

Report of the U.S. Delegation to Assess Recent Changes in Soviet Psychiatry

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EXECUTIVE SUMMARY

A. Introduction

In early 1989 (February 26—March 12), at the invitation of the Soviet Government, a U.S. Delegation visited the U.S.S.R. The Delegation was given an unprecedented opportunity to interview and assess systematically a group of involuntarily committed forensic psychiatric patients of its own choosing—both hospitalized and released—and to discuss the treatment of some of these patients with the patients' relatives, friends, and occasionally, their treating psychiatrists. Members of the Delegation also conducted site visits at a number of Special and Ordinary Psychiatric Hospitals, also of the Delegation's own choosing, where they met with patients and staff.

For the most part, the U.S.S.R. hosts complied with the terms of the agreement under which the visit was made, although the Delegation did encounter significant procedural obstacles that hindered their time-limited task and that appeared to reflect some Soviet reluctance to provide full access to needed information. One limitation of the study was that the Delegation was denied access to the Soviet legal investigative reports.

Within the constraints of a brief visit, the Delegation attempted to obtain an objective assessment of the diagnostic status, psychiatric treatment, and legal and human rights protections of a controversial group of patients: political dissidents who had been involuntarily committed to psychiatric hospitals, either following criminal trials or on the grounds that their dangerousness warranted urgent (civil) hospitalization. The placement and retention of these individuals in mental hospitals had attracted the attention of many observers in the West concerned with human rights.

It had been maintained, in part on the basis of re-examination of former patients, that individuals who would not be regarded as mentally ill (or dangerous) outside the U.S.S.R. were being sent to mental hospitals and subjected to a variety of treatments that could not

possibly benefit them—and might even harm them. Such practices, if verified, would represent an abuse of the legal and mental health systems, of the psychiatric profession, and of the human rights of those individuals, whether they occurred through error or design. Indeed, on the strength of such allegations, ever since 1973 Soviet psychiatrists had been censured by psychiatric bodies, including the World Psychiatric Association, and the issue of psychiatric abuse has been frequently cited among the human rights violations allegedly occurring in the Soviet Union.

At the time of the Delegation's visit, numerous changes had been recently initiated in the Soviet legal system. They allowed somewhat greater freedom of expression and potentially offered stronger protections for the rights of mental patients—including those judged to be "nonimputable" (a status equivalent to "not guilty by reason of insanity" in the U.S.). In addition, during the past couple of years, the U.S.S.R. started to release some of the hospitalized dissidents. This latter encouraging change led to the U.S. decision to interview—and compare—both current and former patients. (Through a series of negotiations and releases, the actual number of interviewed patients was ultimately reduced from 48 patients on the original U.S. list to 27 patients: 15 hospitalized and 12 released.)

The brief "snapshot" of Soviet forensic psychiatry accorded the U.S. Delegation through its interviews, observations, and study of recent changes in Soviet law verifies that the social and legal systems are in flux. There are some signs of movement to bring legal and psychiatric practices closer to those found in the West. Yet there are also many signs that the transition is far from complete. Practices continue that, even allowing for considerable differences in political and economic philosophy, and in social, legal, and psychiatric systems, lend credence to continuing concerns about psychiatric abuse. Furthermore, it is by no means clear that the legal reforms wrought by the current Soviet leadership are sufficient to assure that these serious problems will soon be overcome.

This report represents the Delegation's best effort to synthesize its impressions as quickly as possible in light of the importance of the issues addressed and the considerable international interest in the findings. Although further analysis of the patient records and videotaped interviews is planned, the Delegation is con-

fidient that the conclusions reached in this report are clearly warranted on the basis of the observations made.

More specifically, the following observations, conclusions, and recommendations reflect key issues that, in the view of the U.S. Delegation, deserve further study and consideration by the U.S.S.R. and the international community in assessing the degree of progress of forensic psychiatry and human rights.

B. Clinical Assessment

Observations and Conclusions

Patient Selection

1. Clinical team members of the U.S. Delegation took note of the fact that there was an apparently high rate of patient discharge during the 2-month period between the Delegation's submission of the list of hospitalized patients in December 1988 and the Delegation's departure from the U.S.S.R. in mid-March 1989. Of the original 37 hospitalized patients on the list, four were removed from the list because of death, imprisonment, emigration to the U.S., or insufficient information to locate them. Of the remaining 33, more than half (17) were discharged either before or during the Delegation's visit.
2. Despite this high rate of discharge, five individuals (including one patient undergoing forensic evaluation) remained hospitalized for whom the U.S. team did not believe a mental disorder diagnosis was warranted according to U.S. (DSM-III-R) or international (ICD-10 draft) criteria. Two of these patients remained hospitalized under Article 70, one of the "political articles" of the Soviet Criminal Codes involving Anti-Soviet Agitation and Propaganda (see Appendix F).

Clinical Diagnosis

1. A significant proportion of the hospitalized patients had serious mental disorders. Among the 15 currently hospitalized patients, the U.S. team found evidence of a severe psychotic disorder in 9 patients—diagnoses that generally corresponded with those of the Soviet psychiatrists.

2. One of the hospitalized patients had been recently admitted (in December 1988) with a diagnosis of schizophrenia following his involvement in an intense period of human rights political activity. The U.S. team found no evidence for a mental disorder in this patient. Although he had not been charged under Articles 70 or 190-1 of the Soviet Criminal Codes, it had been possible to rehospitalize him quickly because his name remained on the psychiatric register (for outpatient follow-up and monitoring) following an earlier admission. Since returning to the United States, the U.S. Delegation has received confirmed reports that this patient has been released.
3. The discharged patients had no serious psychiatric disorders, and none of the discharged patients interviewed by the Delegation had been inappropriately discharged from a clinical standpoint. If this difference represents a trend, it indicates a positive change in the practice of Soviet forensic psychiatry.
4. Among the 12 released patients, the U.S. team found no evidence of any past or current mental disorder in 9, and the remaining 3 had relatively mild symptoms that would not typically warrant involuntary hospitalization in the Western countries. All of these patients had medical record diagnoses of schizophrenia or psychopathy; the stigma of these diagnoses is likely to continue to affect their lives adversely as long as the official diagnoses remain and they are retained on the psychiatric register.
5. The broad Soviet concept of mental disorder diagnoses in general, and schizophrenia in particular, was apparent in the medical record diagnoses of schizophrenia or other psychotic disorders in 24 of the 27 patients interviewed. This high number of schizophrenia diagnoses exemplified the problem of "hyperdiagnosis," as verified by a finding of only nine closely matching current diagnoses by both the Soviet and the U.S. interviewing psychiatrists.
6. From the perspective of the U.S. team, the problem of "hyperdiagnosis" persisted in other diagnostic areas, particularly in the psychopathy (personality

disorder) and "schizophrenia in remission" diagnoses. Specific examples of psychopathy symptoms identified in the interviews included "unitary activity," which related to a high level of commitment to a single cause, such as political reform, and "failure to adapt to society," used in describing a patient with "inability to live in society without being subjected to arrest for his behavior."

7. Some of the symptoms incorporated into Soviet diagnostic criteria for mild ("sluggish") schizophrenia and, in part, moderate (paranoid) schizophrenia are not accepted as evidence of psychopathology in the U.S. or international diagnostic criteria. Specific idiosyncratic examples identified in the interviews included diagnosing individuals demonstrating for political causes as having a "delusion of reformism," or "heightened sense of self-esteem" in order to support a diagnosis of schizophrenia.

Treatment

1. Antipsychotic (neuroleptic) medications have been used to treat patients for "delusions of reformism" and "anti-Soviet thoughts" in the absence of accepted medical indications for psychotic ideation. Medical records and patient interviews provided evidence for use of relatively high doses of neuroleptics in some patients who showed no signs of psychotic ideation.
2. Soviet psychiatrists have used sulfazine treatment ostensibly to enhance treatment response to neuroleptic medication. However, they were unable to produce any research evidence of its efficacy for this purpose. Furthermore, the severe pain, immobility, fever, and muscle necrosis produced by this medication, as well as the pattern of its use in 10 patients, suggest that it has been used for punitive rather than therapeutic purposes. In addition to sulfazine, there were reported cases in which insulin coma, strict physical restraints, and "atropine therapy" were used for patients in whom U.S. psychiatrists found no evidence of psychotic or affective (mood) disorder. The use of atropine, which produces a transient

delirium state and high fever, is not an accepted therapeutic modality in the West.

3. Patients who received initial diagnoses of schizophrenia or psychopathy retained their official medical record diagnoses regardless of changes in their clinical status. However, treatment regimens were more frequently modified to reflect changes in psychotic symptoms or need for neuroleptics.

Forensic Practice

1. The concept of a "nonimputable" mental disorder in the Soviet system has been used to encompass at least three different symptom levels found in these patients, as follows:
 - a. Psychotic symptoms associated with the commission of a violent or illegal act, in which the patient's impaired understanding or volitional control was directly related to his or her criminal behavior;
 - b. Any current or past diagnosed mental disorder or psychiatric symptom in a person accused of having committed illegal behavior (even in the absence of any apparent impairment of the patient's understanding of, or capacity to control, his or her behavior);
 - c. Anti-Soviet political behavior, including writing books, demonstrating for reform, or being outspoken in opposition to the authorities, which was defined in some patients as being simultaneously a symptom (e.g., "delusion of reformism"), a diagnosis (e.g., "sluggish schizophrenia"), and a criminal act (e.g., violation of Articles 70 or 190-1).
2. In two cases, Soviet psychiatrists treating a criminally committed patient (i.e., a mentally ill person who had been charged with violation of a criminal statute) were unable to obtain the court's approval to discharge the patient from a Special Psychiatric Hospital (SPH), despite the absence of a psychiatric condition requiring SPH hospitalization. Soviet psychiatrists identified problems in providing treatment plans for patients hospital-

ized under the "political articles" who had no evidence of psychopathology.

3. As noted above, the U.S. Delegation observed mental disorder diagnostic and treatment practices affecting political dissidents that were excessive and inappropriate by Western standards. Nevertheless, Soviet psychiatrists always maintained that all patients had been hospitalized because of some form of mental illness. Since Delegation members were unable to review the investigative reports, it is not possible in this type of study to determine whether the original or current Soviet diagnoses were based on idiosyncratic medical considerations alone or if political pressures influenced their judgment, thus resulting in deliberate misuse of psychiatry for purposes of social control.

Recommendations

1. The accelerated discharge of Soviet psychiatric patients identified by human rights groups and the beneficial professional exchange on psychiatric diagnosis and treatment support a recommendation for continued professional contact between U.S. and U.S.S.R. mental health experts. In the absence of evidence for any inappropriate discharges to date, the prospect of continued release of unnecessarily hospitalized patients is likely to benefit both the human rights of patients and the hospitals (which could thus reduce their overcrowded census).
2. Use of international diagnostic criteria for all mental disorders in the U.S.S.R. (including schizophrenia, affective (mood), and personality disorders) would greatly enhance the possibilities for professional and scientific exchanges. Of particular significance is the current opportunity for Soviet participation in the international field trials of the International Classification of Diseases (ICD-10) sponsored by the World Health Organization (W.H.O.). It is expected that this international classification system will provide the most useful common diagnostic criteria—ones that will be completely compatible with U.S. diagnostic concepts.
3. The current broad diagnostic concepts for schizophrenia and psychopathy used in the U.S.S.R. appear to pose a higher risk of misuse for political purposes than do current Western criteria. Hence, narrowing the Soviet criteria along the lines of ICD-10 would make it more likely that psychiatric diagnoses will be used only for appropriate medical indications.
4. The use of neuroleptic medications for nonpsychotic symptoms should be re-evaluated on the basis of current scientific studies of treatment safety and efficacy.
5. The use of sulfazine and atropine therapy for psychiatric disorders should be re-evaluated on the basis of preclinical or clinical research studies of treatment efficacy. In the absence of supporting evidence of treatment efficacy, the practice should be discontinued. The U.S. Delegation notes that a report by the U.S.S.R. Ministry of Health on the clinical use of sulfazine was to be issued in May 1989.
6. Consistent with the key statutory language of Article 11 (see Appendix F), the determination of "nonimputability" of persons with mental disorders should be limited to those situations in which the psychiatric symptoms impair understanding or control of criminal behavior.
7. The definition of some criminal behaviors as being psychiatric symptoms or disorders requires special attention. The possible confounding of political and psychiatric definitions is problematic and affords opportunities for possible abuse. These definitions should be reviewed by colleagues involved in developing the new international classification under W.H.O. auspices.
8. Four hospitalized patients who were found to have no mental disorder by the U.S. team should be reviewed for possible discharge if they have not yet been released. One of these patients was discharged immediately following the U.S. Delegation's visit, and two additional patients were awaiting discharge. The fourth patient's planned disposition is unknown. The placement of these last three patients should be reviewed as soon as possible.

9. Transfer of some patients who require ongoing psychiatric treatment to Ordinary Psychiatric Hospitals (OPHs) closer to their relatives had been urgently requested by several patients and their families. The U.S. Delegation supports these requests and hopes that such transfers will be feasible.
10. For discharged patients who were not found to have a mental disorder diagnosis according to international diagnostic criteria, consideration should be given to removing their diagnoses (or other indications of mental illness) from draft cards, psychiatric registers, or other records where such notations might impede their employment, education, or other participation in the broader society. Specific examples of this change are already occurring in a limited number of cases, to the great benefit of the patients.
11. Establishment of a U.S./U.S.S.R. study on the diagnosis of schizophrenia, mood disorders, and personality disorders would greatly facilitate professional and scientific understanding between the two countries.

C. Legal Process and Patients' Rights

Conclusions

Social Dangerousness

1. The U.S.S.R. Criminal Codes prohibit certain types of political and religious expression that liberal democratic societies do not regard as criminal or punishable. Because any violation of the U.S.S.R. Criminal Codes is apparently regarded as a "socially dangerous act," these criminal prohibitions of political and religious dissent have provided the legal basis for compulsory psychiatric hospitalization of dissidents who are diagnosed as mentally ill.
2. Until recently, Soviet courts appear to have regarded violations of the "political articles" of the Soviet Criminal Codes (such as Articles 70 and 190-1) almost categorically, as "especially dangerous to society," even though the criminal conduct involved nonviolent expressions of political or religious ideas. As a result, ostensibly "nonim-

putable" political dissidents have been placed routinely in maximum security Special Psychiatric Hospitals.

3. No patient examined by the U.S. Delegation had been hospitalized within the past year as a consequence of arrest under the "political articles."
4. While the matter of "urgent" hospitalization could not be studied in depth, there is some evidence that, within the past 6 months, the involuntary civil process has been used to hospitalize a person whose behavior was essentially political and posed no danger to himself or others. This practice appears to be contrary to the declared policy of the Ministry of Health, which opposes involuntary hospitalization unless the patient "represents a direct danger to those around him, as well as to himself."

