LETTERS

Editor:

Ralph Slovenko's editorial, "On a Therapist Serving as a Witness,"[1] was a wonderful introduction to Donald Meyer's biography[2] of our new president, Larry Strasburger. What could be more fitting than honoring Larry by offering the other side of his own view of the same situation in "On Wearing Two Hats"[3]? This kind of dialogue, or offering two rather contrary opinions, is what makes APPL and the Journal so important to us clinicians who are not looking for simple answers to complex and complicated issues.

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Editor:

Drs. Robert van Voren, General Secretary of the Geneva Initiative on Psychiatry, writes: "Psychiatry was abused systematically in the Soviet Union, there is no doubt about it" (Ref. 1, p 134). No doubt about it? Dr. Alan A. Stone[2] takes issue with the allegations of widespread political abuse of psychiatry. Who or what is to be believed?

Many times in talks or writings I have taken issue with the allegations of widespread political abuse of psychiatry in the former Soviet Union. I have conveyed my opinion on several occasions to Dr. Loren Roth who headed a delegation of the American Psychiatric Association (APA) to the Soviet Union. Needless to say, I did not expect to be included in the delegation, although I was familiar with the country and the language. Also, I expressed my opinion on many occasions to Dr. Gene L. Usdin (among others), my longtime friend who later was a candidate for the presidency of the APA. He too discounted what I had to say.

For the past 35 years, I have visited the Soviet Union/Russia almost annually for periods of six to eight weeks, often at the invitation of Albert Krilov, Dean of the Department of Psychology at St. Petersburg (Leningrad) University; I attended the law school there for a semester, at the invitation of Dean Alekceev, who had been a judge at the Nuremberg trials.

In a letter dated March 17, 1977 (on file), I was invited in behalf of the Scientific Program Committee of the Sixth World Congress of Psychiatry in Honolulu to be the participant from the United States at a special session on "The Ethics of the Psychiatrist." I was ambivalent. I believed that there were a number of cases of political abuse of psychiatry, but I did not feel that condemnation of Soviet psychiatry was warranted. In any event, Dr. Paul Chodoff was selected to make the presentation. As everyone knows, the World Psychiatric Association (WPA) condemned the Soviet Union.

It was my opinion that during the days of the Cold War the West, for political purposes, exploited the dissidents. I had met a few of those who were alleged to have been dissidents and institutionalized allegedly because of their expression of political or religious dissent. They were floridly psychotic. Law professor Richard Bonnie, a member of the Roth delegation, reports that "many hundreds" (Ref. 3, p 138)—not just a few dissidents—were put in mental hospitals and punished by the use of medication. Drs. van Voren wrote: "Approximately one in three political prisoners were held in psychiatric hospitals rather than in camps and prisons. Yet, the thousands of victims of these political abuses form only the tip of the iceberg of millions of Soviet citizens who fell victim to totalitarian Soviet psychiatry" (Ref. 1, p 134). Hundreds? Thousands? Maybe, but maybe not. Maybe a handful?

In reaction to the alleged or occasional misuse of psychiatry, Russia has now enacted commitment laws similar to those in the United States. Actually, the crucial issue was really not how something was accomplished but rather what was accomplished. The political dissidents in the Soviet Union who were put in mental institutions could have readily been prosecuted under its criminal laws, and many were prosecuted. For some dissenters, the worst penalty was the psychiatric hospital; for others, the labor camp; and still for others, exile to the West. The issue was the quashing of dissent, not how it was done. There is a saying, "If your intention is to beat a dog, you can always find a stick," but worldwide, psychiatrists were concerned about the misuse of psychia-

try, not about other ways of quashing dissent. Like a man looking through the wrong end of a telescope, psychiatrists worldwide indulged in what might be called a perspective fallacy.

The former Soviet Union's alleged use of psychiatric hospitalization as a means of social control gave impetus to the view in the United States that the population in American mental hospitals is composed of social or political critics. Indeed, the antipsychiatry movement in the 1960s and 1970s claimed that "schizophrenics" were in fact social dissenters. That was implicit in a 1973 statement made by Jerome J. Shestack, chairman of the American Bar Association Commission on the Mentally Disabled, that the United States must prevent "the kind of situation which is developing in Russia in which a diagnosis of anti-state conduct is equated with being deviate and subject to commitment to a mental institution."[4] The result was a change in focus of civil commitment in the United States from *parens patriae* to police power. Criminal justice criteria were invoked in civil commitment, mental hospitals were closed, and jails housed the mentally ill.

Today, with the economic collapse of the country, Russia's health care system has deteriorated. As in the United States, the mentally ill now sleep on the streets, shout in public places, or are jailed. No one cares. A family seeking help is likely to be told that under the new commitment laws nothing can be done when an individual resists going to a hospital. Moreover, hospital staff is not interested in treating an uncooperative patient. Why bother, when there are many others needing care?

There has been a rash of suicides in Russia committed by jumping in the path of subway trains. In St. Petersburg, just after three deaths on the subway rails within a period of 12 days, the head of the subway police said: "I would not recommend that anyone commit suicide on the subway rails. If it is urgent, jumping from a tall building is better. Death under a train is not necessarily a quick one, and can be very torturous."[5] What else could have been suggested? To suggest social services or psychiatric care would have been fanciful, given the disappearance of these services.

