· Correspondence ·

Involuntary admission or involuntary treatment?

José M. BERTOLOTE

The interesting forum on involuntary treatment that appeared in the previous issue of the Shanghai Archives of Psychiatry[1,2] touches upon two closely related issues that have important and distinct implications both for forensic and clinical psychiatry: involuntary (or forced?) admission and involuntary (or forced?) treatment.

Involuntary psychiatric treatment is one of several methods society uses to deprive individuals of their freedom; the more commonly used methods are incarceration in jails, prisons and penitentiaries. The first "psychiatric hospitals" in 15th century Europe (in Spain, Italy and England) were built under the aegis of the Catholic Church to provide housing for people with strange behavior who were unable to care for themselves. But these asylums subsequently became another type of government-run institution where society could confine people with deviant or unwanted behavior. Involuntary treatment in its statutory form has been with us for more than two centuries, since the Napoleonic Code included it as a legal practice in 1803[3]. Over this long period involuntary treatment has become an integral, albeit not always esteemed, part of clinical psychiatry. The declared good intentions; the pseudo justifications of 'protection of self', 'protection of others', and 'protection of society'; and the unproven assumption that involuntary treatment is 'therapeutic' have all been used to justify seclusion of the mentally and deprivation of their liberty.

More recently some locations have moved away from this repressive approach by introducing laws that make a distinction between involuntary admission and involuntary treatment. An international systematic review of mental health laws conducted between 1992 and 1995 by Poitras and Bertolote[4] found that about 30% of reviewed mental health laws made this important distinction. The jurisdictions with laws that clearly separate involuntary admission from involuntary treatment include Victoria State in Australia, Quebec and Ontario (provinces in Canada), Bavaria State in Germany, Italy, Japan, New Zealand, Norway, Romania, England, Wales, and Massachusetts and Indiana (states in the USA). In most of these location the legislation makes a distinction between persons who have the authority to involuntary lock someone in a psychiatric institution (hospital, clinic or ward) and persons with the authority to treat someone from a mental disorder, even against that person's will. In several of these jurisdictions the legal requirements for involuntary admission have remained the same but there is a further specification that treatment (usually involving the administration of medications) cannot be imposed on someone who refuses it.

The law in Italy is considered one of the most advanced and "libertarian". Involuntary hospitalization in Italy is limited to cases where: 1) urgent intervention is required, 2) the patient refuses necessary treatment on an outpatient basis, and 3) alternative community-based treatment is not available or is not feasible[5]. In other words, hospitalization is authorized against a person's will only after a psychiatrist (not a judge nor a policeman) has certified that that person needs urgent treatment and that treatment cannot be provided outside the hospital. This is very different from the criteria used in most other jurisdictions that sanction involuntary hospitalization on the grounds of "dangerousness to the patient or others", a decision that is often made by judicial officials, not mental health professionals.

For many clinical psychiatrists treatment requires a collaborative relationship between doctor and patient, so the very idea of involuntary (or forced) treatment is hard to accept. But the mental health laws that psychiatrists must implement are developed and promulgated by government agencies, not by psychiatrists (though psychiatrists may be consulted during the drafting of these laws). In their daily practice clinicians should not uncritically accept the role of guardian of society; their application of the laws needs to take into consideration the best interests of the individual they are treating. Psychiatric treatment is already a complex and sometimes arduous task that should not be contaminated with functions alien to its core mission.

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· 读者来信 ·

非自愿住院还是非自愿治疗?

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刊登于《上海精神医学》上一期中的关于非自愿治疗的论坛很有意思,讨论了在司法精神病学和临床精神病学领域均具有重要和显著意义的两个密切相关的问题:非自愿(强制?)住院和非自愿(强制?)治疗。

非自愿精神科治疗是社会用来剥夺人们自由的措施之一,剥夺自由最为普遍的方法是在看守所、监狱和劳教所中的监禁。在罗马天主教的支持下,第一所"精神病医院"创建于15世纪的欧洲(西班牙、意大利和英格兰),专门为那些不能自我照料的行为异常的人提供住所。但是,这些精神病院后来变成了另一种类型的政府管理的机构,成了关押那些行为异常或行为不受欢迎的人们的场所。自从1803年拿破仑法案将非自愿治疗列为合法的医疗实践,在法律框架下的非自愿治疗已经存在了两个多世纪[3]。长期以来,非自愿治疗已成为临床精神病学不可或缺的部分,虽然也不乏批评之声。用来隔离精神病患者以及剥夺他们自由的理由包括:所谓的良好意愿,虚无的"保护自己"、"保护他人"和"保护社会"的需要,以及并未得到证实的"治疗"效果等。

最近,有些地方通过立法来区分非自愿住院和非自愿治疗,改变原有的这种强制性方式。Poitras 和 Bertolote[4] 对1992年至1995年间实施的精神卫生法进行了系统综述,发现约有30%的精神卫生法包含了这一重要的区分。澳洲的维多利亚州、加拿大的魁北克省和安大略省、德国的巴伐利亚州、中国、意大利、日本、新西兰、挪威、罗马尼亚、英格兰、威尔士、美国的马萨诸塞州和印第安纳州的精神卫生法中均包含明确区分非自愿住院和非自愿治疗的内容。在多数这些地方,法律明确区分哪些人有权利强制性地将患者收入精神卫生机构(医院、诊所或病房),哪些人有权利治疗精神病患者,甚至可以是违背患者本人的意愿。有些法律对非自愿住院的法律条件是相同的,但进一步的具体要求是,如果患者不愿意的话,是不可以给予治疗的(通常是指药物治疗)。

意大利的精神卫生法被认为是最先进和"自由的"的法律之一。在意大利,非自愿住院仅限于下述病例:①需要紧急干预;②患者拒绝门诊的必要治疗;③缺乏社区治疗或社区治疗不可行[5]。换句话说,只有在精神科医师(不是法官或警察)确认患者需要紧急治疗,而且在医院之外是无法提供治疗的之后才可以采取非意愿住院措施。这与多数其他法律使用的标准截然不同,即通常由法官,而不是精神科医师,根据"对患者或他人的危险性"来决定是否采取非自愿住院措施。

精神科医师在治疗中通常需要与患者建立合作关系,所以非自愿(或强制)治疗的观点是很难被接受的。但是精神科医师必须遵循的精神卫生法律是由政府机构,而不是精神科医师所制定和颁布的(虽然在法律的起草过程中会咨询精神科医师)。临床医生在日常工作中不应不加思索地接受社会监护人的角色,他们在应用法律时要考虑接受治疗患者的最大利益。精神科治疗本身就已经是一项复杂,有时还是繁重的工作,不应再受到与其核心使命无关的因素的干扰。

参 考 文 献

(此处略,与英文版中的相同,见本页)

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