Procedural Protections

1. According to virtually every patient and former patient questioned by the Delegation who had been hospitalized after findings of "nonimputability" and "social dangerousness," the patients played no role in the criminal proceedings that resulted in their commitments. With the exception of one case, they never met with a defense attorney, even though one may have been appointed in the case. Of those interviewed on these points, only three patients reported seeing the investigative report; none reported being presented with the experts' findings, and all but one were tried *in absentia*.
2. Although the status of patients under compulsory hospitalization orders is reviewed by a psychiatric commission every 6 months, as required by law, it appears that these commission reviews are brief (usually less than 10 minutes) and *pro forma*, and do not involve independent decision making. As a practical matter, patients have no meaningful opportunity to challenge the hospital staff's decisions to retain them in the hospital.
3. Until the new law enacted in January 1988, the civil process of "urgent hospitalization" was regarded as largely within the sphere of psychiatric discretion. There is general agreement that the new

statute represents an important reform because it is known to the public and brings this process within reach of the rule of law. However, the available evidence suggests that the provisions of the new statute do not provide adequate safeguards against unwarranted hospitalization, and that even the legal protections declared by the new law (including representation by an advocate, periodic psychiatric review, and the opportunity to appeal to court) have not yet become operational.

Patients' Rights

1. Based on reports of patients and its own observations, the Delegation believes that the conditions in most Special Psychiatric Hospitals, with the exception of the Leningrad SPH, are unduly harsh and restrictive. Notwithstanding the partially implemented transfer of jurisdiction over the SPHs from the Ministry of Interior to the Ministry of Health, and the apparent goodwill of the administrators of the hospitals the Delegation visited, these facilities continue to have many of the characteristics of psychiatric prisons. Patients are denied basic rights, are apparently subject to punitive use of medication, and are fearful of retaliation if they complain about their treatment, about abusive conduct by the staff, or about restrictive hospital rules or practices. In brief, the transition to a more humane regime has just begun.
2. Although the Delegation's exposure to Ordinary Psychiatric Hospitals was limited, patient interviews and other information indicate that these facilities are decidedly more humane and therapeutic than the Special Psychiatric Hospitals.
3. One discernible characteristic of all institutional psychiatry in the Soviet Union, especially in the Special Psychiatric Hospitals, is that patients do not participate to any significant extent in decisions about their own treatment.
4. The Soviet authorities have declared their intention to decrease greatly the number of persons on the psychiatric register and to require registration only of individuals who are a real threat to others. However, this process is in its early phases. At

present it appears that large numbers of persons are encountering social and legal disadvantage because of their psychiatric histories.

Recommendations

1. Broad concepts of "social dangerousness" have contributed to the U.S.S.R. practice of hospitalizing people who are not mentally ill. For this and other reasons, the Delegation recommends that additional steps be taken to revise the Soviet Criminal Codes to remove all prohibitions against expression of political or religious beliefs.
2. New legislation and regulation appear necessary to allow the Ministry of Health to implement its announced intention to restrict involuntary civil hospitalization ("urgent hospitalization") to patients who are a direct danger to themselves or others, and thereby reduce the risk that this process will be invoked to suppress dissent.
3. Defense lawyers should be appointed early in the criminal process and prior to the time when patients are evaluated by psychiatric commissions for determination of mental illness and nonimputability. Persons subject to forensic examination in criminal cases should be accorded rights already specified in Soviet Codes of Criminal Procedure (e.g., to play a role in the process of investigation, to learn about the charges against them, to receive the investigative and forensic reports, and to be present at their trial).
4. In the light of overly long periods of hospitalization for some patients in SPHs, periodic review of the necessity of continuing hospitalization under compulsory treatment should be strengthened, including meaningful independent review by commissions or other review bodies, with subsequent mandatory court review.
5. In the case of "urgent hospitalization" (civil commitment), additional procedural protections should be implemented. These include mandatory, independent periodic review of the necessity for hospitalization and mandatory court review within at least 6 months of hospitalization. In light of recent statistics documenting only 10 appeals to courts out of 71,000 hospitalizations in

Moscow in 1988, the right to legal representation needs to be made operational, and the appeals process should be rendered less cumbersome. These recommendations appear to have the approval of prominent Soviet lawyers.

6. In keeping with the "Draft Body of Principles and Guarantees for the Protection of Mentally Ill Persons and for the Improvement of Mental Health Care" of the U.N. Commission on Human Rights, the treatment environment of the Special Psychiatric Hospitals should be rendered less restrictive and patients granted more rights and opportunities to engage in normal activities. There should be fewer deprivations and restrictions, such as restriction of access to writing materials, censorship of mail, close supervision of visits, and the absence of personal possessions.
7. Hospitalized patients should be informed of their rights, and these rights should be guaranteed in legislation and regulation. Patients should be invited to participate to a greater extent in treatment decision making. Grievance procedures should be instituted, and patient advocacy services should be implemented through ombudsman or other types of rights protection programs.
8. In keeping with initiatives already begun in the U.S.S.R., the Delegation supports continuing re-evaluation of the medical indications for placing or retaining patients on the psychiatric register. Procedures should be instituted to prevent placement of names on the register without the individuals' knowledge. To prevent their psychiatric histories from stigmatizing persons who are not mentally ill, diagnoses should be removed to facilitate these persons' full reintegration into society.
9. Joint studies between the U.S. and U.S.S.R. related to forensic practices, determinations of nonim-

putability, and the role of law in providing protections for patients' rights should be conducted.

D. Prospect

1. To facilitate a continuing dialogue on issues raised during its visit, the Delegation hopes to receive as soon as possible a status report on each of the patients it interviewed in the U.S.S.R.
2. The U.S. hospital visit team identified 20 patients whose placement and treatment were questionable, even if it was not clear that these were "political cases." The names of these cases have been submitted to the U.S.S.R. The U.S. Delegation has requested follow-up information about the outcome of these cases.
3. The Delegation recommends that the U.S. and U.S.S.R. promptly initiate discussions to:
 - a. Arrange the details of a visit by a Soviet delegation of psychiatrists and other experts to hospitals and forensic facilities in the U.S.;
 - b. Arrange a follow-up visit to the Soviet Union by the U.S. Delegation to allow the Delegation to meet with patients interviewed on the prior visit; and
 - c. Arrange the ongoing collaborative exchanges and joint scientific studies recommended above in this report.
4. The Delegation recommends the formation of an international commission including members from the U.S., the U.S.S.R., and other nations to review alleged psychiatric abuses in any nation. Where indicated, the commission should have direct access to patients and records for purposes of examination.

I. INTRODUCTION

An official United States Delegation of 26 persons visited the U.S.S.R. from February 26 to March 12, 1989 to assess recent changes in Soviet psychiatry. Led by an official of the U.S. Department of State, the Delegation included 14 psychiatrists, 1 psychologist, 2 lawyers, 2 specialists in human rights, and 6 interpreters (see Appendix A for the list of participants).

While in the U.S.S.R., the Delegation examined 27 patients or former patients of its own choice—15 persons who were then hospitalized and 12 who had been released, typically within the preceding 2 years. A subgroup of the Delegation also visited four psychiatric hospitals of its own choice. The Delegation obtained statutes, regulations, and statistical information relating to psychiatric care in the Soviet Union and conducted discussions with Soviet psychiatrists, lawyers, and other professionals.

This report represents the Delegation's best effort to synthesize its impressions as quickly as possible in light of the importance of the issues addressed and the considerable international interest in the findings. Although further analysis of the patient records and videotaped interviews is planned, the Delegation is confident that the conclusions reached in this report are clearly warranted on the basis of the observations made. The Soviet reply to this report, sent to the U.S.S.R. on June 9, 1989, follows this report.

A. The Context for the Visit of the U.S. Delegation

This visit took place in the context of a long-standing controversy about alleged abuses of psychiatry in the Soviet Union (e.g., see Bloch and Reddaway 1977, 1985; Koryagin 1981). The core of the allegation is that political and religious dissidents have been systematically confined to psychiatric hospitals for other than medical reasons. According to one source (Bloch and Reddaway 1985), there had been 346 victims of psychiatric abuse identified in the Soviet Union between 1977 and 1983. This charge of abuse has many dimensions. It has been alleged, for example, that individual Soviet psychiatrists have knowingly collaborated in the punitive use of psychiatry by diagnosing as mentally ill some individuals whom they knew to be mentally healthy, by imposing biological therapies on such "patients" without

medical justification, and by involuntarily confining such persons in psychiatric hospitals for long periods of time. The practice of hospitalizing political and religious dissidents would be problematic from a human rights perspective even if it were not predicated on intentional misdiagnosis. Obviously, the intentional misuse of psychiatric control for political purposes violates basic precepts of medical ethics as well as internationally accepted human rights, norms, and principles—e.g., Universal Declaration of Human Rights and Declaration on the Rights of Disabled Persons (Center for Human Rights, 1988).

Another dimension of the charge of political abuse is that a governmental policy of repressing dissent has been operationalized through clinical practices and philosophies that are easily, though perhaps unwittingly, bent to the task. These include a conception of mental disorder broad enough to include disapproved political and religious ideas, and a conception and definition of "social danger" broad enough to encompass political and religious deviance.

Although small groups of Western psychiatrists had previously visited the Soviet Union to investigate the charge of abuse, adequate access to records and patients was not provided to them. Nonetheless, based on the substantial body of evidence that has accumulated in the West, including extensive clinical examinations of former psychiatric patients who now reside in the West, informed groups have consistently concluded that political abuses did, in fact, occur. The World Psychiatric Association (W.P.A.) condemned the Soviet Union for such practices in 1977, and 6 years later, the Soviet All-Union Society of Neuropathologists and Psychiatrists resigned from the W.P.A. rather than face almost certain expulsion.

Soviet psychiatric officials have repeatedly denied the charges of political abuse. However, they have acknowledged a variety of problems with Soviet psychiatric practice during the past 25 years, including a tendency toward "hyperdiagnosis" and a pattern of over-hospitalization (Churkin 1988). Indeed, over the last 2 years, Soviet psychiatry has been subjected to a persistent barrage of internal criticism, even in the officially controlled Soviet press. A series of newspaper articles in 1987 highlighted problematic cases of hospitalization and called attention to scientific controversies about Soviet diagnostic practices (Novikov et al. 1987).

Occasional references in the Soviet press have specifically alluded to abuses of psychiatry for political purposes. For example, M.I. Buyanov, a Soviet practitioner, recently observed in the teachers' newspaper *Uchitelskaya Gazeta* that "people were placed in mental hospitals for political rather than medical reasons before, but after 1970, this was done more often" (Buyanov 1988). A recent article from *Kommunist*, a Soviet magazine for Community Party leadership, notes that "cases of utilizing psychiatry for the suppression of those who think differently rather eloquently witness the power of this weapon (power over the patient) when it gets into the hands of dishonest politicians" (Protchenko and Rudyakov 1989).

As these press reports suggest, there are considerable signs of ferment and change within Soviet psychiatry, as is true in many other spheres of Soviet society. The momentum for change is most explicitly demonstrated by the "Statute on Conditions and Procedures for the Provision of Psychiatric Assistance," which was enacted by the Presidium of the U.S.S.R. Supreme Soviet in January 1988. This statute is important because it is the first legislative enactment to regulate the process of involuntary civil hospitalization in the Soviet Union. The statute establishes some legal protections for patients who are subject to involuntary hospitalization, and it prescribes criminal sanctions against individuals who knowingly commit a mentally healthy person to a psychiatric hospital. The 1988 statute also transfers jurisdiction over the Special Psychiatric Hospitals (i.e., maximum security forensic hospitals) from the Ministry of Internal Affairs to the Ministry of Health. The significance of this change lies in the fact that conditions in most of these hospitals have been described as harsh and inhumane in reports that have reached the West.

Another important sign of change in Soviet psychiatric practice is the announced intention of the Ministry of Health to reduce the census of Soviet psychiatric hospitals by 30 percent. According to official Soviet reports, the number of hospital admissions in Moscow was reduced by 12 percent from 1987 to 1988 (*Pravda* 1989). Reflecting a similar trend, the census of the Special Psychiatric Hospitals was also reduced by approximately 12 percent from 1987 to 1988 (from 9,859 patients to 8,724).

Soviet psychiatric officials have also announced a new plan to modify significantly the scope and function of the psychiatric register—a formal system for monitor-

ing psychiatric patients in the community. In the past, virtually all patients discharged from Soviet psychiatric hospitals and those who received only outpatient care were placed on this register; in early 1988 the register included some 5.5 million people. Being on the register has significant consequences for released patients, including possible discrimination with respect to employment, driving privileges, travel, and other civil rights. It also subjects individuals to periodic visits by the psychiatric authorities and to the possibility of unwarranted rehospitalization. In a significant reform, the Soviets have announced a plan to remove perhaps 2 million individuals from the register and to require registration only for patients who are regarded as seriously mentally ill and potentially dangerous to others (*Washington Post* 1988; *Pravda* 1989).

Apart from these changes in official policy, there is evidence of intellectual ferment in Soviet psychiatry. Diagnostic practice in much of the Soviet Union has long been dominated by the "Moscow school" of psychiatry, whose leader, Professor Andrei V. Snezhnevsky, was the editor of the principal psychiatric journal in the Soviet Union. Professor Snezhnevsky's diagnostic framework, which has had a major impact on Soviet diagnostic practice, includes a vague concept of "sluggish" or mild schizophrenia, which has been associated with the officially acknowledged tendency toward "hyperdiagnosis" and with allegations of political abuse. Since Professor Snezhnevsky's death in 1987, the diagnostic approach of the Moscow school is now undergoing some re-examination within Soviet scientific circles.

The visit of the U.S. Delegation itself attests to the profound changes now occurring in the Soviet Union at large and in Soviet psychiatry. As will be further described below, the Delegation was permitted an unusual degree of access to individual patients and psychiatric facilities. The willingness of Soviet authorities to permit this visit under these conditions demonstrates both a desire to re-enter the world psychiatric community and a willingness to accept a degree of international accountability for the legal and humanitarian aspects of psychiatric practice. This is in itself a positive step, especially in light of the controversy regarding political abuse that has surrounded Soviet psychiatry for 20 years.

What follows in this report is not intended to resolve the controversy regarding past practices in Soviet psychiatry. To what extent political abuses of psychiatry

have occurred in the Soviet Union in the past and whether Soviet psychiatrists have knowingly colluded in these practices are not readily subject to definitive investigation by a group such as the U.S. Delegation, given its methods and time frame. Instead, the Delegation was directed to focus its attention on the current situation and changes in Soviet psychiatry.

Specifically, the purpose of its mission was to:

1. Provide a more systematic and scientifically based foundation for assessing allegations of psychiatric abuse than was previously feasible;
2. Assess psychiatric diagnoses of hospitalized and recently released patients identified as examples of abuse;
3. Assess appropriateness of treatment for these patients;
4. Assess the laws governing involuntary hospitalization;
5. Assess recent changes in Soviet forensic psychiatry;
6. Assess mechanisms now in place to prevent future problems of abuse from arising.

