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# Compulsory hospitalisation and optimal mental health care: A European perspective and the example of Greece

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Countries offering good psychiatric care which respects their clients' dignity and human rights can be expected to reflect this fact in their official health statistics. Given that European data on compulsory hospitalisation are currently inadequate, we propose that all Member States should collect at least a basic set of figures for calculating the rates or quotas of compulsory admissions and the rate of legally indefensible detentions; this will allow us to examine both the actual cost of freedom lost as well as the extent to which national mental health laws are delivered as prescribed. As shown here by the example of Greece, there is an urgent need to focus on possible infringements on the rights of the mentally ill, because Member States can not be compelled to accept international monitoring or to observe minimum standards of mental health care.

**Key words:** Involuntary admissions, psychiatric services, legal procedures, quality of care.

## Introduction

If acceptance of psychiatric treatment is affected by the degree to which is viewed as stigmatising as well as by the quality of services on offer, one would expect that countries with the least positive attitudes to the mentally ill and the least adequate psychiatric care to have the highest rates of compulsory admissions. If the legal procedures and the psychiatric services across Europe were identical, the lowest rate of compulsory admissions should be found in those countries which detect promptly most persons who are potentially detainable and keep them well for as long as possible, have sufficient numbers of hospital beds, apply their mental health laws in a manner which respects clients' human rights and use involuntary hospitalisation only after all possible alternatives have been exhausted.

A country's official statistics on detained patients could be a valuable index for making inferences as to whether a given country approaches an optimal level of care. Despite national variations and fashions in mental health care, it could be valuable to look at such European statistics because their national laws have now become more or less comparable and also because there is not a wide or prohibiting disparity between most European societies and cultures. As European psychiatry is now moving towards greater integration and harmony,[1] the next obvious step is to examine differences in clinical practice across countries.

This paper aims to draw attention to the relevant European statistics and their inherent problems, to examine their potential value as indicators of quality of care and to highlight the nature of the problem itself -using as an example the current situation in Greece.

## Questions arising from European statistics

Incarceration in the care of the mentally ill has a long history, and the recent emphasis on closing the old asylums by treating people in the community, as well as on updating the relevant European legislation, may have a serious impact on service delivery. A British Government publication[2] records a "striking increase" of compulsory admissions in the nineties suggesting that this may reflect "a greater awareness among clinicians of their powers under the 1983 Mental Health Act". This rise, Jones[3] claims, "follows trends in psychiatric services with which the law has not kept pace: the closing of psychiatric beds, in some areas, of all locked beds; shortage of beds for admissions; consequent premature discharges; and high emergency re-admission rates"; he suggests that this "may represent one aspect of the psychiatric revolving door" and notes that "the main expansion in in-patient services in recent years was in forensic psychiatry".[3] A sharp rise in detentions has also been observed in Germany, France, Austria, Sweden and Finland but not in most other European countries.[4] The likely effects of the revised legislation in each country are, as yet, far from clear.

Any interpretation of national statistics needs to take into account their accuracy and comprehensiveness as well as any factors likely to distort them. There are notable differences among European countries in the definition of 'mental disorder' and in the legal procedures to be complied with before detention as well as in the number or the professional status of those providing the reasons for detention or deciding whether to admit. Nevertheless, although the existing statistics are often inadequate, differences in the legal definition of 'mental disorder' or on whether the professionals who finally commit are legal or medical do not seem to be major factors in determining national rates of detention.[4]

It is surprising that so little attention is paid to recording accurately the days of freedom lost by those who struggle to regain their sanity. It is, however, heartening that some good statistics are available –albeit for the last decade– so that we could now examine trends in national practices and compare with greater confidence one country with another. Currently, no adequate national statistics exist in Belgium, even less adequate in Italy or Spain and none at all in Greece.

In several European countries, especially the Nordic ones, there is a long tradition of collecting high quality official data which could be used for asking questions about differences within a country's psychiatric services or for looking at the possible effects on those concerned. In Sweden, all compulsory admissions are recorded centrally[5] and in Finland "any event of deprivation of liberty" always becomes a statistic.[6] Because of anonymously collected protocols however, even in Denmark, and up to the late nineties, it was not possible to distinguish between "episodes" of involuntary hospitalisation and "persons detained". A similar problem still exists in England and France. Some countries are confined to collecting national quotas and rates, while most of the others still have a long way to go.

