospitalization. A report must be made to the court, which must then issue an order terminating the commitment.

United States of America (Massachusetts)

1. Grounds: Failure to hospitalize would create likelihood of serious harm by reason of mental illness.

   "Likelihood of serious harm" means (a) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (b) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behaviour or evidence that others are placed in reasonable fear of violent behaviour and serious physical harm to them; or (c) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

2. Application: To a local court by an "applicant" (not specified, but can be defined by Department of Mental Health regulations), or by superintendent of mental health facility for voluntary patient who is refused discharge.

   The Act authorizes the Department of Mental Health to make regulations to provide procedures for the examination, reception, restraint, treatment, and discharge of patients. Different procedures may be provided for different types of patients (mentally ill, mentally retarded, etc.) and different facilities.

3. Decision-Making Authority: Local district court.

4. Medical Certification: Court may order an independent medical examination. Hearing may be at hospital with patient present if judge so determines.

5. Length of Stay: First court order cannot exceed six months; one year on subsequent commitments. Patient is entitled to a court hearing on request for each extension of commitment.

6. Appeal: To Appellate Division of the District Court.
7. **Periodic Review**: Required to take place at least on admission of the patient, once during the first three months, once during the second three months, and annually thereafter. Also, the patient must be given a physical examination at least once in every 12-month period of detention.

The periodic examination must include, but need not be limited to (1) a thorough clinical mental examination, (2) an evaluation of the legal competency of the person and the necessity or advisability of having a guardian or conservator appointed or removed, and (3) a consideration of all possible alternatives to continued hospitalization or residential care (for retarded persons) including, but not necessarily limited to, a determination of the person's relationship to the community and to his family, or of his employment possibilities, and of available community resources, foster care, and convalescent facilities. The social service department of the hospital is to take part in the review and may utilize community resources, including the area and regional community health and mental retardation programmes throughout the State of Massachusetts. A subsequently adopted programme of mental health advisors (or attorneys) is also now available to advise patients on commitment and periodic review. The programme provides attorneys to represent patients and retarded residents in matters concerning their hospitalization, including court appearances at hearings.

8. **Discharge Procedure(s)**: The superintendent of a mental health facility may release an involuntary patient at any time. A decision on discharge or continued hospitalization is required at each periodic review, as described above.

**Uruguay**

1. **Grounds**: Patient dangerous to himself or others.
2. **Application**: By spouse, relative, legal representative (for child or incompetent), or interested party.
3. **Decision-Making Authority**: Judicial authority or action by police or public assistance bodies.
4. **Medical Certification**: Certificate of mental disability signed by two medical practitioners.
5. **Length of Stay**: Indefinite.
6. **Appeal**: The hospital must notify the General Supervisory Board within 24 hours of the admission. The patient may appeal against his detention to the General Supervisory Board.
7. **Periodic Review**: Not required.
8. **Discharge Procedure(s)**: The superintendent of the mental hospital may discharge a patient at any time. Also, the relatives or legal representative of a patient may request the discharge of an involuntary patient when he is no longer dangerous to himself or others.

### 4.3 Emergency hospitalization

(Only those countries with specific legal provision for emergency hospitalization are included.)

**Brazil**

1. **Period**: Not stated.
2. **Grounds:** In the interest of the patient or public security.
3. **Application:** On presentation to the hospital with a certificate of identity.
4. **Medical Certification:** One physician.

**Canada (British Columbia)**

1. **Period:** Not to exceed 72 hours.
2. **Grounds:** There are three procedures, as follows:
   
   (a) Police officer: when a police officer or constable is satisfied on his own observation that a person is apparently suffering from mental disorder and is likely to endanger his own safety or that of others, he can take him into custody and forthwith bring him to a physician for examination.
   
   (b) Magistrate or judge: when use of regular procedures would involve dangerous delay.
   
   (c) One-physician certificate: when only one physician is available for an involuntary commitment procedure for which two certificates are usually required, the patient may be accepted for admission at the hospital, but only for a period not exceeding 72 hours. (Emergency grounds are not actually required in the statute, but this procedure is classified in the statute books as an "emergency admission".)
3. **Application:** As stated above.
4. **Medical Certification:**
   
   (a) Police officer: one physician.
   
   (b) Magistrate or judge: not required.
   
   (c) One physician: as stated.