B. Planning the Delegation's Visit

Planning for the U.S. Delegation's visit to the U.S.S.R. began more than a year ago. Because of intense interest within the Soviet Union in improving international perceptions of its human rights policy, the Ministry of Foreign Affairs issued an invitation for foreign psychiatrists to visit the U.S.S.R. A Human Rights Round Table discussion between the U.S. State Department and the Soviet Ministry of Foreign Affairs followed in Washington, D.C. in March 1988, at which time representatives of Soviet psychiatry confirmed the invitation to the U.S. The U.S.S.R. would "provide an opportunity to Western psychiatrists to examine individual patients who are committed to psychiatric institutions in the Soviet Union" (Melekhin 1988). Shortly thereafter, this invitation gave rise to an exchange between U.S. and U.S.S.R. psychiatrists at a Human Rights Round Table held in Moscow in April 1988, where the initial framework for a visit was sketched out.

Subsequently, in May 1988, the U.S. Department of State requested the assistance of the National Institute of

Mental Health (N.I.M.H.), Department of Health and Human Services, to help develop a scientific team to carry out a visit to the U.S.S.R. An advance team trip to negotiate terms and conditions of the visit took place in November 1988. Following this visit, a formal request for N.I.M.H. scientific and logistical support was made in a letter from Secretary of State George Shultz to Secretary of Health and Human Services, Dr. Otis Bowen (see Appendix A). A full scientific team was then selected by N.I.M.H. in consultation with the American Psychiatric Association. The scope of the mission was designed to include a thorough clinical examination of a number of both hospitalized and released patients, using standardized psychiatric diagnostic instruments. It was decided that the U.S. Delegation would be led by a U.S. Department of State official.

During the Fall of 1988, there was also increasing interest in the possibility of a psychiatric delegation visit because of ongoing discussions between the U.S. State Department and the Soviet Union, in which the U.S. insisted, as a barometer of progress on human rights issues, that the U.S.S.R. release all political prisoners, including both those in prisons and in mental hospitals. This included persons who had been prosecuted for violating various well-known articles in the Soviet Criminal Codes (including Article 70—Anti-Soviet Agitation and Propaganda, and Article 190-1—Circulation of Fabrications Known to be False Which Defame the Soviet State and Social System—in the Russian Soviet Federated Socialist Republic (R.S.F.S.R.) Code (see Appendix F for text of these and related articles). These articles define behaviors that, for the most part, would not be regarded as criminal in Western countries. Although most individuals charged with these offenses received prison sentences, a significant number of charges under these articles have, in the past, culminated in persons being found "nonimputable"—a legal status similar to that of "not guilty by reason of insanity" in the U.S.—with subsequent indeterminate commitment to a mental hospital (typically a Special Psychiatric Hospital).

Since January 1987, the U.S. Department of State has received no reports of convictions under Articles 70, 190-1, or under Articles 142 and 227 (the latter articles concern certain religious behaviors). By late 1988, Soviet authorities stated that they had released all prisoners who had previously been incarcerated under these four political and religious articles. In addition, approximately 50 persons thought to be political and religious

prisoners were released from psychiatric hospitals in 1988 (U.S. Department of State, 1988), leaving an unknown number remaining. The continued hospitalization of some individuals in Soviet mental hospitals was of particular interest to the U.S. Helsinki Commission (Commission on Security and Cooperation in Europe). Persons drawn from a list maintained by the Commission were, therefore, included on the list of patients considered for psychiatric examination by the U.S. Delegation.

C. Negotiated Terms and Conditions for the Delegation's Visit

During the visit of the U.S. Advance Team to Moscow in November 1988, terms and conditions were negotiated over a period of 3 1/2 days in order to maximize the probability that a credible study could take place. A primary concern was to assure that the U.S. experts would be granted access to any patients they wished to see under conditions favorable for a research psychiatric examination. These conditions included the availability of hospital interviewing rooms for individuals who remained as patients, as well as suitable rooms outside an institutional setting, such as a hotel, for interviewing discharged and former patients. Each patient was to be interviewed with a series of research diagnostic instruments recognized internationally for their reliability and validity. In addition it was agreed that, with the consent of the patient, the U.S. team could videotape and audiotape the interviews and obtain a urine specimen for toxicology analysis. To maximize the amount of information from each subject, it was agreed that the team members would be permitted to interview one of the patient's relatives or friends as well as the patient's treating psychiatrist (see Appendix B).

An additional source of information was to be the patients' medical records, which the Soviets agreed to make available to the Delegation about 2 weeks in advance of the psychiatric interviews, with specified key portions translated into English. These materials were to include the first and last psychiatric commission reports, the discharge summary, the medical orders, and relevant court orders. The Soviets refused to release the investigative reports on the patients to be interviewed, stating that these were under the control of the Ministry of Justice.

It was also agreed in November that the U.S. team could visit any hospital it wished in the Soviet Union, including Special Psychiatric Hospitals. The U.S. team would be free to approach and talk with any patients it wished in the hospitals.

Although the Soviets agreed to all of the above terms, formal signatures were not affixed to the documents that spelled them out. The reasons for not insisting on formal signatures involved a Soviet request for immediate U.S. agreement to a return Soviet visit under identical conditions. The Soviet principle enunciated was to have "complete reciprocity," as had been guaranteed in mutual military inspection agreements between the two countries. The U.S. position on this issue was that similar conditions did not exist in both countries regarding psychiatric treatment. There has been, for example, no charge from either within or outside the United States of a U.S. Government policy that systematically used psychiatry to suppress political dissent. Since reciprocal conditions did not exist, the as-yet-unspecified objectives of a future return visit to the U.S. would need to be determined.

Based on these considerations, the Soviet Ministry of Foreign Affairs and the U.S. State Department informally agreed that the visit of U.S. psychiatric experts to the U.S.S.R. should take place under the negotiated but unsigned terms and conditions. It was also agreed that some form of return visit, under favorable conditions, would be expected following the successful completion of the U.S. psychiatric Delegation's visit to the U.S.S.R.

During the 3 months between preliminary negotiations between the U.S. Advance Team and Soviet representatives in November 1988 and the actual visit, which began in February 1989, extensive discussions were directed toward identifying the appropriate patient sample and clarifying the conditions under which patients would be seen. The highest priority for the clinical assessment was to be able to all patients selected and to avoid attrition that could bias the sample. The second highest priority was to have all hospitalized and released patients' entire medical and forensic psychiatric records available for review. Additional priorities were to have the key sections translated into English and to have the opportunity to interview a relative or friend of each patient as well as the patient's treating psychiatrist. An agreement was also reached on procedural details for obtaining patient consent for procedures that included being interviewed by the members of the U.S.

Delegation, allowing U.S. access to medical records, audiotaping and videotaping patient interviews, and obtaining a urine specimen for toxicological analysis.

Some of the difficulties in meeting all of the informally agreed to terms and conditions for the visit will be discussed in a later section of the report and are more fully elaborated in Appendix D. Notwithstanding these problems, the level of access granted to the U.S. team facilitated the creation of an unprecedented data base for addressing the original goals of the Delegation's visit.

These findings will be summarized, using illustrative cases to document the basis for conclusions. In addition, summary tabulations of findings from each of the patient interviews and from the review of medical records will be presented. Finally, the implications of these findings will be discussed.

II. CLINICAL ASSESSMENT

A. Patient Selection

The original U.S. list of 48 hospitalized and released patients was drawn from master lists assembled by the U.S. Department of State and the American Psychiatric Association, which had reviewed lists from a wide variety of sources, including Soviet human rights activists, the International Association on the Political Use of Psychiatry, the U.S. Helsinki Commission, Amnesty International, and the U.S. Institute of Medicine/National Academy of Sciences. This list included all 37 then-hospitalized patients who had been identified by the Helsinki Commission. The initial list also included individuals released within the preceding 2 years for whom there was supportive documentation in the West suggesting that these were psychiatric abuse cases.

The hospitalized patients, as a group, were less well known to the West than the released patients, and documentation on the former was not as complete as that for the latter. The original list included patients believed to have been hospitalized in the absence of a mental disorder as well as some patients who, although believed to be mentally ill, were possibly being treated in ways that raised continuing concerns about their human rights status.

Prior to the U.S. Delegation's arrival, the total number of patients was reduced from 48 to 44 because of patient ineligibility for the following reasons: one emigrated to the U.S.; one died; one was placed into prison; and one

could not be located because of insufficient identifying information. Hence, of the names submitted in late December 1988, those eligible for interviews included 11 released and 33 hospitalized patients. During the ensuing 7 weeks prior to the Delegation's arrival, 15 additional patients were released, leaving only 18 of the original 37 hospitalized patients still interned. The U.S. team then selected 13 discharged patients and 18 hospitalized patients—a total of 31—with whom interviews were requested.

During the Delegation's stay in the U.S.S.R., one of the released patients to be interviewed could not be located. In addition, four hospitalized patients refused to give consent for interviews; all were confirmed as refusals, two in personal interviews with members of the U.S. team, one in a telephone interview, and one in an interview confirmed by telegram by a local official. (This latter patient was discharged while the U.S. Delegation was in the U.S.S.R.) One additional hospitalized patient was discharged during the U.S. Delegation's visit and could not be located for an interview.

Hence, from the time the U.S. Delegation submitted a list of 44 eligible patients (33 hospitalized and 11 discharged) to the time it left the U.S.S.R., a total of 17 patients had been discharged, leaving only 16 hospitalized patients; 3 of these refused interviews, leaving 13. In addition, by mutual consent, two hospitalized patients were added to the list after the team began its examinations. As a result of this selection and attrition process, the U.S. Delegation ultimately conducted a total of 27 patient interviews, including 12 discharged and 15 hospitalized patients.

The demographic characteristics of these patients are described in Table 1. All but one were male, and their ages ranged from 18 years to 63 years. There was a relatively even age distribution in four of the five 10-year age groups (25-34, 35-44, 45-54, 55-64). The average level of educational attainment was as follows: 26 percent had a high school education or less, 22 percent had completed a vocational school, 33 percent had obtained a university degree, and 19 percent had a postgraduate education. Two-thirds of the group were single or separated/divorced, and only one-third were currently married. Current resident status of the patients is also described in the Table 1 distribution of 12 released and 15 hospitalized patients, of whom three remained in Special Psychiatric Hospitals.

Table 1. Demographic data on interviewed patients

| | | | |
|-------------------------------------------|-------------|-------|--|
| All cases (n = 27) | | | |
| Sex | | | |
| Male | 26 | (96%) | |
| Female | 1 | (4%) | |
| Age | | | |
| Mean | 44 years | | |
| Range | 18-63 years | | |
| 18-24 years | 1 | (4%) | |
| 25-34 years | 6 | (22%) | |
| 35-44 years | 7 | (26%) | |
| 45-54 years | 6 | (22%) | |
| 55-64 years | 7 | (26%) | |
| Marital status | | | |
| Single | 11 | (41%) | |
| Married | 9 | (33%) | |
| Div./Sep. | 7 | (26%) | |
| Education | | | |
| Primary/Secondary | 7 | (26%) | |
| Vocational (Post-secondary) | 6 | (22%) | |
| University | 9 | (33%) | |
| Post graduate | 5 | (19%) | |
| Residence | | | |
| Special Psychiatric Hospital | 3 | (11%) | |
| Ordinary Psychiatric Hospital | 12 | (44%) | |
| Community | 12 | (44%) | |
| Total length of hospitalization(s) | | | |
| 0-1 year | 2 | (7%) | |
| 2-4 years | 7 | (26%) | |
| 5-9 years | 7 | (26%) | |
| 10-14 years | 5 | (19%) | |
| 15-19 years | 6 | (22%) | |

B. Methods

The available selected patients provided consent to be seen in accord with the previously described terms and conditions of the U.S./U.S.S.R. Memorandum of Understanding (see Appendix B). The patients themselves decided if they wished to have a Soviet psychiatrist present, to have the interview video- and/or audiotaped, and if they wished to provide a urine sample for later laboratory confirmation of their physiological status at the time of the interview.

The U.S. Delegation included three diagnostic interview teams. Each of these teams was headed by a research psychiatrist and included a Russian-speaking psychiatrist trained to conduct the interviews, a forensic psychiatrist or psychologist, and two professional interpreters provided by the U.S. State Department (Appendix A). The interviews were administered in the Russian language, with simultaneous interpretation into English of both questions and answers for the benefit of the non-Russian-speaking research and forensic clinicians.

The diagnostic assessment instruments included the Structured Clinical Interview for DSM-III-R, Psychotic Disorders Version (SCID-PD), the International Personality Disorders Examination (IPDE), the Mini-Mental Status Examination, the DSM-III-R Checklist, and a structured forensic interview constructed to assess the legal history of the patient. (A more detailed description of the instruments and methods is contained in Appendix C). All of these instruments were first translated into Russian under N.I.M.H. contract and received extensive clinical editing by the Russian-speaking U.S. psychiatrists. English-language training sessions in the use of these interviews with volunteer patients were provided at the N.I.M.H. research unit of St. Elizabeths Hospital, Washington, D.C., and Russian-language training sessions with volunteer Russian-speaking psychiatric outpatients were then conducted over 2 days in a local Washington, D.C. area hotel. Following these training sessions, the clinical assessment teams extensively edited and streamlined the interviews.

C. Study Limitations

Access to the medical records of the patients who were to be seen by the U.S. Delegation was provided for the cases interviewed, although there were many limitations

and problems. The prior agreement had been that copies of the records would be provided 2 weeks before the patient interviews; in fact, however, most of the records were made available only 3 or 4 days before. Moreover, significant sections of the record were sometimes missing; e.g., the psychiatric commission reports of evaluations performed at the Serbsky Institute of General and Forensic Psychiatry. In some cases, the relevant missing sections were identified and were later provided by the Soviets—although not in time for the patient interviews.

Since the Delegation did not receive (as initially discussed and agreed in November 1988) key sections of the medical record in English translation (*viz.*, the critical discharge summaries, the various medical orders, and the first and last psychiatric commission reports), and in view of the above-noted delays in gaining access to the patient records, the Russian-speaking U.S. psychiatrists were greatly pressured in their efforts to review and summarize the relevant information before the scheduled patient interviews. In addition, because the relatively brief English capsule summaries of the entire case (provided for most but not all patients) were not very informative, the U.S. clinical teams had to rely heavily on the reviews of the records done by the Russian-speaking psychiatrists.

In contrast to the above difficulties, it is noteworthy that when the logistics of obtaining copies of seven medical records threatened to slow the process unacceptably, urgent requests produced them in 2 days, and unimpeded access was given to the original versions of these records.

Despite the prior understanding, U.S. team members were granted access to the psychiatrists responsible for treating the interviewed patients in only four cases. However, a treating psychiatrist was present for three of five patients seen in the Leningrad SPH. As a result of the absence of Soviet psychiatrists who were directly responsible for the patients' care in their hospital of origin, discussions on the choice of treatment and clinical response were significantly hampered and could only be held on a theoretical basis in most cases. When the Delegation's clinical examination did not corroborate the Soviet clinical record and history, only speculative reasons for this discrepancy could be offered by the Soviet psychiatrists, who at times were no more familiar with individual patients than were the U.S. psychiatrists.

