

Report of the UEMS Section for Psychiatry

PSYCHIATRIC LEGISLATION IN EUROPE 1998

The statement of purpose

The report was produced to provide an outline of differences in mental health legislation across Europe to facilitate free movement of psychiatrists in Europe. It is important to note that there might be some unavoidable mistakes due to national diversities in various member states.

Background

In 1993, sixteen member states of the UEMS-Section of Psychiatry completed a questionnaire concerning legislation for compulsory admission and other compulsory acts in psychiatry. Forensic admissions resulting from criminal behaviour were not included. The survey showed that there was great variation both in legislation of different member states and in the way these were applied from country to country. The European states thus seemed far away from harmonisation of psychiatric legislation.

The same questionnaire was again completed by the delegates of the member states in 1999 (in respect of year 1998). The same 16 member states participated (Luxembourg did not answer, however, Luxembourg has legislation resembling that of Belgium). Since 1993, several European countries had joined, either as associate member states of UEMS-Section, or as observer states. Nine of these "new" states also completed the questionnaire. Thus, in total 25 European states participated in the survey.

It is also worth noting that:

- Each of the 16 German states has its own law. The description in this paper is of the 1985 law from Nordrhein – Westfallen.
- In Switzerland, there is basic Swiss federation legislation. Every canton has its own supplementary law – These latter supplementary laws are not described.
- In the United Kingdom, there are different mental health acts in England, Scotland, and Northern Ireland. This report reflects the Mental Health Act in England and Wales.

Participating states

The following states participated in both 1993 and 1998:

Belgium – B, Denmark – DK, France – F, Germany – D, Greece – EA, Ireland – IRE, Italy – I, Netherlands – NL, Portugal – P, Spain – E, United Kingdom – UK, Finland – FIN, Norway – N, Sweden – S, Switzerland – CH, Austria – A

These states participated only in 1998:

Croatia – CRO, Cyprus – CY, Czech Republic – CZR, Estonia – EST, Hungary – H, Malta – MA, Poland – PL, Slovak Republic – SLR, Slovenia – SLO

Age of the law

The French law dates back to 1838 (the very first in the world), but it has been revised several times in the last century. The laws from the other countries ranged in age from 1945 (IRE) to 1999. Fourteen of the 25 participating states had their psychiatric laws revised in the period after 1993. DK, P, N, NL and SLO revised their laws in 1999 and S in 2000. The law in Malta was enacted 1976, implemented 1981 and is currently being revised. The eight other “new” states have laws ranging from 1993 to 1999.

Criteria for compulsory admission (commitment)

Besides having mental illness as a criterion for compulsory admission, all states except Italy and Finland required the criterion that the patient may only be committed to hospital, if he is an acute **danger to himself and/or others**. Sixteen states accepted the criterion that a patient may be committed, if there is a **danger to his health**, whereas nine states (E, B, S, A, D, NL, H, CZR, EST) did not accept this criterion. In Poland it was the Guardianship Court that decided on commitment, on the grounds that failure to admit would cause deterioration in mental health. Only two member states (Ireland and Cyprus) accepted the criterion that a person may be committed, if his behaviour is not acceptable to the community.

Regarding the type of psychiatric illness required for a person to be committed, nine states did not specify, but used the term “mental disorder” (PL, E, UK, EA, MA, EST, CRO, P, NL).

In 23 states the psychiatrists specified psychosis in the type of psychiatric illness required for commitment to take place. Specification of the actual mental disease varied, e.g. in Denmark only people with a psychosis or a mental state equivalent to a psychosis may be subjected to coercive measures. Besides the states not specifying “mental disorder”, nine states (B, F, IRE, D, CH, H, SLO, CZR, SLR) recognised alcoholism or some other kind of addiction as a criterion for compulsory admission.

A patient admitted voluntarily to a psychiatric ward could only be subsequently detained in 18 of the 25 states whereas this could not be done in I, B, N, NL, CRO, SLR. In some states the detention could last only a few days, and only after decision by a judge.

In some countries, mental retardation was considered to be a psychiatric illness, and described in the laws as an acceptable criterion for compulsory placement in a psychiatric hospital. The questionnaire did not ask about mental retardation, since the focus of the questionnaire was admission to a psychiatric department/hospital for therapeutic reasons, and not placement of incurable mentally disordered people for non-medical reasons. In Poland, compulsory admission of mentally retarded can take place (however, the reason for admission would not be retardation as such, but psychotic and behavioural features, e.g. aggression).