**Cyprus**

1. **Period:** 72 hours.
2. **Grounds:** Necessary for the public safety or for the welfare of the person alleged to be of unsound mind. Also, a police officer finding a person "wandering at large", and whom he has reason to believe is of unsound mind and dangerous, can immediately apprehend the person and take him before a court to be dealt with.
3. **Application:** By a medical officer or a police officer not below the rank of Inspector, to hospitalize the person immediately in an observation ward or hospital designated by the Director of Medical Services.
4. **Medical Certification:** Not required.

**Fiji**

1. **Period:** There are two procedures, as follows:
   
   (a) Hospital-determined: 24 hours.
   
   (b) Magistrate's Order: seven days.
2. **Grounds:**
   
   (a) Hospital-determined: emergency need.
   
   (b) Magistrate's Order: expedient either for the welfare of a person alleged or supposed to be of unsound mind or for the public safety.
3. Application:
   (a) Hospital-determined: not stated.
   (b) Magistrate's Order: on application of spouse, relative, or police officer.
4. Medical Certification: Not required.

France

1. Period: 24 hours.
2. Grounds: Imminent danger to the patient.
3. Application: Order of detention by the police or the mayor of the town.
4. Medical Certification: The order can be based on a medical certificate signed by one physician. In an emergency and in the case of "public notoriety", no medical certificate is required. The hospital must report to the Prefecture of Police within 24 hours of admission and either release the patient or seek further orders of hospitalization.

Ghana

Note: The following procedure for emergency admission is that under the Ordinance of 1888, Section 18. No change is intended in this procedure under the Draft Law of 1971.

1. Period: Not exceeding 14 days.
2. Grounds: Expedient either for the welfare of the person or for the public safety.
3. Application: Certificate of urgency signed by a medical officer and filed with a magistrate. Hospitalization is on order of the magistrate.
4. Medical Certification: By medical officer as above.

Iraq

Note: The current system is informal. The procedure outlined below is that suggested in the Draft Act now under consideration.

1. Period: 72 hours.
2. Grounds: Acute or urgent cases.
3. Application: By a general practitioner or the physician in charge of treatment. Written consent of the patient's family is also required.

Japan

1. Period: 48 hours.
2. Grounds: Liable to injure himself or others.
3. Application: By order of Governor of Prefecture.
4. Medical Certification: One medical examiner.

Lesotho

1. Period: 48 hours.
2. Grounds: Urgency, when responsible relative is not available to care for the patient.
3. **Application**: Any adult may petition the District Commissioner to hospitalize the patient on urgent basis.

4. **Medical Certification**: A medical practitioner may bring the petition or recommend the hospitalization.

**Malaysia**

*Note*: One emergency procedure is noted herein, but three other temporary care procedures are listed under 4.4 which could be utilized in urgent cases.

1. **Period**: Seven days; renewal for three months.
2. **Grounds**: Expedient either for the welfare of a person alleged to be mentally disordered or for the public safety.
3. **Application**: By the spouse, a relative, or a police officer to a magistrate. Hospitalization on urgency order by the magistrate.
4. **Medical Certification**: One medical practitioner.

**Nigeria**

1. **Period**: Not to exceed seven days.
2. **Grounds**: Expedient that a lunatic be placed under observation in an asylum.
3. **Application**: Certificate of emergency signed by a medical officer and filed with a magistrate.
4. **Medical Certification**: Medical officer as above.

**Norway**

1. **Period**: Three weeks.
2. **Grounds**: Emergency.
3. **Application**: Written request for admission giving medical information to physician in charge of hospital; can be arranged by telephone in advance.
4. **Medical Certification**: See 3 above.

**Peru**

1. **Period**: Not to exceed 10 days.
2. **Grounds**: Emergency, or when delay in completing formal admission may be detrimental to the patient or dangerous to those living with him.
3. **Application**: Admission approved by superintendent of the hospital. Within the 10 days, the normal procedures for admission must be completed. (See under 4.2.)
4. **Medical Certification**: Not required.

**Romania**

1. **Period**: Five days.
2. **Grounds**: Urgent cases.
3. **Application**: By health authorities on the advice of a psychiatrist. Admission is on a provisional basis with notice to the Chief Public Prosecutor within
24 hours of admission. The medical board of the hospital must report to the chief public prosecutor on the condition of the patient within the five-day period.