The final report of a recent European research project[4] is a significant contribution to addressing seriously some of the above problems. This report brings together, for the first time, the key factors of the relevant national legislations, looks at the current practice in 15 Member States and attempts to make sense out of the existing good, and not so good, national statistics. It rejects the earlier assumption that there is a "unidirectional influence of legal regulations upon practice" and emphasises that "different

cultural or legal traditions, general attitudes towards the mentally ill people, and the structure and the quality of mental health care systems or administrative procedures must be considered along with other factors when analysing or comparing the outcome from the legal networks of Member States".[4]

## National admission rates or quotas?

The volume of each country's involuntary hospitalisations is usually expressed as the total number of admissions either per 100,000 population (admission rates) or as a percentage of a country's total admissions to psychiatric hospitals or units (admission quotas). Although a much more meaningful statistic here would have been the rate of persons detained, apart from Denmark, no European country currently collects such data. Consequently, we are left with arguing about the relative merits of rates and quotas.

Riecher-Rossler and Rossler[7] claimed that admission quotas are "of limited value for international comparisons" because they "depend heavily on the total admission frequencies of the respective countries" and criticised most previous studies on this account. However, the same criticism also applies to the use of rates because countries with poor after-care services would be expected to end up with a disproportionately large number of re-admissions, thus inflating their national admission rate. Since in most national statistics there is no distinction between first admissions and re-admissions, the crucial issue here is not whether rates are better than quotas but whether the two of them are related and to what extent.

To answer this particular question, we looked at the data gathered by the European research project[4] and ranked the 11 European countries for which data were available on both these measures. It can be seen (table 1) that the rank order correlation between rates and quotas is positive and highly significant: countries with low rates of detention per population have a low percentage of involuntary hospitalisations and vice-versa. Although the baseline data used here were less than perfect, this finding offers some justification for using both rates and quotas as 'measures of outcome' from the (European) legal networks. Furthermore since rates and quotas are the most basic data which could be easily and reliably collected by most European States, the prospect of meaningful inter-national comparisons is now in sight. But if we were to look more closely at the absolute values of these rates and quotas, can we say that they actually mean anything at all?

While the mean values for rates and quotas in those 11 countries are 90/100,000 and 13.6% respectively, the variation is far too great. They range

**Table 1.** Admission rates (A) and quotas (B) of involuntary hospitalisations in 11 European countries and their rank order correlation.*

| *Country* | *Involuntary hospitalisations* | | | |
|---|---|---|---|---|
| | *(A) Per 100,000 population* | *(B) As (%) of all admissions* | *Ranking order (A)* | *(B)* |
| Austria | 175 | 18.0 | 9.5 | 9 |
| Belgium | 47 | 5.8 | 5 | 3 |
| Denmark | 34 | 4.6 | 3 | 2 |
| Finland | 218 | 21.6 | 11 | 10 |
| France | 11 | 12.5 | 2 | 5 |
| Germany | 175 | 15.9 | 9.5 | 8 |
| Ireland | 74 | 10.9 | 6 | 4 |
| Netherlands | 44 | 13.2 | 4 | 6 |
| Portugal | 6 | 3.2 | 1 | 1 |
| Sweden | 114 | 30.0 | 8 | 11 |
| United Kingdom | 93 | 13.5 | 7 | 7 |
| Mean (SD) | 90.1 (72.2) | 13.6 (7.8) | | |

* Spearman's rho: 0.843, $P<0.01$

from an admission rate of 6-11/100,000 in Portugal and France to a rate of 175/100,000 in Austria or Germany to 218/100,000 in Finland; and from quotas of 3.2% and 4.6% in Portugal and Denmark to 21.6% and 30% in Finland and Sweden. Taking these two rankings in combination, we find that Portugal and Denmark are the least likely to resort to involuntary hospitalisation, while Sweden and Finland the most. Should we conclude from this that Portugal and Denmark offer the highest level of mental health care and Sweden and Finland the lowest? Obviously, any explanation for these large differences must be put in context, by looking much more closely on how the legal and psychiatric services of these two sets of countries operate. The available description of their respective legal practices[4] does not allow us to answer the above question with certainty but they at least raise some questions which need to be seriously addressed:

Considering that the above three Nordic countries are not only culturally similar but also excellent in collecting national statistics, what accounts for the fact that Finland and Sweden find it necessary to detain their patients five times more than Denmark in order to treat them? Is it possible for a country to offer a high quality psychiatric care irrespective of the number of persons it detains? Should we opt for a more or a less coercive model of care delivery and, if so, how can we calculate or defend the costs and benefits, as well as the ethics, of our chosen approach?

It may well be argued too that these officially recorded differences are more apparent than real, since crude rates of involuntary hospitalisation do not tell us much about the total of actual 'days of freedom lost'. It may well be that Denmark detains fewer persons but for much longer periods, while in Sweden and Finland the reverse is true. However, countries with accurate and comprehensive records could answer these questions with a fair degree of certainty and –by doing so– they could be in the best position to demonstrate the real benefits of collecting reliable health statistics.

## A European rate of legally indefensible detentions?

Whichever model of psychiatric service one is prepared to adopt, it would seem logical not to lose sight of the perceived cost to the individual who receives that care. Even when it is done right, the actual decision to detain a person in hospital against his own wishes rests upon an interpretation of relevant laws as well as on one or more opinions of physicians or psychiatrists who defend its applicability. Since an individual's experience and behaviour, as well as his or her own views and attitudes, can not always be assessed with sufficient precision, it should not surprise us that there is a variation –or a margin of error– in both our legal interpretations and psychiatric classifications. The size of this variation becomes clear by looking at some of the annual statistics of Mental Health Review Tribunals.[8]

Every year, half of about 30,000 involuntary hospitalised psychiatric patients in England and Wales appeal against detention and –from those– one in two (i.e. about 7,000) finally put their case to a judicial hearing. The three-member Tribunal –a lawyer, a consultant psychiatrist and a lay member– having considered each case by looking at the specially submitted psychiatric, nursing or social reports, hears evidence from the patient's psychiatrist, psychiatric nurse and social worker as well as from the patient himself. Throughout the hearing, the patient is assisted by his legal representative, who has access to all submitted evidence, having also examined the patient's psychiatric records before the hearing. Most hearings last for about two hours, after which the Tribunal decides whether the patient is still detainable under the existing law. If the Tribunal is persuaded that the detention is legally defensible, the patient's solicitor, whose services are paid by Legal Aid –irrespective of whether the patient has the means to afford the fee– may ask for a Judicial Review of the Tribunal's verdict. The whole procedure is described here in some detail in order to show that the Tribunal's task is not simply to examine a set of papers without an opportunity for the patient and his solicitor to ask all the questions they think relevant before the Tribunal reaches its decision.

In England and Wales, the great majority of cases heard by Mental Health Review Tribunals concerns patients detained under Sections 2 and 3 of the 1983 Mental Health Act, i.e. those admitted to psychiatric hospitals and Units for Assessment (for 28 days) or for Treatment (for 6 months and above);

and for the years 1994–1996, the proportions of patients discharged by these Tribunals was 17.3% and 13.6% respectively. For the whole three-year period, 21,548 cases were heard and in 3,107 of these cases (14.4%) the Tribunal had not been persuaded that the patient's detention was legally defensible.[9] Although Ireland also has a system of Tribunals for all detained patients and the relevant legislation in most European countries does allow patients to appeal against detention to an independent body, there are no national statistics to tell us the number of patients who appeal and, of those, how many are judged to be no longer detainable.

Irrespective of a country's legislation, the outcome of independent reviews of detention provide a valuable index of the extent to which each country applies its mental health legislation as prescribed. The most relevant issue here is the availability of free legal support and the finding of the European research project is of particular interest: "Member States which stipulated the mandatory inclusion of an independent counsel in the procedure, showed significantly lower compulsory admission quotas, as well as a tendency towards lower compulsory admission rates than Member States without such stipulation. This preliminary finding invites further testing of the hypothesis, to clarify whether better legal support for the persons concerned might help to lower compulsory admission rates and quotas".[4] Obviously, calculating the rate of the successful appeals against compulsory hospitalisation among European states would be worthwhile.