Other compulsory acts described in the law

Only 7 out of 25 states did not describe other compulsory acts in their law. This was an improvement compared to 1993, where nine of 16 states failed to mention other compulsory acts.

In 18 states, medication was mentioned, and in some states seclusion, restraint and other methods of compulsion for therapeutic reasons were listed in the laws. Several of the laws were unclear and non-specific in this area. The eight states with no specification were: B, EA, E, H, CH, SLO, MA and SLR.

Decision for compulsory admission

In most of the European states, the responsibility for deciding commitment rests with the medical authorities. In 19 states a medical doctor must examine the patient, decide and apply for commitment. In some countries the physician must be a psychiatrist, and in some countries two independent physicians are required. Only in FIN, EST, CRO, IRE, and A may the doctors decide on commitment without reference to another authority, although in Austria, a “patient’s advocate” must review the commitment and report to the Court within four days.

In both Finland and France, three doctors (psychiatrists) must agree that compulsory admission is necessary, whilst in France they must submit certificates for admission. In 16 states a judge must confirm the commitment, before it can take place, and in Italy the responsibility for commitment lies with the local health authority. In some countries it is the next of kin who should alert the attention of the authorities to the patient’s mental illness and need for admission. However, in no country was the next of kin responsible for the commitment?

Appeals (complaints) procedures – commitments

In seven states the appeal goes to the court, in eight states to a judge or a judiciary person, and in ten states to another institution, e.g. a mental health review tribunal (UK and MA) or the Ministry of Health (IRE). In 17 states the patient will get a reply to the appeal within two weeks whereas in eight states it can take more than two weeks. In two states (D and F), the patient will get a reply within 24 hours. The maximum time limit for getting a reply following an appeal was not specified in all countries, and statistics were not available.

Appeals (complaints) procedures – other compulsory acts

Appeals regarding other compulsory acts were referred to the court in seven states, to a judge in seven states, and to other special persons e.g. hospital directors, boards or commissions, in the remainder of states. Since other compulsory acts were not specified in several countries’ laws, it follows that in such countries there was no specified appeals procedure. In some countries the appeals procedure varied depending on the nature of the compulsory act. The time lapse for a reply to be obtained varied between one day and “lifelong”, and for some states the variation in time lapse was not known. In 13 states the patient would wait less than 15 days, including ten states (I, B, F, DK, A, IRE, NL, CH, H, SLR), where the wait was less than seven days. Comparing to the survey in 1993, the time lapse had diminished in several countries, possibly because, when their laws were revised, there had been established a description of appeals procedures with stipulated time limits.

Duration of involuntarily detention

In 12 states there were no replies to this question, possibly because the relevant statistics were not available. The average number of days of involuntarily detention in hospital ranged from one (D) to 73 (FIN) in the states where statistics were available, and the maximum ranged from 90 to 730 days. In nine countries (F, I, S, UK, DK, IRE, D, MA and NL), it was possible to keep the patient in hospital “lifelong”. In some of these countries the power of the compulsory detention was renewed at stipulated intervals by a judge or some other judiciary system.

Proportion of compulsory admissions as compared to all admissions

As happened with the 1993 survey, it was difficult to obtain precise data regarding the percentage of compulsory admissions in relation to total admissions in each member state.

It is well known that in the last 15 years the number of psychiatric beds has diminished dramatically in most of the European states. In the same period, the average length of hospitalisation has also

decreased because many patients are treated in out-patient settings. The number of annual admissions has been more constant, because of revolving patients with several short admissions.

In six member states there were no data available. In the remainder, the percentage of compulsory admissions was a median of 11%, with a range of 2.3% (EST) to 80% (EA). The states with 11% or less compulsory admissions were: B, UK, F, DK, IRE, D, NL, CH, H, PL, SLO, CZR, SLR, and EST.

Conclusion

During the nineties the European states seem to have had great interest in either revising or drafting new legislation regarding compulsory admissions and other compulsory acts in psychiatry. The data presented reflect the situation in the European states in 1998. If the revision of laws carried out in 1999 are included, 18 out of 25 states have laws dating back to 1990. Only France, Italy, United Kingdom, Ireland, Germany, Switzerland, and Malta have older laws. With reference to Germany and Switzerland, several of the local states have newer and more specified revisions, whilst in Italy local bylaws exist.

