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# Legal and cultural aspects of involuntary psychiatric treatment regulation in post-totalitarian milieu: the bulgarian perspective

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ABSTRACT – *Background*: The impact of totalitarian legacy on present changes in legal regulation of mental health care and the interplay between legal and cultural factors in involuntary psychiatric treatment in post-totalitarian states have not been systematically analyzed, neither worked through.

*Objectives:* To assess the characteristics of the legal system and social practices concerning involuntary psychiatric treatment in Bulgaria from historical perspective, parallel with the legal developments in other European countries.

*Methods:* Review of relevant research and historical sources, cultural reference framework, and legal norms.

*Results:* Cultural and legal developments are far from being parallel. Totalitarian legacy in the area of patients' rights and coercion in psychiatric treatment is coped with in a milieu of transitional rules where the basic challenges concern more cultural aspects rather than legislative ones. While legal changes in non-Soviet post-totalitarian states nowadays could be best described as *normalization* (illustrated with Bulgarian legal traditions as an example), the major cultural shift concerning health care impacts novel concepts, e.g. autonomy vs. paternalism, and high tolerance to insecurity vs. fatalism, which mobilize defences and provoke confusion.

*Conclusions:* Culture, and de-culturation in times of transition for that matter, is the limiting factor for practical implementation of law, and contributes to the discrepancy between *written law* and *applicable law*. Problematic issues subject to current changing legislation, such as informed consent, legal competence, disability, guardianship, and compulsory placement and treatment, could be understood and resolved if viewed in the context of a changing culture.

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The aim of this article is to present the development of Bulgarian mental health legislation in the post-communist period, and more specifically, the regulation of involuntary treatment of individuals with mental disorders that have *not* committed offence. The legal institute of medical measures against mentally ill offenders is differentiated from the above and is not subject to this review. It should also be stipulated that written legal acts, rather than their practical implementation, is reviewed – although possible social and cultural sources with impact on the application of legal norms are being outlined.

Our approach to the topic views development in mental health legislation as a process that cannot be comprehended out of the corresponding regional, historical, and cultural context. Dynamic interrelationship between concepts about mental illness, treatment approach and legislation have certainly been delineated by other authors also, e.g. mental health care system is regarded as part of the social programs for ill and for permanently disabled[1]. When assessing the developments of our national psychiatric legislation in particular, analogous processes on different levels should be accounted for: the totalitarian legacy, the wider (European) context, the local context, and the specifics of culture.

## The totalitarian legacy

Historically, the Central and East European countries had come through different routes to the totalitarian regimes. They could be separated into different groups according to: a) their historical fate, e.g. whether were they parts of other state conglomerates or were independent; b) the reached at stage of development when Sovietization was imposed; c) the duration of their exposure to the *totalitarian communism* (a term by Berdyaev[2], and accepted in recent official documents[3]), e.g. number of generations, live links with the pre-totalitarian epoch; d) the extent of the processes during the totalitarian regime, e.g. profoundness of ideological influences, availability of protective factors such as national identity, or dominating religion, and others. Common features for the legal systems and social practices of all totalitarian regimes in the period 1945-1990 however, despite differences in the pre-totalitarian background, were: insensitivity to human rights, prejudices, legal nihilism, under-development of the legal system, and domination of expedience above the conformity with law, regardless of the claims for the opposite.

Changes in mental health legislation after the collapse of totalitarian regimes follow two general trends: turnabouts to own previous models, or acceptance of alien ones, the latter being usually termed *harmonization with international standards*. The balance between the two trends depends on: whether previous models were actually present, and are they nowadays readily applicable. Changes in mental health context in general, and in the legal regulation of involuntary psychiatric treatment in particular, in Bulgaria, follow largely the trend towards *normalization*, i.e. return to the natural, evolutional development that was deviated when communist regime was imposed (1944). It is our view, much in accordance with Malia's[4] definition of Soviet period as "the great aberration" in Russia's development, that development never ceases and could be characterized therefore, more as aberrant rather than being arrested, in the totalitarian period (1945-1990).

## European mental health legislation: the phylogenesis

Although precise phases cannot be delineated, the historical periods that generate certain mental health laws could be outlined with some approximation. Below, brief characteristics of psychiatric legislation developments, concerning in a summarized way involuntary psychiatric treatment, are presented, based mostly on the delineation and descriptions made by other authors[1,5,6].