## The example of Greece

It is well recognised in Greece that the level of mental health care and the dedication to observing the human rights of the mentally ill as well as the speed of progress towards community psychiatry leaves much to be desired.[10] The custodian law of 1862 relating to involuntary hospitalisation had remained in force till 1973, when it was replaced with an inferior version of the English 1959 Mental Health Act. The current legislation, however, which was officially adopted in 1992, is broadly comparable with that of the rest of Europe.

Though statistics on involuntary hospitalisation are not collected on a national scale, two painstaking studies by a legal expert in this field[11–12] which deal with figures and procedures, including illustrative case reports, show conclusively that, in respect of the deadlines for submitting applications for detention to a Magistrate's Court or for delivering the Court's decision, "the letter and the spirit of the law has not been observed in a proportion well in excess of 90% of cases"! From his study of 903 such cases during the 9 years following the introduction of the new Greek Act, Kosmatos[12] concludes that this practice continues with no sign of improvement; he notes that, out of these 903 cases, in only 7 there was a lawyer present during the Court hearing, only one patient appealed against detention and that one in six patients had not been invited by the Court to attend the hearing. In another survey of 45 consecutive detentions,[11] he found that none of these patients was informed about his rights under the current law, only 9 patients were present during the Court hearing and one in two patients had already been discharged by the time the Court issued its official verdict authorising their detention! He concluded that such blatant disregard for the patients' personal freedom and human rights is tantamount to "a dereliction of duty" [by legal and psychiatric services] "which is punishable under the Greek Penal Code".[12]

The Greek Ombudsman[13] has noted serious problems with "patients" kept in police cells, with common criminals, for several days while awaiting for the legal detention order papers to be completed because either the Public Prosecutor or the second psychiatrist could not be contacted within the periods prescribed by law. It also notes that patients who may be detainable are transferred from home to police cells –and from there to hospital– in handcuffs and without the presence of any kind of health personnel. The mere failure to apply the existing law need not necessarily imply that either the rate of involuntary hospitalisations in Greece is excessive or that its psychiatric services are grossly deficient. However, further evidence also points to the persistence of a unsatisfactory state of affairs.

A survey of admissions to all state mental hospitals showed that, out of 4,394 hospital admissions in the whole of Greece in 1979, 97 per cent had been compulsory.[10] There are no national data for the more recent years but, according to estimates by senior psychia-

trists, the current figure for such admissions is well in excess of 40–50 per cent.[10,14] Support for this estimate also comes from a study of 2,758 emergency referrals for psychiatric assessment to the main University psychiatric clinic in Athens, in the second half of 1997.[15] Out of the 773 patients from this sample for whom the interviewing psychiatrist recommended admission, 322 (42%) had been seen after an order by the Public Prosecutor and were, presumably, taken to hospital; however, since the study sample is neither sufficiently representative of psychiatric referrals nor does it tell us how many of the voluntarily referred patients did accept the idea of admission, the quota of 42 per cent may well be a gross underestimate.

Furthermore, Public Prosecutors –who are the first to assess the justification for a patient's involuntary admission– may be somewhat overinclusive in issuing orders of detention for allowing time to two independent psychiatrists to make their assessment. A study in the late nineties found no signs of psychopathology in one in ten of such patients[10] while a more recent one[15] discovered that as many as one in six patients, from a consecutive sample of 272, did not fulfil the legal criteria for detention at the time of psychiatric interview. Although there are no current data for admissions to private Greek psychiatric clinics, which provide as much as 44 per cent of the available psychiatric beds in the whole country,[16] the existing evidence strongly suggests that the quota of involuntary hospitalisations in Greece is at least four times higher than the European average.