Limited access was provided to patients' relatives or friends, whose inclusion was intended, in the original terms, to provide an additional perspective on the patients' clinical status and course of illness, as well as the social/legal context of the patients' care. Only 14 patients had relatives or friends accompanying them. Of these, only five relatives or friends said they had been contacted and invited by the Soviet authorities. The other nine had been reached—through telephone calls or unofficial contacts—to secure their participation in the interview process and were often given transportation and housing in Moscow by local human rights activists. A number of patients indicated that they had not received any request for a relative or friend to accompany them or an offer from the Soviet government to arrange for necessary transportation or lodging. Again, the Leningrad SPH was the exception, providing relatives for four of five patients. (A more detailed description of study limitations is found in Appendix D.)

D. Summary of Diagnostic Issues: U.S.-U.S.S.R. Comparisons

1. Schizophrenia Diagnosis

As conceptualized in the American Psychiatric Association (1988) Diagnostic and Statistical Manual—Third Edition, Revised (DSM-III-R), the diagnosis of schizophrenia implies the presence of a long-term, severe psychiatric disorder whose characteristic symptoms include delusions, hallucinations, deterioration in functioning, and the absence of a prominent mood disorder. The treatment of patients in this diagnostic category usually implies need for some hospitalization (possibly involuntary) during the most florid stages of the illness, as well as treatment with neuroleptic (antipsychotic) medication and supportive forms of psychosocial intervention. Once psychotic symptoms have subsided, most people with schizophrenia are successfully treated as outpatients. In the U.S., the median length of stay in inpatient services ranges from 10 days (non-Federal multiservice general hospitals) to 42 days in State and County mental hospitals (National Institute of Mental Health 1985).

Other forms of psychiatric disorder within the DSM-III-R spectrum of schizophrenia include such personality disorders as schizotypal or schizoid. Patients with these disorders rarely require involuntary hospitalization or

treatment with neuroleptic medication. Borderline personality disorder, which is generally not considered to be within the schizophrenia spectrum, is a disorder with emotional instability and considerable potential for disruptive behavior. These patients represent a difficult and often treatment-refractory population in the United States, with hospitalization (sometimes involuntary) and multiple pharmacologic interventions often features of their clinical course.

Mood disorders, including both depression and bipolar disorder (manic-depressive illness) with or without psychotic features, are not considered a part of schizophrenia in DSM-III-R, and their treatment is far more likely to include antidepressant medication or lithium than neuroleptic medication. Bipolar disorder has as its essential feature one or more manic episodes, usually associated with one or more major depressive episodes.

Because reports detailing the Soviet concept of schizophrenia are sparse in the Western scientific literature, much of what is known about Soviet diagnostic work is derived from the seminal article by Holland and Shakhmatova-Pavlova (1977). The brief description below is principally derived from that article, as are the quoted diagnostic percentages. (Both a paper presented by a Soviet psychiatrist during the visit of the Delegation, which describes U.S.S.R. schizophrenia subtypes, and a corresponding paper by an American psychiatrist have been published in the *Schizophrenia Bulletin*, Vol. 15, No. 4, and will serve as a much-needed step toward mutual understanding of diagnostic practices.)

The Soviet diagnosis of schizophrenia includes three subtypes—continuous, shift-like and periodic—and several forms within the subtypes, such as malignant and moderate. Within the continuous subtype, which represents approximately 25 to 35 percent of schizophrenic patients in the U.S.S.R., there are multiple forms of major interest for comparing U.S. and Soviet concepts. In general terms, there is considerable overlap between the DSM-III-R diagnosis of schizophrenia and the malignant and moderate forms of continuous schizophrenia in the Soviet nomenclature. The malignant form of continuous schizophrenia would include Western categories of simple, hebephrenic, and chronic undifferentiated.

The moderate form of continuous schizophrenia would include an overlap with paranoid schizophrenia. Chronic paranoid schizophrenia in the Soviet classifica-

tion system has three variants: 1) "paranoial" with slow development of delusions without hallucinations; 2) hallucinatory paranoid with the addition of hallucinations; and 3) paraphrenia, which includes, in addition to hallucinations, paranoid and grandiose delusions.

A third form of continuous schizophrenia—sluggish—is a diagnosis in which psychotic features sufficient to meet DSM-III-R criteria for schizophrenia are not necessarily required. This diagnosis comes close to the DSM-III-R concept of personality disorder, and may include the following symptom clusters: obsessional, hysterical, borderline, psychopathic, or paranoid. Of particular importance in this diagnosis is the inclusion of symptoms of "delusions of reformism," "overvalued ideas" and ideas that are not considered "socially useful" by Soviet authorities.

Shift-like (or attack-like) schizophrenia is a transitional diagnosis between continuous and periodic in which there may well be remissions, but without return to pre-illness levels of functioning. This form most closely corresponds to schizophreniform disorder in DSM-III-R or some forms of schizophrenia with intermediate outcomes. Forty percent of Soviet patients with schizophrenia fall into the category of shift-like schizophrenia, indicating that it certainly includes far more than those who would be diagnosed as having schizophreniform illness in the U.S., where this diagnosis is found at much lower relative rates.

The final subtype of schizophrenia—periodic—represents approximately 30 to 35 percent of Soviet patients with the diagnosis of schizophrenia. This form of schizophrenia is characterized by onset typically with affective (mood) symptoms and, during remission, a return to pre-illness levels of functioning. Periodic schizophrenia would correspond most closely, therefore, to mood disorders with psychotic, mood-incongruent symptomatology, brief reactive psychosis, schizoaffective illness, or some forms of bipolar disorder.

2. Personality Disorders (Psychopathy) Diagnosis

Psychopathy is a Soviet diagnostic category related to the concept of personality disorder in the International Classification of Diseases (ICD-10) and the U.S. diagnostic system (DSM-III-R). In ICD-10 and DSM-III-R, these diagnoses are distinct from schizophrenia and from mood disorders with psychotic features in that there are generally no hallucinations or fully developed delusions. These disorders include a group of be-

haviors, traits, and cognitive approaches to life that are relatively long lasting and result in significant impairment in social or occupational functioning or subjective distress.

In the Soviet system, the diagnoses of some forms of psychopathy appear to carry an antisocial or dyssocial connotation that is not included in the DSM-III-R or ICD-10 concept of personality disorder. Several subtypes were encountered by the Delegation, including paranoid, histrionic, and a unique form of personality alteration that the Soviets consider a consequence of an earlier case of schizophrenia. An unbalanced passion for pursuing one goal in life ("unitary activity"), such as "freedom fighting" through the writing of unauthorized political books, was a major criterion used by one prominent Soviet psychiatrist to define this disorder during the Delegation's visit. Other symptoms of psychopathy (e.g., stable obsessive-compulsive, asthenic or cyclothymic features) do not carry antisocial connotations.

E. Clinical Assessment Results

Diagnostic findings from three sources will be reviewed: the medical record, the Soviet psychiatrist interviews, and the U.S. psychiatric interviews. Comparison diagnoses from these sources are provided in Table 2. (All individual case numbers relate both to Table 2 and Table 6.)

1. Soviet Diagnoses

A review of all 27 cases revealed a high frequency of schizophrenia diagnoses by Soviet treating physicians among these patients (Table 3). Of the 27 patients, 24 were hospitalized initially with one or more medical record diagnoses of some type of schizophrenia including paranoid (15), unspecified subtype (7), sluggish (3), and attack-like (1). The second most common medical record diagnosis was found under the general classification of psychopathy. Seven of the 27 patients had a diagnosis of psychopathy—two of which had no additional medical record diagnosis of schizophrenia. The psychopathy subtypes included paranoid (3), histrionic (1), and an unspecified subtype (3).

Only one of the patients had no medical record psychiatric diagnosis. He was in the process of having a forensic psychiatric evaluation to determine whether a mental disorder might affect his disposition for legal

charges of refusing to be drafted into the military. No further comment will be made on this unique case (#5), who was not found to be mentally ill by the U.S. Delegation; the following discussion will focus on the remaining 14 hospitalized and 12 discharged patients.

It was possible to assess the changes in diagnosis over time as recorded in the medical records and, most importantly, to obtain the impressions of the Soviet psychiatrists who also reviewed the records and were able to interview the patients. These latter interview diagnoses were of particular significance since they were contemporaneous with the diagnoses made by the U.S. research psychiatrists during the current visit. This also afforded the U.S. team an opportunity to see first-hand the Soviet formulation of psychopathologic features of each case. The comparisons were most meaningful when the treating psychiatrists were present—a condition that was regrettably met in only four cases (#7, #14, #18, and #19).

a. Hospitalized Patients

It was striking that the Soviet psychiatrists differed markedly from the medical records in their assessment of a number of patients with an active schizophrenia diagnosis in their records. Out of the total of 24 patients with a medical record diagnosis of schizophrenia, only 10 active diagnoses of schizophrenia or psychotic delusional disorder were confirmed by the Soviet psychiatrists. Nine of these patients were currently hospitalized (Table 4).

Among the five remaining hospitalized patients, the Soviet clinicians diagnosed two of those with schizophrenia in their medical records as now having schizophrenia in remission (#24, #26); both patients were expected by the Soviets to be discharged soon. Two of the hospitalized patients were diagnosed as having psychopathy (#11, #16). One remaining hospitalized patient (#1), not interviewed by the Soviets, was in the unusual position of having refused for 3 years to be discharged despite the willingness of his physicians to discharge him. He wanted the psychiatric diagnosis expunged from his record and assurance that he would be removed from any psychiatric register so that he could recover his reputation and find a job.

Two of the patients with a Soviet interview diagnosis of psychopathy were of particular interest to the U.S. Delegation since their future appeared somewhat in doubt—they were not simply awaiting discharge. One

Table 2. Soviet/U.S. diagnoses

| Number | Soviet chart diagnosis | Soviet physician diagnosis | U.S. current diagnosis |
|---------------------------|----------------------------------|--------------------------------------------------------------|---------------------------------|
| Hospitalized cases | | | |
| 1 | Paranoid schizophrenia | None given | Paranoid personality disorder |
| 2 | Schizophrenia | Paranoid schizophrenia | Paranoid schizophrenia |
| 5 | Eval—no mental disorder | No mental disorder | None |
| 7 | Paranoid schizophrenia | Chronic paranoid schizophrenia | Schizophrenia—hypothyroidism |
| 8 | Schizophrenia | Delusional disorder | Delusional (paranoid) disorder |
| 9 | Paranoid schizophrenia | Paranoid schizophrenia | Delusional (paranoid) disorder |
| 10 | Schizophrenia; par psychopathy | Schizophrenia | Delusional (paranoid) disorder |
| 11 | Paranoid schiz; psychopathy | Paranoid psychopathy— not requiring hospitalization | None |
| 14 | Paranoid schizophrenia | Paranoid schizophrenia | Paranoid schizophrenia |
| 15 | Paranoid schizophrenia | Delusional (paranoid) disorder | Delusional (paranoid) disorder |
| 16 | Paranoid psychopathy | Psychopathic personality | None |
| 18 | Paranoid schizophrenia | Schizophrenia—continuous progressive/deterioration | Bipolar—manic disorder |
| 22 | Paranoid schizophrenia | Paranoid schizophrenia | Paranoid schizophrenia |
| 24 | Schizophrenia; avolitional | Schizophrenia in remission | None |
| 26 | Paranoid schizophrenia | Schizophrenia in remission— discharge now planned | None |
| Released cases | | | |
| 3 | Par schiz; atck schiz; psychop | Post schizophrenic psychopathy | None |
| 4 | Psychop; sluggish schizophrenia | Paranoid psychopathy | None |
| 6 | Schizophrenia | Chronic hypomania with ideas of reference—hostile | Hypomania—bipolar II |
| 12 | Schizophrenia | No mental disorder now—may have exaggerated symptoms | None |
| 13 | Paranoid schizophrenia | Paranoid schizophrenia in remission—emotional will defect | Cognitive impairment—mild |
| 17 | Paranoid; psychopathy | Political views no longer considered dangerous | None |
| 19 | Paranoid schiz; hist psychopathy | Histrionic psychopathy— patient simulated symptoms | None |
| 20 | Paranoid schizophrenia | No interview | None |
| 21 | Sluggish schiz; alcoholism | Sluggish schizophrenia | Borderline personality disorder |
| 23 | Schizophrenia | Post schizophrenic psychopathy | None |
| 25 | Sluggish & paranoid schiz | Paranoid litigious tendency | None |
| 27 | Paranoid schizophrenia | Chronic hypomania; history of schizophrenia | None |

Table 3. Diagnostic summary: Interviewed patients

| All cases (n = 27) | U.S.S.R. chart diagnosis ¹ | U.S.S.R. current diagnosis | U.S. current diagnosis |
|-----------------------------------------------------|------------------------------------------|-------------------------------|---------------------------|
| Schizophrenia: TOTAL | 24² | 8 | 4 |
| Paranoid | 15 | 5 | 3 |
| Undifferentiated | 7 | 1 | 1 |
| Continuous progressive | 0 | 1 | 0 |
| Attack-like | 1 | 0 | 0 |
| Sluggish | 3 | 1 | 0 |
| Delusional disorder (paranoid) | 0 | 2 | 4 |
| Bipolar disorder (manic-depressive) | 0 | 0 | 1 |
| Hypomania (bipolar II disorder) | 0 | 2 | 1 |
| Psychopathy (personality disorder: TOTAL | 7 | 6 | 2 |
| Paranoid | 3 | 2 | 1 |
| Histrionic | 1 | 1 | 0 |
| Post schizophrenic | 0 | 2 | 0 |
| Undifferentiated | 3 | 1 | 0 |
| Borderline | 0 | 0 | 1 |
| Paranoid litigious tendency | 0 | 1 | 0 |
| Alcohol dependence | 1 | 0 | 0 |
| Cognitive impairment (mild) | 0 | 0 | 1 |
| Schizophrenia in remission | 0 | 3 | 0 |
| No current psychiatric disorder | 1 | 3 | 14 |
| No interview/no diagnosis given | 0 | 2 | 0 |

¹Multiple diagnoses per patient.