**Senegal**

2. *Grounds*: Extreme agitation or serious depression of the patient or when the patient refuses necessary treatment.
3. *Application*: By parents or people living with the patient, or by the police.

**Switzerland (Basel-Stadt)**

1. *Period*: 24 hours.
2. *Grounds*: Urgent or acute cases where there is immediate danger to the patient and his immediate surroundings.
3. *Application*: To the hospital superintendent.

**Switzerland (Geneva)**

1. *Period*: 48 hours.
2. *Grounds*: There are two procedures, as follows:
   (a) Hospital authorization: in cases of emergency where delay could be detrimental to the patient or where there is obvious danger to the public security.
   (b) Health Department authorization: in cases of emergency, or obvious neglect of or danger to the patient.
3. *Application*:
   (a) Hospital authorization: admission by hospital director.
   (b) Health Department authorization: admission authorized by Health Department.
4. *Medical Certification*: One physician. Where the hospital director authorizes the admission, the case must be reported to the Health Department within the 24-hour period. Further hospitalization must follow usual procedures for voluntary or involuntary admission.

**Trinidad and Tobago**

1. *Period*: 24 hours.
2. *Grounds*: Person is mentally ill and in the interest of his health and for the safety and protection of others ought to be detained in hospital.
4. *Medical Certification*: One medical certificate other than from medical officer in charge of admissions at the hospital.
**Union of Soviet Socialist Republics**

*Note:* As indicated under 4.2, the Regulations on psychiatric hospitals provide for emergency hospitalization under the general framework of "immediate hospitalization". The provisions of special relevance to emergencies are described here.

1. **Period:** Patient must be examined by panel of three psychiatrists within 24 hours of admission.

2. **Grounds:** Where a patient's mental activity is acutely impaired, he may be sent for inpatient treatment with the agreement of his relatives as an emergency psychiatric care measure. In cases in which the patient or his relatives do not agree to his being placed in a psychiatric hospital, the instructions in force on the immediate hospitalization of psychiatric patients who constitute a public danger are put into application (see under 4.2.)

3. **Application:** In urgent cases, patients may be accepted for emergency treatment without referral by a duty physician. Also, public health authorities can order immediate hospitalization of a patient without the agreement of the patient's relatives or guardians or other persons close to them when patients constitute a public danger, or whenever they are clearly a danger to themselves or those around them.

   Medical workers immediately carry out emergency hospitalization when directed to do so by the psychiatrists whom the health authorities have made responsible for placing patients in psychiatric hospitals (emergency care doctors in neuropsychiatric dispensaries, etc.).

   In case of emergency admission to hospital, the doctor sending the patient is bound by law to set out in detail the medical and social grounds for emergency admission, giving at the end of the statement his place of work, the post he holds, his name, and the time at which the patient was sent to hospital.

   The local police authorities are required to assist medical workers, whenever requested, in the emergency hospitalization of mental patients who constitute a public danger.

4. **Medical Certification:** See 3 above.

**United Kingdom (England and Wales)**

1. **Period:** 72 hours.

2. **Grounds:** There are three procedures, as follows:
   
   (a) General: urgent necessity.

   (b) Neglected person: person who is mentally disordered and being ill-treated or neglected or is living alone.

   (c) Public place: person appears to be mentally disordered in a public place and in need of immediate care and control, in the interests of that person or for the protection of others.

3. **Application:**
   
   (a) General: any relative or a mental health officer (social worker).

   (b) Neglected person: on information by mental health officer.

   (c) Public place: a police officer may detain person and take him to a place of safety or to a mental hospital.
4. Medical Certification:
   (a) General: one physician.
   (b) Neglected person: not required.
   (c) Public place: police officer must take person to be examined by a medical practitioner and to be interviewed by a mental health officer to make proper arrangements for hospitalization.

United States of America (Indiana)

1. Period: 72 hours.
2. Grounds: Person is mentally ill and dangerous and in need of immediate treatment.
3. Application: By a police officer, health officer, or other person. Report to local court within 72-hour period.
4. Medical Certification: At least one physician.