To date, no empirical data exist concerning the quality of mental health services in Greece, especially in respect of those involuntarily hospitalised. However, inspections of psychiatric hospitals and units by the Greek Committee for the Protection and Care of the Mentally Ill[14,15] and by the Greek Ombudsman's Office[13,17] have drawn attention to a number of persisting problems: (i) many patients are currently admitted compulsorily while they do not fulfil the legal criteria for detention, (ii) most patients are not informed about their legal rights on admission, (iii) in some hospitals, nursing staff treat voluntary patients as if they were detained, (iv) no records are kept about secluded patients or about the frequency of their observation, (v) lack of sufficient or trained hospital personnel, (vi) no facilities to be used as alternatives to compulsory admission and (vii) inertia of hospital officials in confronting the issues dealing with the protection of patients' rights.

Greek professionals entrusted with the implementation of the current program of modernising an outdated and largely institutional psychiatric service testify that the daily messages they receive are "of psychiatric hospitals replete with compulsorily detained patients, of incidents of violence against inmates and of frequent protests or threats of violence by members of the public who live near the newly created psychiatric hostels".[18] A recent nationwide survey also showed that one in two Greeks disapprove of mental health consumers residing near their home.[19] Such problems, if they indeed apply to the country as a whole, are not consistent with the view that those in need currently receive an optimal level of mental health care.

## Conclusions

Despite the current emphasis on de-institutionalising the psychiatric services and the wider recognition of patients' human rights, leading to the formulation of the United Nations' Principles for the Protection of Persons with Mental Illness,[20] no attempt has been made to look consistently for possible infringements on patients' rights by individual countries. This may be because, as Harding eloquently puts it, these Principles lack the status of a formal international treaty, they do not oblige States to adopt these Principles as minimum standards and, last but not least, because they do not provide for any form of monitoring by an independent international body; he argues that, as a result, they have had "little material effect on the lives of psychiatric patients".[21] The persistence of indefensible practices –as shown by the example of Greece– is a case in point.

It is too easy to get lost in arguments about the shortfalls and the real meaning of national statistics of involuntary hospitalisation. Crude rates do not mean much and reference to hospital beds can be misleading at a time when, in many European countries, the psychiatric services are in a flux. The same applies to the changes in current legislation, the speed and accuracy of their implementation and –in some countries– the adoption of treatment orders for patients who do not occupy actual hospital "beds" but their personal freedom and choice are

restricted while living in the community. Moreover, the rising numbers of compulsory treatment orders in recent years, in many European countries, raise questions as to whether what we have come to view as real "progress" in our handling of the mentally ill may in effect be contaminated by a more rather than a less coercive practice. Such developments may be difficult to quantify, especially when we compare European countries which differ in their prevailing attitudes and cultures as well as in their determination to keep accurate and reliable health statistics.

Nevertheless, focusing on the event of involuntary hospitalisation is a relatively straightforward task since all such events are precisely defined by similar legal procedures and they could, therefore, be meaningfully counted. Translating such events into rates per population or into quotas in relation to all "admissions" could offer a useful index of how well –or at least how restrictively– our services actually operate as well as a rough measure for quantifying the actual cost to those affected. A useful adjunct could be the rate of legally indefensible detentions: This also could be compiled by each European country without much difficulty and will allow us to examine more directly if the delivery of mental health legislation corresponds with the lawmakers' true intentions. European countries, especially some of its new members or candidates, can not be legally compelled to comply with the United Nations' resolution for respecting the human rights of the mentally ill, but they could at least be persuaded to accept that they are morally obliged to look directly and candidly behind the closed doors of their mental hospitals, psychiatric units or private institutions. Arguably, the information to be derived from such a minimum of statistical data should allow us to ask questions about the link between involuntary hospitalisation and quality of mental health care which are much more meaningful than hitherto.