²Two cases received two schizophrenia diagnoses.

patient (#11) was originally arrested for "hooliganism" for vandalizing property of his treating psychiatrists following an 8-day psychiatric hospitalization that he considered to be harassment for his human rights political activities. He was then diagnosed as schizophrenic and given a 2-year hospitalization, which ended in July 1988. In December 1988 he was active in the Ukrainian Helsinki Committee and was involved in a human rights rally, an anti-nuclear power plant campaign, and activity in support of Ukrainian language teaching in schools. It was possible to commit him under the urgent

hospitalization law because he was still on the psychiatric register with a diagnosis of schizophrenia, despite the fact that the Soviet psychiatric records state that he was alert and cooperative, and had no formal thought disorder, delusions, or hallucinations. In fact, all Soviet psychiatric records concerning this case from December 23, 1988 to January 24, 1989 were free of any reference to psychotic symptoms. Ideas of a persecutory nature are noted for the first time 2 days prior to the meeting of the psychiatric commission. The U.S. team could find no evidence of a serious psychiatric disorder

Table 4. Diagnostic summary: Interviewed patients

| Hospitalized Cases Only (n = 15) | U.S.S.R. chart diagnoses ¹ | U.S.S.R. current diagnoses | U.S. current diagnoses |
|--------------------------------------------------|------------------------------------------|-------------------------------|---------------------------|
| Schizophrenia: TOTAL | 13 | 7 | 4 |
| Paranoid | 9 | 5 | 3 |
| Undifferentiated | 4 | 1 | 1 |
| Continuous progressive | 0 | 1 | 0 |
| Delusional disorder (paranoid) | 0 | 2 | 4 |
| Bipolar disorder (manic-depressive) | 0 | 0 | 1 |
| Psychopathy (personality) disorder: TOTAL | 3 | 2 | 1 |
| Paranoid | 2 | 1 | 1 |
| Undifferentiated | 1 | 1 | 0 |
| Schizophrenia in remission | 0 | 2 | 0 |
| No current psychiatric disorder | 1 | 1 | 5 |
| No interview/no diagnosis given | 0 | 1 | 0 |

¹Multiple diagnoses per patient.

and could find no justification for involuntary psychiatric hospitalization. The Soviet psychiatric interviewers also failed to confirm any past or present psychotic symptoms and changed the diagnosis to paranoid psychopathy.

Case #16 remained in a Special Psychiatric Hospital for violation of Article 70 with a diagnosis of psychopathy. There were no apparent justifiable medical reasons for a continuous 9-year hospitalization, mostly in SPHs. The Soviet records describe a brief reactive (hysterical) psychosis in 1980 at the time of his forensic psychiatric evaluation. However, the patient claims that these symptoms were feigned to mock the commitment proceedings, which he considered to be a sham. Since that time there are no descriptions of any psychotic symptoms to justify continued involuntary hospitalization and compulsory treatment. Treatment in 1986 with sulfazine (an extremely discomforting medication of dubious therapeutic worth, discussed in more detail later), particularly in the absence of a Soviet record of psychotic symptoms, can only be assumed to have been punitive in nature. The Soviet psychiatric examiners believed that the patient suffered only from psychopathy with overvalued ideas of himself,

histrionic behavior, and persistent lying. His psychiatrists from Leningrad, where he had recently been transferred, emphasized that a person committed on criminal charges, including violation of Articles 70 and 190-1, could only be released by the courts. Although they could see no medical requirement for hospitalization, as law-abiding physicians they had to provide custodial care as long as the courts refused to allow a criminally committed patient's release or transfer to an OPH.

The final hospitalized patient required diagnostic considerations separate from the others because he appeared to pose a potential nonpolitical threat of violence. This patient (#15) had a long history of antisocial behavior (including conviction for forgery, conviction for medical malfeasance, assaulting his wife, and terrorist bombing activities). His original Soviet psychiatric diagnosis was "litigious and paranoid development of a psychopathic personality." It was subsequently changed in his medical record to schizophrenia following description of delusions of reference, grandiosity, and incoherent thinking. The examining Soviet psychiatrist considered him to have a diagnosis of true paranoia; the U.S. team's diagnosis was

delusional disorder, paranoid type. However, his behavior may have been due to bipolar disorder in combination with or without a co-existing dyssocial personality disorder. There were many allusions to increased energy, talkativeness, grandiosity, irritability, and interpersonal difficulties. The patient, however, denied current or past frank manic symptoms. In the opinion of the U.S. examining psychiatrists, a trial of lithium treatment might be extremely helpful for the patient. The U.S. clinicians were uncertain, however, whether the patient should be incarcerated in prison or involuntarily hospitalized. His most recent hospitalization followed arrest for several bombings in which at least one person was killed.

b. Released Patients

The patients who had been discharged will be discussed separately because their release represents decisions by the courts and the psychiatrists that they no longer required hospitalization for either legal or clinical purposes. As such, these patients, all of whom had been discharged in the 2 years preceding the Delegation's visit, illustrate recent changes in the clinical and forensic practice of Soviet psychiatry. The 12 discharged patients included 11 who had at least one medical record diagnosis of schizophrenia, several of whom had additional psychopathy diagnoses, and 1 whose only medical record diagnosis was of paranoid psychopathy. Hence, the heavy reliance of Soviet psychiatrists on the diagnosis of schizophrenia to justify admission was no different for the discharged than for the currently hospitalized patients (see Table 5).

For the released patients, the Soviet psychiatrists' interview diagnoses were strikingly different from those found in the medical records. There was a marked reduction in the diagnosis of schizophrenia, with only one active case (#21) of schizophrenia, sluggish subtype, and one case of schizophrenia in remission (#13) found by the U.S.S.R. examining psychiatrists. Two patients were diagnosed as having chronic hypomania (#6, #27), and four were given psychopathy diagnoses. Of particular interest were two cases (#3, #23) in which the diagnosis was a post-schizophrenic psychopathy, despite the absence of any psychotic symptoms recorded in the medical record. The firmness with which these diagnoses were maintained, despite multiple challenges from the U.S. psychiatrists to specify the diagnostic criteria, was noteworthy. Another patient (#4), with an

original medical record diagnosis of sluggish schizophrenia, was diagnosed by Soviet psychiatrists at interview as having paranoid psychopathy. As a result of the widely varying course of schizophrenia diagnoses illustrated above, it was difficult to determine why some patients with original schizophrenia diagnoses were later diagnosed as being in remission while others had diagnoses changed to some form of psychopathy.

Among the discharged patients, there were two (#12, #19) who volunteered that they had feigned psychiatric symptoms after their arrest to avoid the usual sentence for their Article 70 or Article 190-1 offense: up to 7 years imprisonment and up to 5 years in exile from their home city, and for Article 190-1, up to 3 years imprisonment. For one such patient, the Soviet interview diagnosis was no mental disorder, and for the other, a diagnosis of histrionic psychopathy was given. One released patient (#17) was diagnosed with unusual candor by the Soviet examining psychiatrist as a person whose political views are no longer considered dangerous and hence does not have a psychiatric diagnosis. There was one released patient (#25) who had been assessed by Soviet interviewers as having a paranoid personality trait with no mental disorder diagnosis. Soviet psychiatrists declined an offer to interview another patient (#20), recently discharged and difficult to locate, who appeared late in the U.S. Delegation's visit and asked for a Delegation interview.

2. U.S. Diagnoses

a. Hospitalized Patients

It is noteworthy that all nine of the hospitalized patients who were identified by the interviewing Soviet psychiatrists as having a current schizophrenia or psychotic delusional disorder diagnosis were confirmed by the U.S. psychiatrists to have a significant psychotic condition—four with schizophrenia (#2, #7, #14, #22), four with a paranoid delusional disorder (#8, #9, #10, #15), and one with bipolar illness in an acute manic state (#18) (see Table 2). Of these nine patients, two remained in the Special Psychiatric Hospital (SPH) in Leningrad and seven were in Ordinary Psychiatric Hospitals (OPH). Several had recently been transferred from an SPH to an OPH in the 3 months between the November 1988 U.S. Advance Team visit and the current examination.

Table 5. Diagnostic summary

| Released cases only (n = 12) | U.S.S.R. chart diagnosis ¹ | U.S.S.R. current diagnosis | U.S. current diagnosis |
|--------------------------------------------------|---------------------------------------|----------------------------|------------------------|
| Schizophrenia: TOTAL | 11² | 1 | 0 |
| Paranoid | 6 | 0 | 0 |
| Undifferentiated | 3 | 0 | 0 |
| Attack-like | 1 | 0 | 0 |
| Sluggish | 3 | 1 | 0 |
| Hypomania (bipolar II disorder) | 0 | 2 | 1 |
| Psychopathy (personality disorder): TOTAL | 4 | 4 | 1 |
| Paranoid | 1 | 1 | 0 |
| Histrionic | 1 | 1 | 0 |
| Post schizophrenic | 0 | 2 | 0 |
| Undifferentiated | 2 | 0 | 0 |
| Borderline | 0 | 0 | 1 |
| Paranoid litigious tendency | 0 | 1 | 0 |
| Alcohol dependence | 1 | 0 | 0 |
| Cognitive impairment (mild) | 0 | 0 | 1 |
| Schizophrenia in remission | 0 | 1 | 0 |
| No current psychiatric disorder | 0 | 2 | 9 |
| No interview/no diagnosis given | 0 | 1 | 0 |

¹Multiple diagnoses per patient.²Two cases received two schizophrenia diagnoses.

These nine cases illustrate relatively mild disagreements between the U.S. and Soviet psychiatrists on the nature of the specific disorder. All of these cases met the relatively strict DSM-III-R and draft ICD-10 diagnostic criteria of having bizarre psychotic delusions that could have no basis in reality. However, for one case, the U.S. diagnosis of bipolar (manic-depressive) psychosis implies a different treatment regimen than does the Soviet schizophrenia diagnosis for the same patient.

Included in this group of nine was one case (#2) of paranoid schizophrenia who had a fixed delusion that was seemingly unresponsive to available treatments. The delusion was a conviction that he had special genetic assets that allowed him to participate in advancing medical research by trying out various medications.

He felt that the two sexual contacts he had in his life had altered his genes, which were now "open" in some special way to respond more sensitively to medication. With the exception of the delusional system, the patient could discuss all other aspects of his life with insight and humor. (He joked that patients had to be careful who they picked as a partner to share the one bed available for two patients—one needed to be sure that the bedmate would not urinate or defecate in the bed during the night.) Despite the delusion mentioned above, the patient appeared to pose no threat to society or himself that would have required 19 years of hospitalization in an SPH; he could be treated in a less restrictive OPH environment closer to his relatives or on a properly supervised outpatient basis. The delusion of Case #2

contrasts markedly with the Soviet concept of "delusions of reform," which psychiatrists in most countries would consider in the range of normal human aspiration.

In addition to the general level of agreement between the currently interviewing Soviet and U.S. psychiatrists on diagnoses of the nine hospitalized patients with psychotic disorders, the U.S. diagnosis of paranoid personality for Case #1 was in partial agreement with the apparent diagnosis of the Soviets, as reflected in their proposal to discharge this patient on no medication. (This patient had a medical record diagnosis of paranoid schizophrenia but was not interviewed by a Soviet psychiatrist.) Among the four hospitalized patients with current Soviet diagnoses of psychopathic personality (#11, #16) or schizophrenia in remission (#24, #26), the U.S. psychiatrists could find no evidence of a mental disorder.

Aside from the previously mentioned nine patients with continuous psychotic disorders, for the majority of all patients interviewed, the U.S. and U.S.S.R. psychiatrists agreed that the original Soviet medical record diagnosis of schizophrenia should be seriously questioned on the basis of the clinical course. The lack of deterioration and the absence of psychotic symptoms after many years (and with no current medication) caused both the interviewing Soviet psychiatrists and the U.S. psychiatrists to question these medical record diagnoses. A specific example is provided by the course of a then-hospitalized patient (#26) who had an initial diagnosis of paranoid schizophrenia and had a persistent 4-year state of illness recorded in his chart. Following identification of this patient by the U.S. Delegation in December 1988, all antipsychotic (neuroleptic) medication was stopped in January 1989, and discharge was being planned because the patient was no longer considered dangerous and was much improved. His earlier symptoms had included "philosophizing" (he has a Ph.D. in philosophy), and "enhanced feelings of dignity" (or self-importance). He had earlier criticized Stalin, and felt that the views for which he had been treated as a criminal were now perfectly acceptable within the framework of "glasnost."

b. Released Patients

Diagnostic agreement between U.S. and U.S.S.R. psychiatrists was obtained for one discharged patient who had chronic hypomania and two discharged patients identified by both groups as having no mental

disorder. Regarding the remaining discharged patients, there was partial agreement concerning Case #27, who demonstrated persistent hypomanic behavior with no episodic course and no history of depression episodes. While recognizing the same symptoms, members of the U.S. team felt he did not qualify for a diagnosis of hypomania. These symptoms were in no way dysfunctional for the goals of this patient, which were to develop a new political party in the U.S.S.R., nor did they meet diagnostic criteria. Another patient (#21) met the Soviet criteria for sluggish schizophrenia and the U.S. criteria for borderline personality disorder--this would be a possible fit based on the preceding discussion of U.S. and Soviet diagnostic concepts. One patient (#13) was found to have similar symptoms by the Soviets and the U.S. team but was found by the latter to have only a mild level of cognitive impairment, with no mental disorder diagnosis. For the two patients diagnosed by the Soviets as having post-schizophrenic psychopathy, there was no evidence of any present or past psychopathology in the U.S. evaluation (Tables 4 and 5).

Another discharged patient (#4) had medical record diagnoses of both psychopathy and sluggish schizophrenia based on such symptoms as delusions of reformism, emotional blunting, lack of insight, and paranoid ideation. These symptoms were identified after the patient had been arrested under Article 190-1 of the Criminal Code for human rights activities that included dissident writing. Following his release in 1988 after a 6-year hospitalization, no evidence of paranoid ideation was found by the U.S. team. The Soviet interviewer retained the psychopathy diagnosis but dropped the diagnosis of schizophrenia.

Of the four released patients with an original psychopathy diagnosis, three were given the same diagnosis by Soviet examining psychiatrists, although one patient was diagnosed by them as having "no clinical disorder now that the political situation in the Soviet Union had changed." The U.S. psychiatrists concurred with the latter diagnosis and found that none of the other three met current diagnostic criteria in either the DSM-III-R or the ICD-10 draft criteria for a personality disorder.

In summary, nine of the released patients were found by the U.S. team to have no mental disorder, and the remaining three had a history of mild symptoms that could not be used to sustain a finding of nonimputability (or not guilty by reason of insanity) in the U.S.

3. Urinalysis Results

The urine screens on the available samples, conducted by a contractor to the N.I.M.H., validated the presence of medications as reported by the Soviets, including low levels of phenobarbital in two released patients (medications which were used for one patient's seizure disorder and another patient's gastrointestinal treatment). Particular attention was given to hospitalized cases for assessment of current medication treatment and toxicology screening. One hospitalized patient (#7), was so overmedicated with neuroleptics and anticholinergic drugs that he was unable to produce sufficient urine for the analysis. No unreported medications were detected in the samples.

4. Treatment Issues

Despite the predominance of schizophrenia diagnoses in the medical records of almost all of the patients, the descriptions of clinical symptoms reported on admission were very heterogeneous. Virtually all of the patients received one or more neuroleptic medications—some at unusually high doses in oral or injectable form. For those nine patients with active psychotic symptoms, there would be little question in the West about the appropriateness of these medications for clinical care. However, the use of such medications to treat patients for "delusions of reformism" following an arrest under Articles 70 or 190-1 is clearly an aberrant therapeutic approach for psychiatry throughout the world.

The physiological and psychological side effects of the neuroleptic medications, including severe muscle spasms and mental clouding, were clearly described in both the medical records and the clinical interviews. In particular, the documented increase of medication levels for apparent infractions of institutional rules rather than for psychotic symptoms had raised questions for the U.S. Delegation about the therapeutic intent of the treating physicians. In several patients who had no psychotic symptoms but had received neuroleptic medication, the drugs had a devastating effect on their mood, self-confidence, and temporary cognitive functioning.