***Initial period – up to 1955.*** Usually the first mental health Act is considered to be the French one from 1838, although some authors point to even earlier laws in other European countries concerning specific matters. The general characteristics of these acts is establishment of *care under supervision* and protection of society against mentally ill. A change in attitudes in the first half of the 20 century is mirrored by change in terms: *mentally ill* instead of *insane*, *psychiatric hospital* instead of *asylum*, and *admission* instead of *detention*. Introduction of voluntary treatment regulation, development of procedures for admission and for discharge, and regulations for some special categories of patients, i.e. mentally disabled, epileptics, alcohol and drug addicts, are basic features of this period.

***The period 1955-1975.*** Having also been called "y*ears of fundamental changes in the world and in psychiatry"*[1], these are years of a powerful human rights movement and rapid developments of techniques and treatment approaches, e.g. limitation of large hospitals' role, psychopharmacology, treatment in the community and in psychiatric wards in the general hospitals, evaluation of social attitudes towards mentally ill. These changes however, have limited implications in legislation illustrating the discrepancy between existing legislation and treatment programs. Until the 70's, the medical criteria and procedures for involuntary detention and treatment are dominating. Increasing emphasis afterwards has been placed on respect to individual rights and awareness of the necessity about a procedure for detention in *"due process of law"*[7].

***The period 1975-1990.*** Major characteristics of this period are: stricter guarantees for patients' rights, introduction of new forms of protection of the legal status of the mentally retarded, new forms of guardianship, formalized transition from in-patient to out-patient care, notions about consent to treatment and second opinion, and more procedural sophistication for coercive treatment. A special case, against general European trends, is Italy with the total abolition of coercive treatment in psychiatric hospitals (while being allowed in the general hospitals) and total transformation of the mental health care[5].

***The period after 1990.*** Different aspects of involuntary treatment are continuously debated: about acceptability of limitations of personal liberty when the dangerousness criterion is present vs. when the need for treatment criterion only is present; and about whether the responsibility for application of coercion should go to the legal or to the medical authorities. Delineation between involuntary detention and involuntary treatment is being made in increasing number of legislations. Besides, Jensen[6] points out the increasing focus on the legal status and the rights of the involuntary detained patients, the new regulations for home involuntary treatment unless constituting direct danger to others (Israel, Belgium), and the stipulated quality assurance standards for hospital care in some legislations (Denmark, Belgium, Finland, Netherlands, and Norway).

More detailed data about developments of the national legislations concerning coercive psychiatric treatment in 15 member states of the European Union are to be found in the report of Salize *et al.*[8]. Evidence from these sources, as well as from the increasing number of national legislations concerning psychiatric involuntary treatment having been passed or amended during this period, convincingly illustrate the intensification of legal changes in this area.

## Bulgarian mental health legislation in historical perspective: the ontogenesis

Historical fate of Bulgaria limits our focus to the modern Bulgarian state (after 1878, when Ottoman rule was overthrown), since continuity with previous, i.e. medieval, ages has been interrupted.

***Initial period: 1878-1951.*** After the first national health acts were passed (*Sanitary Act, 1888, and Act for Protection of Public Health, 1903)*, without any particular references for the mentally ill, a special *Statutes for care of the mentally ill* was approved in 1905[9]. Its Article 13, § 20, rules admission by doctor's judgment on the grounds of "*inevitable danger for others or for the patient or when immediate placement is needed in the best interest of patient's health*", while discharge "*…could be refused until the patient presents danger for himself or for the society*" (Art. 27). This act regulates all issues concerning care for the mentally ill until 1951. It contains norms that are to be abolished decades later, such as: "special protection" of psychiatric patients by state, guardianship and advocacy, and regulation of admissions in and discharge from the psychiatric wards of the general and psychiatric hospitals. Special emphasis is due to the text regulating voluntary admission – concerning patients, presumptively capable of giving consent for treatment, and voluntary discharge – when wish has been declared. In Western Europe, explicit legal regulations of voluntary admission appear later, in the 30's.

***The period 1951-1974.*** An unprecedented *Act for abolition of all previous acts - up to 09.09.1944*, was approved in 1951[10], with a single Article declaring all legal acts up to 09.09.1944 abolished due to "*…contradictions with the new Dimitrov's Constitution and with the socialist legal system established after 09.09.1944 in Bulgaria*". In 1961, an *Amendment to the Penal Procedure Code* from 1952 was passed[11], stating that the prosecutor may apply, and the District Court decide on, detainment for involuntary treatment for a subject that "may perpetrate a crime of significant community danger or constitutes a danger for oneself or for one's relatives" (Art. 124, § 2). Thus, the institute of preventive involuntary detainment and treatment of mentally ill who had not committed a crime was introduced, obliging the legal system to prevent crimes by coercive measures for treatment, with penal procedure for their implementation.