# Αναγκαστική νοσηλεία και βέλτιστη φροντίδα ψυχικής υγείας: Η ευρωπαϊκή προοπτική και το παράδειγμα της Ελλάδος

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Αν δεχθούμε πως ένας σημαντικός δείκτης της ποιότητας των ψυχιατρικών υπηρεσιών μιας χώρας είναι και ο τρόπος με τον οποίο χειρίζεται τα πιο σοβαρά ψυχικά προβλήματα, οι επίσημες στατιστικές ακούσιας νοσηλείας μας προσφέρουν μια βάση σύγκρισης τόσο μεταξύ χωρών όσο και μεταξύ χρονικών περιόδων. Από Ευρωπαϊκή σκοπιά, το θέμα έχει ιδιαίτερο ενδιαφέρον όχι μόνο επειδή η σχετική νομοθεσία τείνει να εναρμονιστεί αλλά και επειδή έχει δοθεί ιδιαίτερη έμφαση στην αξιόπιστη συλλογή των αναγκαίων στατιστικών στοιχείων. Από τις πληροφορίες που έχουν ήδη συγκεντρωθεί, φαίνεται να υπάρχουν σημαντικές διαφορές μεταξύ Ευρωπαϊκών χωρών τόσο όσον αφορά στα ποσοστά ακούσιας νοσηλείας όσο και στον τρόπο καταγραφής τους. Μολονότι τα ήδη υπάρχοντα Ευρωπαϊκά στατιστικά στοιχεία θέτουν πολλά ερωτήματα ως προς την εγκυρότητα και την ερμηνεία τους, η υιοθέτηση μιας κοινά αποδεκτής μεθόδου καταγραφής θα μπορούσε να συμβάλλει στη βελτίωση της παρούσας κατάστασης και να διευκολύνει τη διερεύνηση της ποιότητας νοσηλείας των ψυχικά ασθενών και των λόγων που την υπαγορεύουν. Προτείνουμε πως κάθε Ευρωπαϊκή χώρα θα πρέπει να καταγράφει συστηματικά τρία τουλάχιστον βασικά στατιστικά στοιχεία: (1) το συνολικό αριθμό ακούσιων εισαγωγών σε σχέση με τον πληθυσμό της χώρας (admission rates per 100.000

population), (2) το εκατοστιαίο ποσοστό ακούσιων εισαγωγών επί του συνόλου των εισαγωγών στα ψυχιατρικά της ιδρύματα (admission quotas) και (3) το ποσοστό των νομικά μη εγκύρων εγκλεισμών (legal indefensible detentions) που προκύπτει από τις αποφάσεις των δικαστών που αποδέχονται τις ενστάσεις ασθενών κατά του εγκλεισμού τους. Μια συστηματική καταγραφή των τριών αυτών στοιχείων θα μας επιτρέψει να εξετάσουμε το πραγματικό μέγεθος στέρησης της ελευθερίας των ψυχικώς πασχόντων σε κάθε χώρα καθώς επίσης και το βαθμό στον οποίο η ισχύουσα νομοθεσία εφαρμόζεται σωστά. Η Ελλάδα προσφέρει ένα –αλλά όχι και το μοναδικό– παράδειγμα με σοβαρά προβλήματα στο πως ακριβώς εφαρμόζεται η τρέχουσα νομοθεσία, στην ενημέρωση των ακουσίως νοσηλευόμενων ασθενών για τα ανθρώπινα δικαιώματά τους και στην εξάσκηση του δικαιώματος ένστασης κατά του εγκλεισμού, ενώ το πρόβλημα της παντελούς έλλειψης στατιστικών στοιχείων για ολόκληρη τη χώρα κάνει ανέφικτη την απευθείας σύγκρισή της με άλλες χώρες της Ευρώπης. Το ότι από υπάρχουσες έρευνες έχουμε ήδη σαφείς ενδείξεις ότι το ποσοστό ακουσίων νοσηλειών στη χώρα μας είναι τουλάχιστον τετραπλάσιο σε σχέση με τον Ευρωπαϊκό μέσο όρο, υπογραμμίζει την ανάγκη περαιτέρω μελετών του προβλήματος και καθιστά επιτακτική τη διερεύνηση της σχέσης μεταξύ ποιότητας ψυχιατρικής περίθαλψης και κατάχρησης του μέτρου της αναγκαστικής νοσηλείας στη θεραπεία των ψυχικώς πασχόντων στην Ευρώπη.

**Λέξεις ευρετηρίου:** Ακούσια ψυχιατρική νοσηλεία, ψυχιατρικές υπηρεσίες, σχετική νομοθεσία, ποιότητα ψυχιατρικής περίθαλψης.

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