Of equal interest was the cessation of all neuroleptic medications for some patients despite the retention of a medical record schizophrenia diagnosis, which was affirmed every 6 months by a psychiatric commission. These patients remained incarcerated in a psychiatric

hospital because of their original crimes—many of which were for violation of the Articles 70 and 190-1 (political crimes). When these violations were no longer considered worthy of prosecution during the past 2 years, a substantial number of these patients were released on no medication. However, their medical record diagnoses of schizophrenia were usually retained, as were their names on the psychiatric register.

As documented by both patient interviews and the hospital records, one medication—sulfazine—had been used in 10 of the 27 patients during their hospitalization. The medical indications for sulfazine provided to the U.S. Delegation by Soviet psychiatrists include its use to increase the metabolic rate, treat alcoholism, and to potentiate the effectiveness of neuroleptic medication for treatment-resistant schizophrenia. However, no preclinical research or human clinical trial research data were provided to support the continued use of this very discomforting treatment regimen, which had been developed many years ago as a form of fever treatment similar to the use of malaria fever treatment for central nervous system syphilis. Courses of sulfazine injections were given for weeks to some patients, with resultant high fevers, severe pain, immobility, and occasional septic ulcerations of the injection sites. Patients also reported that the rationale for treatment frequently given by the staff was for some infraction of institutional rules or as an introductory form of treatment for some patients with no acute psychotic symptoms.

Sulfazine treatment had become a symbol of punitive treatment among most of the interviewed patients. By way of circumstantial evidence for this finding, one of the interpreters overheard a little jingle that was used to bolster morale among these patients, which goes as follows: "Nashi popy kak rezina, ne boyatsya sulfazina." A rough translation of this is: "Our butts are like rubber, they're not afraid of sulfazine."

Several of the patients received insulin coma or atropine therapy without sufficient medical indication. The use of insulin to induce convulsions is more dangerous to the patient than electroconvulsive therapy and is, therefore, rarely used in the U.S. The U.S. Delegation was not familiar with the use of atropine for antipsychotic treatment—it produces a severe delirium and fever.

A final treatment issue is the relative absence of the use of lithium or tricyclic antidepressants for several of the patients whose medical records and clinical inter-

views clearly indicated a history of an affective (depression) disorder. For at least three patients lithium would have been indicated in the U.S. for either hypomanic symptoms or a U.S.-diagnosed bipolar (manic-depressive) disorder. In one patient who met the classic diagnostic criteria for bipolar disorder in either the ICD-10 draft criteria or the DSM-III-R, low doses (600 mg) of lithium carbonate had been used, along with neuroleptics. When the patient's psychosis seemed to worsen prior to the visit of the U.S. team, all of his medications were discontinued on the reported basis that the treating psychiatrist did not wish to force medication on the patient, who did not want it. It should be noted that this response was challenged by the chief psychiatrist of the Ministry of Health. The U.S. psychiatrists assumed that the Soviets wanted to demonstrate a patient on the U.S. list who had blatant psychosis. As a result of this withholding of appropriate treatment, the patient had become violent and aggressive, and had recently received a prominently black eye from another patient who was defending himself.

5. Clinical Diagnostic Interview Practice in Soviet Psychiatry

The interview approach used by the Soviet psychiatrists was of particular interest to the U.S. clinical evaluation teams. The team members recognized that many of these patients were held on criminal charges, and that most did not have their treating psychiatrist present. However, the confrontational approach frequently used by the Soviet psychiatrists drew considerable attention from the U.S. visitors, who were interested in both the theoretical and practical issues raised by such an interview method. In particular, the adversarial approach in some cases took on the characteristics of a prosecutor's cross-examination of the patient regarding facts contained in the medical record. There was often little effort to conduct the interview in a positive or even neutral emotional context that would encourage the patient to describe his medical experience—i.e., to use the patient as an independent source of information that could then be compared with the medical record. In several prominent cases, the patients' hostility to this aggressive interview style was interpreted by the Soviet psychiatrists as evidence of paranoia (#4, #6). With two cases (#4, #23), the Soviet psychiatrists evidently assumed that since the KGB would never act in the unethical manner described by the patients, such

descriptions by patients were evidence of paranoid ideation.

In one case, the Soviet psychiatrist had agreed that the patient's estranged wife, who was absent from the first interview with the U.S. Delegation, would be the best judge of whether the patient ever had the psychotic symptoms recorded in the medical record but denied by him. A subsequent interview with the wife, at which the patient was not present, confirmed the patient's report, much to the discomfort of the Soviet psychiatrist, who continued to assert that the patient had delusions. In general, there were no indications in the records or in the Soviet psychiatrist's discussion that an effort would be made to ascertain the facts where patient reports contradicted the initial assertions of authorities.

Exceptions to this general observation occurred in a few cases in which there was a clear-cut psychosis present or the treating physician was present. In these cases, there was evidence of an active alliance between the patient and physician to describe the patient's experiences accurately. In the case of one patient in Leningrad, the Soviet psychiatrist showed a clear interest in expediting the patient's return to a status where his name could be removed from the psychiatric register so that he could be employed again at a professional level.

From the patient reports, there was also evidence that some treating physicians had actively or passively collaborated in accepting patients' feigned symptoms as evidence of a psychiatric disorder for the patients' presumed benefit—to prevent several years of imprisonment and exile from their home. For some patients this appeared to have been a gamble that had paid off in a shorter incarceration. However, others who had not dissembled were outraged that they had been diagnosed as psychiatrically ill and were now unable to find a job or were subject to immediate rehospitalization as a result of their being listed on a psychiatric register.

In several of the interviews with discharged patients, Soviet psychiatrists, including some at the Serbsky Institute of General and Forensic Psychiatry in Moscow, commented that they had not seen patients charged with such political crimes (Articles 70 or 190-1) for the last 2 years. There was a general impression that Soviet psychiatrists would welcome the removal of Articles 70 and 190-1, which resulted in their being responsible for involuntary patients who would otherwise be suitable for inpatient treatment at an Ordinary Psychiatric Hospi-

tal or for outpatient treatment, if any treatment were needed at all.

F. Observations and Conclusions

Patient Selection

1. Clinical team members of the U.S. Delegation took note of the fact that there was an apparently high rate of patient discharge during the 2-month period between submission of the list of hospitalized patients in December 1988 and the Delegation's departure in mid-March 1989. Of the original 37 hospitalized patients on the list, four were removed from the list because of death, imprisonment, emigration to the U.S., or insufficient information to locate them. Of the remaining 33, more than half (17) were discharged either before or during the Delegation's visit.
2. Despite this high rate of discharge, five patients (including one patient undergoing forensic evaluation) remained hospitalized for whom the U.S. team did not believe a mental disorder diagnosis was warranted according to U.S. (DSM-III-R) or international (ICD-10 draft) criteria. Two of these patients remained hospitalized under Article 70, one of the "political articles" in the Soviet Criminal Codes involving Anti-Soviet Agitation and Propaganda (see Appendix F).

Clinical Diagnosis

1. A significant proportion of the hospitalized patients had serious mental disorders. Among the 15 currently hospitalized patients, the U.S. team found evidence of a severe psychotic disorder in 9 patients—diagnoses that generally corresponded with those of the Soviet psychiatrists.
2. One of the hospitalized patients had been recently admitted (in December 1988) with a diagnosis of schizophrenia following his involvement in an intense period of human rights political activity. The U.S. team found no evidence for a mental disorder in this patient. Although he had not been charged under Articles 70 or 190-1 of the Soviet Criminal Codes, it had been possible to rehospitalize him quickly because his name remained on the

psychiatric register (for outpatient follow-up and monitoring) following an earlier admission. Since returning to the United States, the U.S. Delegation has received confirmed reports that this patient has been released.

3. The discharged patients had no serious psychiatric disorders, and none of the patients interviewed by the Delegation have been inappropriately discharged from a clinical standpoint. If this difference represents a trend, it indicates a positive change in the practice of Soviet forensic psychiatry.
4. Among the 12 released patients, the U.S. team found no evidence of any past or current mental disorder in 9, and the remaining 3 had relatively mild symptoms that would not typically warrant involuntary hospitalization in Western countries. All of these patients had medical record diagnoses of schizophrenia or psychopathy; the stigma of these diagnoses is likely to continue to affect their lives adversely as long as the official diagnoses remain and they are continued on the psychiatric register.
5. The broad Soviet concept of mental disorder diagnoses in general, and schizophrenia in particular, was apparent in the medical record diagnoses of schizophrenia or other psychotic disorders in 24 of the 27 patients interviewed. This high number of schizophrenia diagnoses exemplified the problem of "hyperdiagnosis," as verified by a finding of only nine closely matching current diagnoses by both the Soviet and the U.S. interviewing psychiatrists.
6. From the perspective of the U.S. team, the problem of "hyperdiagnosis" persisted in other diagnostic areas, particularly in the psychopathy (personality disorder) and "schizophrenia in remission" diagnoses. Specific examples of psychopathy symptoms identified in the interviews included "unitary activity," which related to a high level of commitment to a single cause, such as political reform, and "failure to adapt to society," used in describing a patient with "inability to live in society without being subjected to arrest for his behavior."

7. Some of the symptoms incorporated into Soviet diagnostic criteria for mild ("sluggish") schizophrenia and, in part, moderate (paranoid) schizophrenia are not accepted as evidence of psychopathology in the U.S. or international diagnostic criteria. Specific idiosyncratic examples identified in the interviews included diagnosing individuals demonstrating for political causes as having a "delusion of reformism," or "heightened sense of self-esteem" in order to support a diagnosis of schizophrenia.

Treatment

1. Antipsychotic (neuroleptic) medications have been used to treat patients for "delusions of reformism" and "anti-Soviet thoughts" in the absence of accepted medical indications for psychotic ideation. Medical records and patient interviews provided evidence for use of relatively high doses of neuroleptics in some patients who showed no symptoms of psychotic ideation.
2. Soviet psychiatrists have used sulfazine treatment ostensibly to enhance treatment response to neuroleptic medication. However, they were unable to produce any research evidence of its efficacy for this purpose. Furthermore, the severe pain, immobility, fever, and muscle necrosis produced by this medication, as well as the pattern of its use in 10 patients, suggest that it has been used for punitive rather than therapeutic purposes. In addition to sulfazine, there were reported cases in which insulin coma, strict physical restraints, and "atropine therapy" were used for patients in whom U.S. psychiatrists found no evidence of psychotic or affective (mood) disorder. The use of atropine, which produces a transient delusional state and high fever, is not an accepted therapeutic modality in the West.
3. Patients who received initial diagnoses of schizophrenia or psychopathy retained their official medical record diagnoses regardless of changes in their clinical status. However, treatment regimens were more frequently modified to reflect changes in psychotic symptoms or need for neuroleptics.

Forensic Practice

1. The concept of a "nonimputable" mental disorder in the Soviet system has been used to encompass at least three different symptom levels found in these patients, as follows:
 - a. Psychotic symptoms associated with the commission of a violent or illegal act, in which the patient's impaired understanding or volitional control was directly related to his or her criminal behavior;
 - b. Any current or past diagnosed mental disorder or psychiatric symptom in a person accused of having committed illegal behavior (even in the absence of any apparent impairment of the patient's understanding of, or capacity to control, his or her behavior).
 - c. Anti-Soviet political behavior, including writing books, demonstrating for reform, or being outspoken in opposition to the authorities, which was defined in some patients as being simultaneously a symptom (e.g., "delusion of reformism"), a diagnosis (e.g., "sluggish schizophrenia"), and a criminal act (e.g., violation of Articles 70 or 190-1).
2. In two cases, Soviet psychiatrists treating a criminally committed patient (i.e., a mentally ill person who had been charged with violation of a criminal statute) were unable to obtain the court's approval to discharge the patient from a Special Psychiatric Hospital (SPH), despite the absence of a psychiatric condition requiring such hospitalization. Soviet psychiatrists identified problems in providing treatment plans for patients hospitalized under the political articles who had no other evidence of psychopathology.
3. As noted above, the U.S. Delegation observed mental disorder diagnostic and treatment practices affecting political dissidents that were excessive and inappropriate by Western standards. Nevertheless, Soviet psychiatrists always maintained that all patients had been hospitalized because of some form of mental illness. Since Delegation members were unable to review the investigative reports, it is not possible in this type of study to determine whether the original or current diagnoses were

based on idiosyncratic medical considerations alone or if political pressures influenced these judgments, thus resulting in deliberate misuse of psychiatry for purposes of social control.

G. Discussion of Clinical Conclusions

Significant diagnostic and treatment issues are raised by the clinical examinations summarized above. The first is the high rate of schizophrenia diagnoses and the low rate of affective disorder diagnoses found in both the patient sample and in the hospitals visited by the U.S. Delegation. This situation is very much like that found between the U.S. and U.K., which led to the now famous U.S./U.K. study by Cooper and colleagues (1972). That study demonstrated that the differences in diagnostic rates between the two countries were the result of both different diagnostic criteria and the lack of a systematic method for applying the criteria. A similar type of study comparing U.S. and U.S.S.R. diagnostic practices may be useful in the future.

A second diagnostic issue is the apparent long-term effect of a diagnosis of transient psychotic or other mental disorders on subsequent diagnostic and treatment decisions. It was apparent in several cases (e.g., #6, #8) that a single florid episode of psychopathology resulted in a persistent diagnosis and treatment regimen long after the initial symptoms ceased to exist. This pattern had been previously noted by a Soviet psychiatrist publishing in the West (Kazanetz 1979). The effect of a patient's clinical course on the ultimate diagnosis was unclear. In the medical records there were multiple examples of seemingly permanent diagnoses despite marked improvements in symptomatology. In some cases, the treatment plan remained the same, and in others, medications were completely stopped but hospitalization continued for years.

From a scientific standpoint, a diagnosis is generally thought of as a hypothesis that is subject to being proven or disproved on the basis of clinical course and treatment response. The issue is not simply a clash between diagnostic approaches. Rather, it concerns the development of a systematic approach for following patients with diagnoses such as continuous or chronic forms of schizophrenia. Progression of the illness is required to validate the diagnosis. However, the U.S. team evaluated some cases in which, although years had passed since the original diagnosis, the illness had not

progressed. The absence of progression, of continued symptoms, and of deterioration invalidates the diagnosis of schizophrenia within the Soviet approach, yet the records did not reflect such change.

A third diagnostic issue is the concept of, and related inclusion criteria for, psychopathy or personality disorders. In several of the cases, the Soviet concept appeared to be closely related to an assessment of social utility or social acceptability of behavior. For example, behavior that was used by Soviet psychiatrists to support such a diagnosis could vary from simple rudeness or anger, to passing out political leaflets, and even to assaultive behavior. They identified multiple subtypes of psychopathy in these patients, with some described as consequences of schizophrenia. Individuals whom the Soviet psychiatrists viewed as demonstrating too much devotion to a single area of life, such as reforming the political system (#3, #4, #23), could be diagnosed as having a psychopathy. It was apparent that the area of concentrated activity rather than the level of devotion was most significant for the diagnosis—publication of political reform views was much more likely to precipitate a diagnosis than devotion to artistic, academic, or athletic pursuits.