United States of America (Massachusetts)

1. Period: 10 days.
2. Grounds: Likelihood of serious harm.
3. Application: By a physician, or, when not available, by a police officer. Any persons brought for emergency admission under this provision must first be given the opportunity to apply for voluntary admission if they wish to do so.
4. Medical Certification: One physician as above. When person refuses examination, the physician may make the application based on facts known at the time. If the application is made by a physician designated by the Department of Mental Health, the patient is admitted without delay. If not, the hospital must conduct an examination prior to admission. The hospital examination must be conducted by a physician so authorized by the Department of Mental Health.

Uruguay

1. Period: 24 hours.
2. Grounds: Condition of insanity dangerous for public security or for the patient himself.
3. Application: Admission by superintendent of the mental hospital. Within the 24-hour period, the superintendent must report the admission to the General Inspector of Psychiatry (the report must be accompanied by a medical certificate).
4. Medical Certification: See 3 above.

4.4 Observational hospitalization

(Only those countries or jurisdictions with specific legal provision for admission to hospital for observation are included.)

Australia (South Australia)

1. Period: There are two procedures, as follows:
   (a) General observation: two months; renewable for a period not exceeding four months.
   (b) Court remand: 30 days; renewable for a period not exceeding six months.
2. **Grounds:**
   
   (a) General observation: for observation and treatment of patient.
   
   (b) Court remand: advisable to remand.

3. **Application:**
   
   (a) General observation: upon request of the patient or other person to the superintendent.
   
   (b) Court remand: a justice or justices directing the person to be removed and received.

4. **Medical Certification:**
   
   (a) General observation: one physician. After reception, the patient is examined by the superintendent without delay and is released if not mentally defective. If the patient is mentally defective, he can be retained in the receiving ward for up to four months, or the superintendent can transfer the patient to a mental hospital.
   
   (b) Court remand: one physician. Report to the court within 30 days by superintendent.

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**Australia (Victoria)**

1. **Period:** 21 days; renewable up to six months.

2. **Grounds:** Patient for observation.

3. **Application:** On request of some person.

4. **Medical Certification:** One physician. During observational period, the superintendent must examine the patient and discharge him if he is not mentally ill; or he may authorize detention and treatment for a period not exceeding six months; or, after an examination and report by a medical practitioner, the superintendent may order that the patient be transferred to indefinite involuntary status in the mental hospital.

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**Egypt**

1. **Period:** Up to eight days.

2. **Grounds:** Observation of a person alleged to be mentally ill.

3. **Application:** Not stated.

4. **Medical Certification:** Medical examination within 24 hours of admission; if medical officer cannot give definite diagnosis, the patient must be placed in a general hospital. The patient receives a daily medical examination. The patient may be transferred to indefinite hospitalization when the medical officer signs a medical certificate stating that the patient is mentally ill and in need of treatment.

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**Iraq (draft law)**

1. **Period:** Two weeks.

2. **Grounds:** When patient's condition requires further study in hospital.

3. **Application:** By medical committee recommendation to the local court.

4. **Medical Certification:** Medical committee.
Japan
1. **Period:** Three weeks.
2. **Grounds:** When hospital administrator believes longer period is necessary for diagnosis of the mental illness of the patient.
3. **Application:** Hospital administrator to Governor of Prefecture. The consent of the spouse, guardian, or person responsible for the patient must also be obtained.
4. **Medical Certification:** Not required except as above. The hospital administrator must also report on the condition of the patient to the Governor of Prefecture within 10 days of the observational admission.

Lesotho
1. **Period:** Not exceeding 21 days; renewable for seven-day periods but not exceeding six weeks altogether.
2. **Grounds:** Same as for involuntary hospitalization.
3. **Application:** By responsible relative to District Commissioner.
4. **Medical Certification:** One medical recommendation.

Malaysia
1. **Period:** There are three procedures, as follows:
   (a) Inquiry: one month.
   (b) Person at large: 14 days.
   (c) Public safety: three days.
2. **Grounds:**
   (a) Inquiry: on information and inquiry as to whether person is or is not of unsound mind.
   (b) Person at large: person suspected of being mentally disordered and found wandering at large, or to be dangerous, neglected, or ill-treated.
   (c) Public safety: person alleged to be of unsound mind and a danger to the public safety or public welfare.
3. **Application:**
   (a) Inquiry: on information to the local court.
   (b) Person at large: order of detention signed by a medical officer.
   (c) Public safety: removal to the mental hospital by a police officer or medical officer.
4. **Medical Certification:**
   (a) Inquiry: not required.
   (b) Person at large: medical officer as above.
   (c) Public safety: not required.