There is a continuing interest in revision of such laws. Norway has, in its 1999 revision, included mandatory out-patient treatment (community treatment), which is also an issue under discussion in other European states, currently in the process of changing their laws.

Between 1993 and 1998 several of the states have specified appeals procedures for other compulsory acts, and also stipulated time limits for patients to receive a reply. States have very seldom included in their legislation a clause on the minimum standard of hospital facilities that must be provided to patients compulsorily detained in psychiatric establishments.

The survey reveals that unfortunately, drafted legislation and its application in reality are not the same thing, and to be effective, legislation has to be both correctly interpreted and properly implemented.

Besides the fact that different ideologies impinge on legislation, the local culture and the local organisational set up of psychiatric services can influence legislation in member states. The economic situation for each state and the political priorities regarding allocation of health care resources, will also influence the extent of compulsory treatment in psychiatry.

Despite the trans-European variation in mental health legislation and its application, European states do seem to be in a process of harmonisation regarding such legislation. So as to promote this process, minimising the extent of compulsion in treatment and safeguarding the human rights of persons compulsorily admitted, the following are crucial:

- Psychiatric treatment must be offered in a comprehensive setting including not only high quality in-patient, but also high quality out-patient and community treatment.
- Sufficient financial resources must be allocated to ensure adequate provision of high quality structural services and a well trained, qualified staff, both in hospitals and in community psychiatric services.
- Appeals and complaints procedures must be specified, with stipulated time limits and their implementation must be monitored and audited.
- Statistical information regarding the number of compulsory admissions, other compulsory acts, and appeals/complaints must be publicly available.
- Systems for monitoring and auditing quality standards must be implemented in all member states.
- The human right to high quality treatment for mentally disordered individuals with treatable psychotic illness must be safeguarded.

REFERENCES

Member Countries

Austria	A	Law on commitment (Unterbringungsgesetz (UBG), Bundesgesetzblatt) 1990/155
Belgium	B	Law on the protection of mentally ill persons (Loi sur la protection de la personne malade mentale), 1991
Denmark	DK	Deprivation of Liberty and other Restraints in Psychiatry (Lov om frihedsberøvelse og anden tvang i psykiatrien) Act no 331 of 24 May 1989, last modification 1998 with effect from 1 January 1999
Finland	FIN	Law of Mental Health, 1991
France	F	Law of the 30 th June on alienated persons (Loi du 30. juin 1838 sur les Aliénés), last modification 27.6.1990
Germany	D	Law on commitment (Psych – Krankengesetz, Nordrhein – Westfalen), 1985
Greece	EA	2071: Modernization and Organization of Health System (Included one chapter 11. Mental Health. Involuntary commitment), 1992
Ireland	IRE	Mental Treatment Act, 1945
Italy	I	180/833, Health Law 1978
Netherlands	NL	Extraordinary Admissions in Psychiatric Hospitals' Law (BOPZ) 1992
Norway	N	Psychiatry Law (Lov om etablering og gjennomføring av psykisk helsevern (Psykiatriloven), 1999 (Mental Health Act, 1961)
Portugal	P	Mental Health Law (Lei de Saude Mental), 1999
Spain	E	Civil Law, Art 211, last modification 1996
Sweden	S	The compulsory psychiatric care act (Lov om psykiatrisk tvångsvård), 1991:1128, modifications 2000:353
Switzerland	CH	Loss of liberty due to depriving of sufficient care (Fürsorgerische Freiheitsentziehung), 1981
United Kingdom	UK	Mental Health Act in England and Wales, 1983

Associate Member Countries

Croatia	CRO	The Law on the protection of mentally disturbed persons, 1998
Cyprus	CY	Psychiatric Hospitalization (Peri Psychiatrikis Nosilias), 77 (I) 1997
Czech Republic	CZ	No 20 Law about care of peoples health, 1966. Document on basic rights on freedom, 1993
Estonia	EST	The Mental Health Act, 1997
Hungary	H	Law of Health, 1998
Malta	MA	Chapter 262, Mental Health Act, 1976
Poland	PL	Polish Mental Health Act 1994, Amendments 1997
Slovak Republic	SLR	Zbierka zákonov c. 303/1998
Slovenia	SLO	Law on Health 1992, modifications 1999

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