In 1970, a *Decree nr. 1196 for compulsory treatment of alcohol or drug addiction* was approved[12], creating the legal opportunity for compulsory treatment of addicts who are legally competent and penalty sane "*but refuse to be treated or do not comply with voluntary treatment*", thereby "*destroying their health*" or "*disturbing their families or the community order and the rules of the socialist community*". The prosecutors apply for, and the court decides on detainment. Part of the treatment is compulsory vocational therapy.

***The period 1974-2004.*** The *Public Health Act* from 1973[13], the first general Health Act

after 1929 (and in force until 2004), and the *Statute* for its implementation[14], introduce in the national legislation: the general principle for consent for each assessment and treatment, the concept of "*obligatory treatment*", the definition of the mental disorders subject to coercion, the deadlines for forensic psychiatric assessment, and the regulation of admission on emergency basis, while actually reinforcing the penal procedure as described above and the rules of the *Decree nr. 1196*[12] for compulsory treatment of alcohol and drug addicts. There are no special texts in this Act about mentally ill, apart from those regulating the involuntary treatment.

The terms used for involuntary treatment reflect ambivalence of the attitudes and of the approach. While "*obligatory treatment*" is the same term as the one used in infectious diseases, implying that the coercive measures are of preventive nature, there is clear procedural difference in their application: administrative procedure for individuals with infectious diseases, and a penal one for the mentally ill. Involuntary treatment applied to non-psychotic alcohol and drug addicts according to the *Decree nr. 1196/1970*, from the other side, is named "*compulsory*", and the same term is also used in the Penal Code for treatment of mentally ill offenders. With the amendment of the *Public Health Act*[13] from 1997 compulsory treatment of non-psychotic drug and alcohol addicts was abolished and out-patient and day centre forms of involuntary (e.g., "*obligatory*" according to the Act) treatment were introduced.

## The Bulgarian cultural context

Legal developments should be viewed in the appropriate cultural context, if social practices of their implementation are to be understood and placed into a perspective. One of the numerous ways to define culture is based on meaning that people invest in their behaviors and emotions: culture is the system of meanings used to interpret one's experience and to guide behavior[15]. Contemporary cultural context in Bulgaria could be best understood through the concept of de-culturation. De-culturation, viewed as loss of culture basis when no new cultural rules are internalized, is the basic phenomenon in the nowadays experience of change. Core aspects of culture are precisely those that the participants from inside are not usually, or explicitly, aware of. They are to such an extent embedded in the cultural matrix that no formal rules are required for them; they are taken for granted. When cultural rules are questioned, e.g. in migration, or rapid social changes, the unwritten rules – rather than those that are explicitly formulated (such as laws) – are the ones that are most painfully challenged.

From phenomenological viewpoint, Bulgarian culture in the post-totalitarian period is transitional, i.e. in a state of de-culturation with co-existing polar values and intermediate stages. The basic descriptor accounting for the heterogeneity is the collectivistic/individualistic dimension. While in cultures with priority of collectivistic values, extended families and group acceptance are frequent, and theories about equality are popular, in cultures with priority of individualistic values, nuclear families and social isolation are the rule, and theories about personal freedom are the dominating (and, politically correct) ones[16]. The simultaneous co-existence of features from both types of culture pre-determines polar and contradictory self-assessments, with non-homogeneous self-knowledge and frequent fluctuations between the cultural poles. One of its consequences is *fatalism*, i.e. the conviction that

life is dependent on forces out of one's control, leading to anticipation of unpredictability, and to behaviour of learned helplessness. Fatalistic philosophy is characteristic for *cultures of poverty*[17], dominated by image of limited welfare (i.e. one's success feasible only at the expense of others' loss), attitude of helplessness, high insecurity avoidance, and by pessimistic mentality in general.