Peru
1. **Period:** Not exceeding 30 days.
2. **Grounds:** Not stated.
3. **Application:** By the patient to a special admission and observation service under direction of the superintendent of the mental hospital.

4. **Medical Certification:** Not required. After observation, the patient may be discharged or transferred to the appropriate service in the hospital.

**Saudi Arabia (draft law)**

1. **Period:** Eight days.
2. **Grounds:** When the physician has been unable to decide definitely whether the patient is suffering from a mental disease.
3. **Application:** By transfer order of a government physician in a hospital which is not a mental hospital.
4. **Medical Certification:** Government physician as above. The patient must be examined each day during the observational period and at end of period either released or recommended for confinement.

**Syrian Arab Republic**

*Note:* Under the Regulations governing mental hospitals, involuntary hospitalization may be for an indefinite period or for observation. Observational admission is usually limited to certain detained or accused persons sent by the courts to the hospital for evaluation in criminal cases. See Article 3(b) of Instruction No. 1 of 17 January 1965. No time limit is specified for the observation.

**Trinidad and Tobago**

1. **Period:** Not exceeding 14 days. (See also mental health officer admissions for 72 hours listed under 4.2.)
2. **Grounds:** None required.
3. **Application:** Order of judge or magistrate.
4. **Medical Certification:** None required; as soon as practicable after admission, hospital director must make such examination as he deems necessary to determine if person is mentally ill and in need of care and treatment and report to the court.

**United Kingdom (England and Wales)**

1. **Period:** Not to exceed 28 days.
2. **Grounds:** Patient is suffering from a mental disorder and "ought to be detained" for his own health or safety or for the safety of other persons.
3. **Application:** By nearest relative or mental health officer (social worker) to the head of the hospital.
4. **Medical Certification:** Two medical practitioners, one of whom must have specialized knowledge in mental disorders and be on list approved by Secretary of State.
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Legislation

**Australia**

*South Australia*

The Mental Health Act, 1935-1974

*Victoria*

The Mental Health Act 1959 (*IDHL*, 1963, 14, 236)

**Benin**

Law of 30 June 1838 on lunatics

**Brazil**

Decree No. 24559 of 3 July 1934 containing provisions on the care and protection of the person and possessions of mentally ill persons, as amended in 1961 and 1974

**Canada**

*Alberta*

The Mental Health Act, 1972 (*IDHL*, 1974, 25, 48)

*British Columbia*

The Mental Health Act, 1964 (*IDHL*, 1965, 16, 48), as amended by the Mental Health (Amendment) Act, 1968 (*IDHL*, 1969, 20, 401) and an Act dated 7 November 1973 (*IDHL*, 1975, 26, 275) (the title of the Act is now the "Mental Health Act")

**Costa Rica**


**Cyprus**

The Mental Patients Law. Dated 29 May 1931

**Democratic Yemen**

Aden Laws, Chapter 87

The Lunacy Ordinance. Dated 20 July 1938

**Denmark**

Law of 1933 on public assistance

Law No. 118 of 13 April 1938 on the hospitalization of mentally ill persons

Order No. 229 of 9 September 1957 relating to State mental hospitals, in particular admission of patients and hospitalization charges (*IDHL*, 1958, 9, 691)

Law No. 190 of 5 June 1959 relating to State hospitals for the treatment of persons suffering from mental disorders and to psychiatric departments (*IDHL*, 1960, 11, 633)

Law No. 192 of 5 June 1959 relating to the care of mental defectives and of other severely subnormal persons (*ibid.*)

**Egypt**

The Mental Health Act (No. 141) of 1944

**Ethiopia**

**Fiji**

The Mental Treatment Ordinance (dated 28 February 1940), as amended by the Mental Treatment (Amendment) Ordinance, 1964 (*IDHL*, 1968, 19, 189)

The Mental Treatment Ordinance, 1967

**France**

Law of 30 June 1838 on lunatics

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*a* This Law was promulgated under French rule.

*b* This Law was repealed as of 1 April 1976.