In many countries, for better or worse, the United States is the model. Until the 1990s, Poland did not have commitment laws. Individuals were admitted into a mental hospital no differently from the way they were admitted into other hospitals. There were no complaints, as the care was fairly decent, particularly if a *lapowka* (payment under the table) was given to the doctor. The publicity of the alleged misuse of psychiatry in the Soviet Union prompted the enactment of commitment laws in Poland, just as it had an impact on commitment laws in the United States, though it clearly did not have a history of abuse of psychiatry. The law in Poland was pushed by Dr. Stanislaw Dabrowski, who was in tune with U.S. laws.

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Editor:

I found the Legal Digest article by Dr. Dike, "Not Yet Uhuru,"[1] very informative. I practice as a forensic psychiatrist in England and would like to point out some similarities under our Mental Health Laws.

In England and Wales, two legal concepts parallel the Parole with Special Limitation and Conditions as practiced in the United States: Early Release on License, and Conditional Discharge of a Restricted Psychiatric Patient.

Early Release on License was established by the Criminal Justice Act of 1991. It is applicable to prisoners and originated from the parole system in 1967.[2] Prisoners serving fixed sentences other than life imprisonment are eligible for release on parole after serving a third of the sentence. In the community, they receive supervision by the probation officer who monitors adherence to the conditions of their release. The conditions depend on the index offense, and may include abstention from drinking or participation in a sexual education program for sex offenders.

Prisoners on early release are subject to recall until the expiration of their full sentence. For sentences of life imprisonment, however, eligibility for early release depends on whether it is a mandatory life sen-

tence (for murder) or a discretionary life sentence (for crimes other than murder). For those with a mandatory life sentence, the judiciary determines the length of time to be served, but for the discretionary life sentence prisoner, the Parole Board sits as a Discretionary Lifer Panel (DLP) when the tariff part of the sentence has been completed. In this case, early release on license depends on the perceived risk to the public.[2] The individual may also be subject to supervision, including psychiatric aftercare. Default from stipulated conditions may lead to recall to prison.

Under § 73 of the Mental Health Act (1983), the Mental Health Review Tribunal may order the absolute or conditional discharge of a restricted patient if they are satisfied that ". . .the patient is not suffering from mental disorder, or not to a degree which warrants continued detention in hospital. . . ." The Home Secretary may also exercise this power under § 42 of the same Act (1983) (Ref. 3, pp 258–61). If the discharge is conditional, the conditions usually relate to supervision, residence, and medical treatment. Such discharge may be immediate, if all the necessary conditions are already in place, or may be deferred until the conditions are put in place. If the tribunal discharges a restricted patient without conditions, the Home Office may request social and psychiatric supervision under § 73(4) of the Mental Health Act (1983) (Ref. 4, pp 1011–12).

The purpose of conditional discharge is to protect the public from serious harm in two ways: by assisting the patient's successful integration into the community, and by closely monitoring the patient's mental health. During a conditional discharge, progress reports from supervisors are furnished to the Home Secretary, initially after one month and thereafter, every three months (Ref. 4, pp 1011–12). The duration of the "conditions" depends on the originally imposed restriction order. If the restriction order is of a specified duration, the conditions attached to the discharge cease to apply on the date of expiration of the restriction order.

If, however, as in most cases, the restriction order is of indefinite duration, the Home Secretary normally requires the conditions be kept in serious cases for at least five years after discharge from the hospital or for at least two years in less serious cases.

If medical treatment is part of the conditions, as it usually is, the patient is no longer subject to the consent to treatment provisions contained in Part IV of the Mental Health Act. However, despite this, treatment cannot be forced on the patient. The Psychiatric Supervisor may recommend that the Home Office recall the patient to the Hospital if this or any of the other stipulated conditions are breached. Once recalled to the hospital, the conditions cease to exist. During conditional discharge, patients may apply to the Mental Health Review Tribunal to vary the conditions or to request an absolute discharge (Ref. 4, pp 1013–14).

The case of Mr. Closs, described in the Legal Digest article,[1] seems more similar to the conditional discharge of a restricted psychiatric patient. In England, as in the United States, his medications could not be forcibly administered in the absence of an emergency. Because his discharge depended on his taking psychotropic medication, the Home Secretary could recall him to the hospital based on his failure to comply. This is crucial because as Dr. Dike pointed out, although we do not know whether Mr. Closs was ill at the time of the offense and whether he had been taking medications in prison, the appeals court noted that ". . .when Mr. Closs took his medication in the past, his social skills improved, and he was less likely to be aggressive. . . ." (Ref. 1, p 149).

Based on this, it is safe to assume that without the medication, Mr. Closs was liable to relapse and thus place himself and others at risk. This would be sufficient ground for the Home Secretary to recall the patient. Instead of unilaterally deciding to default from his medication, Mr. Closs could have appealed to the Mental Health Review Tribunal to vary the conditions of his discharge.

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