Clinical and health care consequences of cultural differentiation could be numerous[18,19], but the major impact of culture's transitional state on the health care area is centred around an *antagonism* between medical paternalism (belonging to the collectivistic pole) and informed consent (individualistic creation). Inherent to the *collectivistic* pole and to the authoritarian traditions are features linked with the very roots of stigmatization, as demonstrated convincingly by Haghighat[20], as well as domination of the role of family over that of personal choice and responsibility. Opposite attitudes of total personal autonomy vs. group pressure for treatment, and opposite perceptions about what constitutes coercion in particular (e.g. liberty of choice vs. family arrest "for one's own benefit"), do frequently co-exist within a family, or within a ward. The major challenge nowadays ahead of the Bulgarian health care cultural context is the transition from paternalism and fatalistic mentality to personal autonomy. Thus, culture appears to be the limiting factor for law enforcement.

## Current Bulgarian legislation: recent developments

A major achievement in the legal field is the new general *Health Act*[21], in force since January 1, 2005. It contains a special chapter concerning patients' rights, with detailed ruling about giving informed consent: information needed to be presented when asking for informed consent, specification of informed consent giving when legally incompetent, assessment of the specific capacity to give informed consent, forms of registration, and representation of patient's will by others.

Involuntary treatment of psychiatric patients is regulated in another chapter (fifth), with the following developments when compared to the *Public Health Act*[13]:

- Detention for hospital expert assessment possible only with court decision, not prosecutor's.

- Differentiation between obligatory detention and obligatory treatment.

- Differentiation between criteria for involuntary treatment and capacity to give informed consent for treatment, with the consequent requirement for their separate expert assessment and separate court ruling.

- Definition of the conditions for treatment in cases of detainment for expert assessment.

- Definition of the conditions for application of measures for temporary physical restraint, and for emergency care.

- More procedural sophistication, i.e. shortening of all procedural deadlines; two court trials: one for review of applications for order of expert assessment, and the second one for review of expert report and for decision about obligatory detention and/or treatment, and about who should give informed consent on behalf of the patient if his capacity is judged to be disturbed; feasible hospitalization up to 72 hours with permission by

judge only, without requirement for expert assessment report.

Despite these developments, the general criteria for involuntary treatment in the new *Health Act* (Art. 155) however, follow the tradition from the previous law(s): broad formulation requiring hypothesizing about future offence, and no specification of the type or degree of dangerousness required so that the criteria could be fulfilled. Besides, in those criteria important pre-requisites for involuntary treatment, as formulated in the most recent Recommendation Rec (2004)10 of the Council of Europe[22], are missing: a) the placement includes a therapeutic purpose; b) no less restrictive alternative for providing appropriate care is available; and c) the opinion of the person concerned has been taken into consideration.

Another problem concerns the capacity to give informed consent. The patients that have been detained and treated involuntarily (whose capacity should according to the law, be assessed) represent insignificant portion of all that are admitted in psychiatric hospitals. The majority of the hospitalized patients are de jure competent, while there is serious clinical doubt about or evidence of de facto limited capacity for giving consent. Although there is a procedure about who can express consent for the patient, this procedure is not applicable in cases admitted voluntary. It remains unclear why these regulations refer to psychiatric patients being treated involuntary only, and not to all psychiatric patients and all general health care patients. It should also be shortly noted that in our legislation the regulation of the issues of legal competence and guardianship is dispersed in 3 different general (civic) laws, and quite out-of-date.

## Summarization and perspectives

The follow-up of the Bulgarian mental health legislation in historical perspective illustrates a development that parallels processes in other European countries until the totalitarian regime was imposed. The *Statutes for care of the mentally ill*[9] in particular, albeit in the custodial attitude characteristic for the epoch, contain norms defending patients' rights that are to be found in most European countries formulated later, such as assessment of the capacity to give consent, right to refuse treatment, and regulation of voluntary admission.

Aberration from this development during the totalitarian regime is rather conspicuous against this background. After years of total abolition of pre-existing norms, the matter is again regulated only in the 70's, concerning however consent for treatment in general and not specifically for the psychiatric patients[13]. It could be argued that, from historical viewpoint, and as far as the legislation *on paper* is concerned, the evaluation of Appelbaum[23] that psychiatric systems in post-communist countries operate in a *legal vacuum*, and similar conclusions of Polubinskaya & Bonnie[24], are only partially valid for Bulgaria.

The basic laws in Bulgaria from the 60's and the 70's were indeed relevant to the social and legal doctrines at that time, thereby placing the country in this respect closer to the Check Republic, Hungary, Romania, and Poland, rather than to the countries from the former Soviet Union[25]. In the post-communist period however, until recently there were no evident changes for more than a decade in this field, thus increasing the delay up to 30 years – as compared with the situation in the 70's.