Among the treatment issues of concern is the rather standard use of neuroleptic treatment despite considerable variability in clinical presentation. It is possible that the higher rate of schizophrenia diagnoses in the U.S.S.R. results in greater use of accepted treatments for this disorder—a practice that might be modified if a wider range of diagnoses were used. A second possibility is that some of these patients were given medication for punitive purposes.

The use of sulfazine and atropine as therapeutic agents is also a matter of concern to the U.S. Delegation. When the Delegation brought these concerns to the attention of Soviet psychiatric officials at the end of its visit, it was told that the use of sulfazine is to be reviewed by a special panel of experts in the U.S.S.R. in May 1989, at the request of the Deputy Minister of Health. It is hoped that a more definitive statement on the future use of this medication will be forthcoming shortly.

A final treatment issue is the relative infrequency of the use of lithium or antidepressant medication in the U.S.S.R. compared with U.S. psychiatric practices. This may be closely tied to the relative lack of affective (mood) disorder diagnoses as well as to the absence of laboratory equipment for monitoring lithium levels.

Since patients with affective disorders have specific therapeutic requirements, failure to recognize such disorders can systematically deprive Soviet patients of effective treatment.

H. Clinical Recommendations

1. The accelerated discharge of Soviet psychiatric patients identified by human rights groups and the beneficial professional exchange on psychiatric diagnosis and treatment support a recommendation for continued professional contact between U.S. and U.S.S.R. mental health experts. In the absence of evidence for any inappropriate discharges to date, the prospect of continuing release of unnecessarily hospitalized patients is likely to benefit both the human rights of patients as well as the hospitals (which could thus reduce their overcrowded census).
2. Use of international diagnostic criteria for all mental disorders in the U.S.S.R. (including schizophrenia, affective (mood), and personality disorders) would greatly enhance the possibilities for professional and scientific exchanges. Of particular significance is the current opportunity for Soviet participation in the international field trials of the International Classification of Diseases (ICD-10) sponsored by the World Health Organization (W.H.O.). It is expected that this international classification system will provide the most useful common diagnostic criteria—ones that will be completely compatible with U.S. diagnostic concepts.
3. The current broad diagnostic concepts for schizophrenia and psychopathy used in the U.S.S.R. appear to pose a higher risk of misuse for political purposes than do current Western criteria. Hence, narrowing the Soviet criteria along the lines of ICD-10 would make it more likely that psychiatric diagnoses will be used only for appropriate medical indications.
4. The use of neuroleptic medications for nonpsychotic symptoms should be re-evaluated on the basis of current scientific studies of treatment safety and efficacy.
5. The use of sulfazine and atropine therapy for psychiatric disorders should be re-evaluated on the basis of preclinical or clinical research studies of treatment efficacy. In the absence of supporting evidence of treatment efficacy, the practice should be discontinued. The U.S. Delegation notes that a report by the U.S.S.R. Ministry of Health on the clinical use of sulfazine was to be issued in May 1989.
6. Consistent with the key statutory language of Article 11 (see Appendix F), the determination of "nonimputability" of persons with mental disorders should be limited to those situations in which the psychiatric symptoms impair understanding or control of criminal behavior.
7. The definition of some criminal behaviors as being psychiatric symptoms or disorders requires special attention. The possible confounding of political and psychiatric definitions is problematic and affords opportunities for possible abuse. These definitions should be reviewed by colleagues involved in developing the new international classification under W.H.O. auspices.
8. Four hospitalized patients who were found to have no mental disorder by the U.S. team should be reviewed for possible discharge if they have not yet been released. One of these patients was discharged immediately following the U.S. Delegation's visit, and two additional patients were awaiting discharge. The fourth patient's planned disposition is unknown. The placement of these last three patients should be reviewed as soon as possible.
9. Transfer of some patients who require ongoing psychiatric treatment to Ordinary Psychiatric Hospitals (OPHs) closer to their relatives had been urgently requested by several patients and their families. The U.S. Delegation supports these requests and hopes that such transfers will be feasible.
10. For discharged patients who were not found to have a mental disorder diagnosis according to international diagnostic criteria, consideration should be given to removing their diagnoses (or

other indications of mental illness) from draft cards, psychiatric registers, or other records where such notations might impede their employment, education, or other participation in the broader society. Specific examples of this change are already occurring in a limited number of cases, to the great benefit of the patients.

11. Establishment of a U.S./U.S.S.R. study on the diagnosis of schizophrenia, mood disorders, and personality disorders would greatly facilitate professional and scientific understanding between the two countries.

III. LEGAL PROCESS AND PATIENTS' RIGHTS

In this section, we discuss legal issues and patients' rights. The sources of information for this section include: 1) interviews with the 27 patients described in the previous section of the report; 2) visits by the Delegation's hospital team to two Special Psychiatric Hospitals and two Ordinary Psychiatric Hospitals; 3) analysis of applicable provisions of Soviet law; and (4) discussions with Soviet patients. These materials are presented in the following sections before presentation of the Delegation's conclusions and recommendations.

A. Patient Interview Data

This section presents interview data concerning 26 of the 27 patients whom the Delegation examined in the Soviet Union. The other patient was a forensic evaluation case who had been recently hospitalized when he resisted military service. This person was informed that he had a right to a lawyer's assistance.

All but one of the 12 released patients had been discharged within the last 2 years. The 14 hospitalized patients had been in a psychiatric hospital from 3 months to 19 years, most for 3 to 9 years. At the time of their examination, their average duration of hospitalization was about 8 1/2 years. All but two of the 26 patients had at one time been hospitalized in a Special Psychiatric Hospital receiving compulsory (court-ordered) treatment. However, the major focus of the Delegation's interviews was on the patients' most recent hospitalization, whether it was court ordered or not.

Table 6 indicates patient behaviors just prior to their arrest and hospitalization, the articles of the Russian Soviet Federated Socialist Republic (R.S.F.S.R.) Criminal Code under which they were accused, dates of arrest, the Special Psychiatric Hospital or Ordinary Psychiatric Hospital to which they were first committed, date of commitment, length of subsequent hospitalization (typically including time spent in Ordinary Psychiatric Hospitals prior to release), and date of release.

Of the 14 hospitalized patients, 11 were first committed to SPHs as a result of court orders after findings of nonimputability, although at the time of the Delegation's visit, 8 of these 11 patients had been transferred to OPHs. Three additional patients were hospitalized in Ordinary Psychiatric Hospitals, not as a result of compulsory, court-ordered treatment, but instead through the medical commitment process (urgent hospitalization) in which the necessity of hospitalization is reviewed only by psychiatrists.

Among the 12 released patients, 9 had recently been in SPHs. The most recent psychiatric hospitalization for two released cases had been in Ordinary Psychiatric Hospitals (OPHs). One released patient, processed through the criminal procedure, was initially hospitalized at an OPH; however, he was later transferred to an SPH.

1. Pre-Arrest Behaviors

The pre-arrest behaviors of virtually all the released cases (11 of 12) constituted political or dissident behavior. Examples include activities on behalf of Ukrainian dissidents (signing petitions, distributing literature) (Case #23); activities in support of veterans and invalids (#25); writing books and taking up the cause of the Crimean Tatars (#03); distributing a copy of a book by Solzhenitsyn (#19). These behaviors (see Table 6) fall into categories of writing and distributing anti-Soviet literature, aiding nationalistic aspirations or identity, political organizing, defending rights of disabled groups, or furthering religious ideas.

For the hospitalized persons, most of the offenses committed prior to hospitalization did not involve the nonviolent, "political" or religious behaviors that human rights advocates often associate with psychiatric abuse. However, such behaviors did precede the hospitalizations of some patients (Case #16—visiting Andrei Sakharov's apartment; Case #26—writing a book on the poet, Vysotsky) (see below). The offenses of three hospi-

Table 6. Patient offense and disposition—Most recent hospitalization

| Case # | Behavior | Article | Arrest | Hospitalized | | Com- mitted | Length hosp. | Re- leased |
|--------|-----------------------------------------------------------------------------------------------------|------------------------------------------|--------|-------------------------------------------------|-----------------------|----------------|-----------------|-------------------|
| | | | | SPH to which first committed ¹ | OPH | | | |
| 01 | No internal passport | Not clear | 1970 | ---- | Sevan-Sovetashenskaya | 1971 | 16 years | ---- ² |
| 02 | Crossed Mongolian border | 83 | 1969 | Blagoveshchensk | ---- | 1970 | 19 years | ---- |
| 05 | Resisted military service | 80 | ---- | ---- | Kashchenko (Eval.) | 1989 | 1 month | ---- |
| 07 | Set fires, destruction of State property | 98.2 | 1985 | Kazan | ---- | 1986 | 3 years | ---- |
| 08 | Crossed Finnish border | 83 | 1979 | Kazan | ---- | 1980 | 9 years | ---- ² |
| 09 | Threw manuscript (of invention) over fence of French Embassy (distributed anti-Soviet literature) | 190-1 | 1982 | SPH | ---- | 1983 | 6 years | ---- |
| 10 | Crossed Polish border | 75 Ukrainian/CC (83 R.S.F.S.R./CC) | 1971 | Denepetrovsk | ---- | 1971 | 18 years | ---- |
| 11 | Human rights activities, Ukrainian Helsinki Committee (emotional outburst in Social Service Office) | ---- | 1988 | ---- | Nikolayev | 1988 | 3 months | ---- ³ |
| 14 | Armed hijack taxi, entered U.S. Embassy, fired weapon | 206.3, 207, 212.1, 218.1 | 1979 | Chernyakhovsk | ---- | 1979 | 9 years | ---- |

Table 6. Patient offense and disposition—Most recent hospitalization—*Continued*

| Case # | Behavior | Article | Arrest | Hospitalized | | OPH | Com- mitted | Length hosp. | Re- leased |
|--------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------|-------------------------------------------------|--|---------|----------------|---------------------------------|---------------|
| | | | | SPH to which first committed ¹ | | | | | |
| 15 | Made explosives (1 person killed and 4 injured) | 15, 190-1 102.1, 218 | 1979 | Kazan | | ---- | 1980 | 8 years | ---- |
| 16 | Visit to Andrei Sakharov's apartment — history of human rights activities | 67 and 201 Byelorussian CC (70 & 190-1 R.S.F.S.R./CC) | 1980 | Mogilev | | ---- | 1980 | 9 years | ---- |
| 18 | 1974, entered U.S. Embassy; 1984, anti-Soviet statements, destroyed cello with meat cleaver (on escape status) | 195.3 Estonian/CC | 1974 1984 (escape status) | Tashkent Leningrad | | ---- | 1974 1985 | 10 years 4 years 14 years | ---- |
| 22 | Wife's initiative; ? patient suspicious | ---- | ---- | ---- | | Donetsk | 1988 | 1 year | ---- |
| 24 | Larceny (prior behavior — attempted to cross Soviet-Turkish border and anti-Soviet activities) | 132-2 | 1984 | Alma Ata | | ---- | 1985 | 3 years | ---- |
| 26 | Wrote book on poet Vysotsky—other anti-Soviet writing | 70 | 1984 | Kazan | | ---- | 1984 | 4 years | ---- |

Table 6. Patient offense and disposition—Most recent hospitalization—*Continued*

| Released | | | | | | | | |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------|-------------------------------------------|--------------|------------|--------------|-----------|
| Case # | Behavior | Article | Arrest | SPH to which first committed ¹ | OPH | Com-mitted | Length hosp. | Re-leased |
| 03 | Wrote articles and book defaming State, helped Crimean Tatars | 97.1p.1 UzSSR/CC (190-1 R.S.F.S.R./CC) | 1983 | Tashkent | ---- | 1983 | 4½ years | 1987 |
| 04 | Complaining letters, dissident writing (e.g., in past to TV news regarding blood pressure program, problems of mentally retarded; letters to President of U.S.S.R.), human rights activities | 190-1 | 1982 | Volgograd | ---- | 1982 | 6 years | 1988 |
| 06 | Editorial work, Free Union Bulletin, and other publication | 190-1 | 1982 | Alma Ata | ---- | 1983 | 5 years | 1987 |
| 12 | Anti-Soviet manuscript (thesis) on Socialism | 70 | 1986 | Sychovka | ---- | 1987 | 1½ years | 1988 |
| 13 | Anti-Soviet writing (political-religious) - letter to Gorbachev | 190-1 | 1986 | Chernyakhovsk | ---- | 1986 | 2½ years | 1988 |
| 17 | Wrote articles criticizing Soviet activities in Chile and supporting Solidarity, trade union in Poland, audiotaped VOA and BBC | 70 | 1982 | ---- | Leningrad #3 | 1983 | 4½ years | 1987 |
| 19 | Distributed books (Solzhenitzen, Zinoviev, Medvedev) | 70 and 190-1 | 1984 | Leningrad | ---- | 1985 | 3 years | 1987 |

Table 6. Patient offense and disposition—Most recent hospitalization—*Continued*

| Case # | Behavior | Article | Arrest | Released | | Committed | Length hosp. | Released |
|--------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------|-------------------------------------------|-------------|-----------|--------------|----------|
| | | | | SPH to which first committed ¹ | OPH | | | |
| 20 | Distributed anti-Soviet leaflets plus other activities, wrote letter re asylum, Society for Solzhenitzen | 70 | 1975 | Sychovka | ---- | 1976 | 13 years | 1989 |
| 21 | Verbal altercation with M.D. (at time of Int. Youth Festival, patient on register) | ---- | 1986 | ---- | OPH | 1986 | 4 months | 1986 |
| 23 | Multiple human rights activities, writing, distributed literature, Helsinki monitor group activities, Ukrainian rights activist | 62 Ukrainian /CC (70 R.S.F.S.R. /CC) | 1980 | Kazan | ---- | 1981 | 7 years | 1988 |
| 25 | Defended rights of disabled (invalids), signed petitions | 190-1 | 1983 | Novosibirsk | ---- | 1983 | 4 years | 1988 |
| 27 | No internal passport, political organizing (advocate two-party system) ?manic behavior | ---- | 1987 | ---- | Chelyabinsk | 1987 | 2 months | 1988 |

Abbreviations.—SPH = special psychiatric hospitals; OPH= ordinary psychiatric hospitals; R.S.F.S.R. = Russian Soviet Socialist Republic; CC = criminal code; UzSSR = Uzbek Soviet Social Republic.

¹Of the 11 patients first committed to an SPH, 8 were in ordinary psychiatric hospitals at the time they were interviewed by the Delegation.

²Patient released 4/89.

³Patient released one day after U.S. team departed U.S.S.R.

talized patients had been border crossings—nonviolent offenses that could have a political significance.