*c* Reference is made to a "Draft Law".
Circular of 15 March 1960 concerning the programme for the organization of and the development of an infrastructure for the control of mental diseases at the département level

Circular of 15 March 1960 concerning the master plan for old psychiatric hospitals

Circular No. 148 of 18 January 1971 concerning the control of mental diseases and the development of a health chart in the psychiatric field

Circular of 14 March 1972 concerning the regulations of the départements for the control of mental diseases, alcoholism, and drug dependence

**Ghana**

The Lunatic Asylums Ordinance, 1888

The Mental Health Decree (No. 30) of 1972

**India**

The Indian Lunacy Act, 1912

**Iraq**

**Japan**

The Mental Hygiene Law (No. 123) of 1 May 1950 (IDHL, 1952, 3, 341), as amended

**Lesotho**

The Mental Health Law, 1963

**Malaysia**

The Mental Disorders Ordinance, 1952

**Mauritius**

The Mental Health Law, 1858

The Lunacy Ordinance, 1906

**Nigeria**

The Lunacy Law. Dated 21 December 1916

Laws of Nigeria, Chapter 121. An Ordinance to provide for the custody and removal of lunatics

**Norway**

Law No. 2 of 28 April 1961 on psychiatric care (IDHL, 1962, 13, 745)

**Pakistan**

The Lunacy Act, 1912

**Peru**

Executive Decree of 14 October 1952 prescribing regulations on mental health pursuant to Law No. 11272 (IDHL, 1955, 6, 274)

Supreme Resolution No. 194-DGS of 18 September 1963 to amend Chapters 1 and 2 of the Regulations on mental health at present in force (IDHL, 1965, 16, 169)

**Poland**

Instruction No. 120/52 of the Ministry of Health of 10 December 1952

**Romania**

Decree No. 246 of 1958

Ordinance No. 1005 of 1958 of the Ministry of Health

Decree No. 12 of 25 January 1965 concerning the medical care of dangerous mental patients (IDHL, 1966, 17, 140)

Ordinance No. 126 of 1972 of the Ministry of Health

Ordinance No. 74 of 1973 of the Ministry of Health

**Saudi Arabia**

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\(a\) The Mental Health Act, 1971 was promulgated as a Decree on 22 February 1972 (note added in proof).

\(b\) Reference is made to a "Draft Law".

\(c\) Reference is also made to a new enactment on mental health, apparently promulgated around 1965, but which has evidently not yet entered into force.

\(d\) Reference is made to a "Draft Law".
Senegal

Law No. 75-80 of 9 July 1975 concerning the treatment of mental diseases and conditions for the commitment of certain categories of the mentally ill (IDHL, 1976, 27, 833)

Sudan

Public Health Law of 1975

Switzerland

*Basel-Stadt*

Law of 21 December 1961 on the hospitalization of mentally ill persons

*Geneva*

Law of 14 March 1936 on provisions governing persons suffering from mental disease

Syrian Arab Republic

Decree No. 687 of 12 May 1954
Regulations of 17 January 1965
Instruction No. 1 of 17 January 1965

Trinidad and Tobago

The Mental Health Act, 1975 (IDHL, 1976, 27, 874)

United Kingdom (England and Wales)

The Lunacy Act 1890
The Mental Treatment Act 1930
The Mental Health Act 1959 (IDHL, 1961, 12, 207)

United Republic of Tanzania

The Mental Disease Ordinance, 1958

Uruguay

Law No. 9581 of 8 August 1936

United States of America

*Federal*

The Mental Retardation Facilities and Community Health Centers Construction Act of 1963 (Public Law 88-164, approved 31 October 1963)
The Uniform Alcoholism and Intoxication Treatment Act, 1971

Indiana

Indiana Code, Chapter 9, Sec. 2
An Act (Public Law 158, approved April 16, 1973) to amend IC 1971, 16-14 concerning Health and Hospitals, by adding a new chapter concerning the rights of persons in psychiatric hospitals and IC 1971, 35-29 by adding a new chapter concerning abuse of the mentally ill (IDHL, 1976, 27, 900)
An Act (Public Law 154, approved April 21, 1975) to amend IC 1971, 16-14 and IC 1971, 35-5 concerning care and treatment of mentally ill persons (IDHL, 1976, 27, 904)

Massachusetts

Massachusetts General Laws, Chapter 123
Laws of 1970, Chapter 888

Reference is made to a "Draft Act for Hospitalization of the Mentally Ill", first drawn up by the Federal Government in 1952.
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