An intriguing finding, although without clear implications on the general trends discussed, is that the first three of the abovementioned countries and Bulgaria (as well as some of the member-states of the EU) do not have special mental health acts, and the issues concerning mental health regulation are in their judicial systems incorporated into the general health acts.

The main reason for this delay is the *interplay between cultural and legal factors.* Culture and legal developments are far from being parallel, and as Carothers[26] formulates it, "…the primary obstacles to such reform are not technical or financial, but political and human". The ongoing debate in the professional community of the psychiatrists in Bulgaria remained in the 90's somehow isolated, and not grounded in authentic social processes and attitudes; the agenda of the society was not up to the need for legal changes that were discussed. Powerful factors of influence are also phenomena that are not confined to Bulgaria only: underestimation and negligence of the mentally ill, stigma, prejudices, dominant paternalistic attitudes in general, and authoritarian trends in psychiatric professionals in particular[24,27].

The legal regulation and the practice of involuntary treatment of psychiatric patients in the country, even after the new *Health Act*[21], continue to deserve criticism and to present challenges. It was shown that the formulation of the criteria for involuntary treatment is common to that in the previous law, and some important pre-requisites from recent instruments containing international standards are not included. The major problem however, is that the whole procedure is settled in the logic and spirit of the criminal laws, implying prevention of crime – a sign of persisting paternalistic and custodial attitudes towards psychiatric patients.

The "court model" of the procedures presents another problem due to the continuing slowness and rigidity of the procedures, actually leading to avoidance of legal forms of coercion even in cases where it is essentially needed. In a follow-up study, Boyadjiev et al.[28] show convincing evidence about the "*grey zone*" between legally involuntary and genuinely voluntary patients, i.e. admitted on their own initiative. The attitudes of hospitalized psychiatric patients towards their own hospitalizations were assessed in 17 years period. Data was gathered through a short questionnaire filled by the treating doctors concerning all patients admitted after a certain date in 6 (in 1983) and in 8 (in 2000) in-patient psychiatric services (hospitals, dispensaries and wards). Probably this information was representative for the Bulgarian practice at that time (all psychiatric hospitalizations in the country being between 30,000 and 40,000 per year for the period), although this has not been estimated statistically (Table I).

Those admitted on their own initiative were assumed to be the genuinely voluntary patients, while all the rest were in fact involuntary (i.e. 72% in 1983 and 62% in 2000, when figures from the second and the third

Table I
Attitudes of hospitalized psychiatric patients towards their own hospitalization: a 17 years follow-up (Boyadjiev *et al*., 2000)

| Attitudes | 1983 (n = 420) | 2000 (n = 215) |
|---|---|---|
| Explicit consent to treatment, i.e. admitted on their own initiative | 28% | 38% |
| Submit, or do not consent but without resistance | 66% | 55% |
| Actively resist to treatment | 6% | 7% |

row of Table I are summed). Among them were those that had their involuntary hospitalization formally legally sanctioned (7% in 1983 and 16% in 2000). The majority of the patients however, were in the above-mentioned "*grey zone*" between consent and coercion, most of them being subject to *informal coercion*. This large group has diminished for 17 years but the problem still persists. Within this group are the patients known as *non-protesting*. It is precisely their rights, of those that, according to Article 26 of the Recommendation (2004)10 of the Council of Europe "…do not have the capacity to consent and who is considered in need of placement, and do not object to the placement"[22], that need to be specially guarded.

Perspectives for future developments in the legal regulation of involuntary psychiatric treatment in Bulgaria could be centered around the issues of legal competence, guardianship, and informed consent. Probably a common characteristic for the post-totalitarian countries remains a relative underdevelopment in these areas – as compared to the expansive, and in some cases compensatory, progress regarding some more visible and public aspects of application of coercion in psychiatry. Specific challenges *in our case* are: a) need for differentiation of the capacity for informed consent from the general legal competence, b) lack of requirement for assessment of the specific capacity for informed consent when consenting or not consenting to treatment - not only psychiatric, and not only involuntary, c) need for procedures facilitating the patient in decision-making or in cases where his/her will is replaced (besides those that are legally incompetent), e.g. the institute of the *patient's council* according to UN's Principles[29], or a temporary guardianship for treatment, and d) need for guaranteed defence not at trial only, but beforehand also.

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