Four other hospitalized patients had committed acts, including violent acts, that would be crimes in any country. These included killing one and injuring four by explosives (#15); hijacking a taxi and entering the U.S. Embassy, where a weapon was fired (#14); destroying property while obviously disturbed (#18); and setting fires in a workplace (#07). One hospitalized person charged with larceny attributed his arrest to prior political activities (#24).

Among five persons most recently hospitalized through the medical process, none had committed violent acts prior to hospitalization. Two patients connected their hospitalization to their political behavior: Case #11—engaging in activities in support of Ukrainian rights (this patient had requested to be interviewed by the U.S. Delegation); and Case #27—activities in pursuit of establishing a two-party system in the U.S.S.R. The connection between political behavior and hospitalization for the remaining patients was not evident, even though one patient (#22) was deeply suspicious of the KGB, very anti-Soviet, and had previously spent time in an SPH.

2. Detention Process

Typically, patients had been initially arrested and interrogated. After a period of time in jail or prison, they were sent for psychiatric examination, often at the Serbsky Institute of General and Forensic Psychiatry in Moscow. Following examination and trial, they were sent to Special Psychiatric Hospitals in practically all cases.

Some patients noted previous involvement with the KGB prior to their arrest, attesting that the KGB had been monitoring them and had orchestrated their arrest and subsequent disposition. For example, #23, a well-known Ukrainian activist, reported that the KGB attempted to recruit her. When they failed, she attests, they harassed her and brought trumped-up charges against her. This culminated in a period of what she described as compulsory labor. She was arrested and eventually hospitalized after a finding of nonimputability.

Case #04 explained that he was charged with slander. As an attorney, he could defend himself adequately. Therefore, he believes, the KGB decided to utilize

psychiatric hospitalization as an alternative means of control.

After sending telegrams to Dr. Anatoly Koryagin and the Central Committee, Case #11 reported that he was picked up at his apartment by the KGB and taken directly to an Ordinary Psychiatric Hospital (his previous hospitalization). He was told that his plan to attend a human rights demonstration was a symptom of "delusions of social reform."

Case #16 was well known to the KGB; he had engaged in many human rights activities. He said he had been charged with "hooliganism," and mental hospitalization was threatened by the procurator. He believes he was not sent to prison on his present charge (visiting Sakharov's apartment) because a public trial would have been embarrassing. He stated that the examining psychiatrist did not conduct an examination but merely told him, "I have a family and I need this job. I and the rest of the Commission will do what we are asked [by the KGB]."

Many other examples could be given. However, not all the patients mentioned the KGB. The Delegation was not given access to the investigative reports, which are important sources of information about precisely what the patients did and who was concerned about their behavior.

Following examination by the U.S. Delegation, some patients who alleged that KGB activity was instrumental in their psychiatric handling were challenged by the Soviet psychiatrists, who attributed the patients' views to psychopathology (paranoid ideation). It is likely, however, that, considering the patients' behaviors, KGB interest in them was great, and the patients' "paranoid" views would not necessarily represent psychopathology.

3. Criminal Proceedings

Contrary to several explicit provisions of Soviet law (see Appendix F), patients played virtually no role in the process of their investigation, examination, and trial. For example, of the cases questioned that involved court-ordered compulsory treatment (most recent hospitalization), only one patient (#17) indicated that he was informed of his rights, consistent with the provisions of Article 149 of the Code of Criminal Procedure (R.S.F.S.R.).

Only 10 patients said they had lawyers representing them (data were insufficient to judge in three cases), although Articles 49 and 405 of the Code of Criminal

Procedure (R.S.F.S.R.) require appointment of counsel after charges are filed by the procurator and even earlier in some cases in which mental illness is established. Of the 10 patients who said they had lawyers, only one actually met his lawyer.

Based on information supplied by 17 patients whose most recent treatment had been court ordered (data were insufficient to judge in 4 other cases), only 1 (#19) was present at his trial. His was an unusual case in which he had been accused of distributing anti-Soviet books under Article 70. He told the U.S. Delegation that after he deliberately acted in a peculiar way, it was decided to send him for psychiatric examination. He was subsequently found nonimputable at a trial he did not attend. (The patients' relatives attended trials in seven cases under discussion.)

Case #25 offered a good description of a trial, which was attended by the patient's sister and daughter. The patient was accused of having a bad work record, treating his mother poorly, and associating with enemies of the State. He had said there was bad food at the local store at Novosibirsk. The psychiatrist who testified said that the accused could not be helped in the local hospitals and needed to be sent to Kazan or Alma Ata (both SPHs) to be cured. The defense attorney said nothing at the trial, at which the patient was found nonimputable and committed to a hospital. The family was told they could appeal in 10 days, but when they tried, they were told it was too late, the case was closed. The patient's sister stated that his lawyer told his daughter, "If you appeal, they will put you in jail."

Only one patient said she signed the accusation against her (#23), as required by Article 148 of the R.S.F.S.R. Code of Criminal Procedure (see also Appendix F). Only three patients (#12, 19, 23) reported seeing the investigative report, or part of the report, or receiving (although too late) a copy of the investigative report, as required by Article 201; none reported being presented with the experts' findings as required by Article 193.

There are exceptions in the R.S.F.S.R. Code of Criminal Procedure that permit a patient to be absent from his/her trial because of mental disorder, or to play no role in the investigation because of mental disorder (Articles 404 and 407). However, the patients described here were apparently never included in the legal process, despite their ability to be involved.

Comparing the released cases to those still hospitalized, there was no difference in the granting of most rights because few rights were granted to any patient.

4. Nonimputability

In the U.S.S.R., insanity (a finding of nonresponsibility for a criminal act) is labeled "nonimputability." To be found nonimputable, a patient must meet both juridical and mental criteria. The judicial criterion relates to the mentally disordered person's understanding and control of behavior. The medical criterion relates to the presence of mental disorder diagnosed in the accused (Babayan undated; see generally Morozov and Kalashnik 1970).

Article 11 of the R.S.F.S.R. Criminal Code specifies the Soviet approach to nonimputability:

A person shall not be subject to criminal responsibility who at the time of committing a socially dangerous act is in a state of nonimputability; that is, cannot realize the significance of his actions or control them because of a chronic mental illness, temporary mental derangement, mental deficiency or other condition of illness. Compulsory measures of a medical character may be applied to such a person by order of the court (Berman 1972, page 128).

We have previously discussed the patients' psychiatric diagnoses. Given that the events in question occurred many years ago in most cases, and that the major focus of the Delegation's effort related to the patients' present status, it was not possible to assess imputability fully during these examinations. However, during their interviews with Delegation members, patients were asked a number of questions about their behavior prior to arrest, including: "At the time of the incident, what did you think would be the consequences of [your behavior]?" and "Had you given some thought to the possible consequences at any point before the incident?" and "Can you tell us about the reasons for your behavior?" These questions furnished an opportunity for patients to describe what they had done and why.

The released patients' answers to these questions suggested that their behaviors had been deliberate and knowing. They understood the consequences and could offer rational reasons for their behavior. Even though there was a discrepancy between the Soviet and U.S. diagnoses (see above), the mental disorders diagnosed by the Soviet psychiatrists did not appear to be of a type

likely to prevent these patients from giving clear and understandable accounts of their behavior. As noted elsewhere in this report, the impression of the Delegation is that in the U.S.S.R., the major determinant of nonimputability is the diagnosis of a mental illness plus the commission of a socially dangerous act. In practice, impairment of a person's capacity to understand the significance of his or her behavior or to control it may not necessarily be explored in forensic evaluations or during the trial.

Among the released patients, two said that their mental illness had been feigned. These persons (#12, #19) thought they would prefer psychiatric hospitalization to punishment under Article 70 (a maximum of 7 years imprisonment followed by 5 in exile). They also thought that some of the psychiatrists knew of the ruse and collaborated with them for benign reasons. Aside from these two cases, however, accounts of their offenses by the other released patients provided no basis whatsoever for finding that the juridical criterion for nonimputability had been satisfied.

The findings were different for many of the hospitalized patients. Two of the three patients hospitalized in Special Psychiatric Hospitals at the time of the Delegation's visit were obviously severely mentally disordered (#14, #18). Their behavior at the time of arrest was described in such a way that findings of nonimputability (according to the medical criterion) would be clear. Of the other eight persons then hospitalized and receiving compulsory treatment, three described their criminal behavior in a manner compatible with a finding of nonimputability (#02, #07, #10); in three other cases, (#08, #09, #15), a finding of nonimputability was understandable even if the evidence was not always clear cut.

5. Urgent Hospitalization

Five patients were examined whose most recent hospitalization had been to an OPH. Three of these hospitalizations occurred either very late in 1987 or in 1988, in proximity to passage of the new law.

Hospitalization in OPHs often began with patient arrests for behavior such as having no internal passport or disorderly conduct, but some patients were brought directly to the Ordinary Psychiatric Hospital by the psychiatric emergency team. One of these cases, (#21), illustrated the ease of hospitalization in an OPH in the U.S.S.R. when a person is already on the psychiatric register. In the discussion of this case, the Soviet

psychiatrist indicated that this patient's hospitalization was probably a mistake.

Two patients (#11, #27), were hospitalized, in their view, because of their political activities. Case #11 involved human rights activities such as distributing petitions, opposing nuclear power plants, and proposing that Ukrainian rather than Russian be taught in Ukrainian schools. This patient also wished to be interviewed by the U.S. Delegation. On the day prior to hospitalization, he had gone to a local social service office and had an emotional outburst which included demands regarding claims for alleged past wrongs. However, he was cooperative and rational in the mental hospital emergency room, and his mental status then and later was not compatible with the diagnosis of schizophrenia he was given.

Another recent case of urgent hospitalization (#27) involved a political activist and advocate for a two-party system in the U.S.S.R. The patient was initially detained in Moscow, released, and then transferred to another city, Chelyabinsk, where he was hospitalized for what was reported by the Soviets to be manic behavior. There was no apparent evidence of dangerous behavior. This patient was not diagnosed to be mentally ill by the U.S. Delegation.

The new Soviet statute of January 1988 requires that patients be examined by a psychiatric commission within 24 hours of hospitalization, and subsequently every 30 days. Although the patients who recently had been urgently hospitalized reported that a commission had been held at some time early in their hospitalization (if not within 24 hours), this was frequently the only commission held. In one older case, when a criminal charge was also brought against the patient, he obtained a lawyer and the charge was dropped. No other patients had lawyers, and there were no appeals of urgent hospitalization.

6. Conditions of Hospitalization

a. Special Psychiatric Hospitals (SPHs)

Virtually all patients described very poor and harsh conditions in the Special Psychiatric Hospitals; those having a comparative perspective viewed them as worse than prison. Virtually no patients said anything positive about the Special Psychiatric Hospitals, except for the Leningrad SPH, which has recently been opened to visitors from the West. Indeed, one patient described the

Leningrad SPH as a "real resort compared to those other places." Another patient described his treatment at a different SPH (Chernyakhovsk) as humane.

Until recently, SPH staffing included, in addition to doctors and nurses, criminal orderlies who were sent to these hospitals as a part of their sentences. The patients describe sadistic activities by these orderlies; e.g., severe beatings or prevention of toileting. In addition, orderlies were reported to have stolen food sent by relatives, and bribery of orderlies was said to be common. These conditions were reportedly condoned by some doctors and nurses.

Hospitals were organized in tiers, with patients progressing over time from the most to least secure wards. Typical days were devoid of any meaningful activity or recreation, and the patients were given little or no choice of reading materials. Patients were forbidden to keep a diary, and the possession of pen and paper was a serious offense. Writing a letter critical of the hospital (on letter-writing day) was punished in one hospital by 3 weeks of solitary confinement. All incoming and outgoing correspondence was read, and no telephone calls were permitted. Visitors to the Special Psychiatric Hospitals were usually limited to family, and the visits were monitored.

Some patients felt that they could mix more or less freely with other patients, while others felt that they were limited because they were political detainees. Most said that they were kept isolated from other political persons.

Most patients described some form of mistreatment in the Special Psychiatric Hospitals in relationship to harsh conditions, very poor food, arbitrary treatment by the criminal orderlies, use of forced medication, beatings, and threats of electroconvulsive therapy (ECT).

Patients were not told about their rights while in the SPHs. For example, there was poor access to information about the new law. One person explained that articles on psychiatry, including the new commitment law (March 1988), were cut out of magazines and newspapers before patients could read them (at Chernyakhovsk).

Treatment options appear to have been quite limited. No psychotherapy or individual group therapy was reported, and no form of recreational therapy was described.

Treatment in the Special Psychiatric Hospitals consisted most commonly of neuroleptic (antipsychotic)

drugs, either by injection or by mouth. Some patients described side effects, including muscle spasms and extreme restlessness. Patients generally reported that they had minimal contacts with their physicians, including chief doctors, and little ability to negotiate dosage changes. Some patients received insulin shocks and coma, and a few received atropine treatment.

Patients also received sulfazine, a drug believed in the West to be without therapeutic value. As noted earlier, although its use is explained in the U.S.S.R. as a treatment for alcoholism, or as a prelude to a new course of antipsychotic medications to supplement their action, this theory of drug action is idiosyncratic to the U.S.S.R. Because sulfazine is painful and causes high fever and prostration, it is experienced by patients as a punitive treatment. Furthermore, its episodic use in SPHs following rule infractions (e.g., criticizing the hospital, looking down a nurse's bosom, having cigarette ashes found under a patient's bed), or in one case having "anti-Soviet thoughts," also suggests that the purpose of sulfazine administration is punishment or aversive behavioral conditioning. Ten patients reported receiving sulfazine during their most recent (SPH) hospitalization. The Delegation was told by one of the Soviet psychiatrists that the drug is not used at the Serbsky Institute. Nor was it used with any frequency at OPHs in which the interviewed patients were held.

According to patients interviewed by the U.S. clinical team, antipsychotic drugs were increased following rule infractions or when patients complained. This finding was confirmed by the U.S. Delegation hospital team (see below), which received many complaints from patients about the nontherapeutic and possibly punitive use of medications.

There was apparently minimal, if any, improvement in the conditions in the SPHs during recent years, except in hospitals where the criminal orderlies were being replaced by other staff. Some patients commented that in the last year the food was better, or there was less use of ECT, but there did not appear to be recent substantial changes in hospital conditions.

b. Ordinary Psychiatric Hospitals (OPHs)

The Ordinary Psychiatric Hospitals were described as much less harsh than the Special Psychiatric Hospitals, a finding compatible with the observation of the Delegation's hospital team. One patient noted that OPHs had deteriorated in the past decade because of

economic conditions; as a result, there were few programs available for patients. One patient reported the use of patients to do a great deal of work in the hospital. Food and sanitary conditions were described as poor, but not as bad as those of the Special Psychiatric Hospitals. There were so few beds at one OPH that patients were reportedly forced to sleep two in a bed.

Reading, writing, and visits were all available to the patients. However, two patients who were under compulsory treatment in OPHs were transferred to an SPH when they wrote letters critical of the hospital.

7. Social Dangerousness

Other than the behaviors that had precipitated the most recent hospitalization of some patients (see Table 6), there was relatively little evidence of prior dangerous behavior among the study sample. Only the hospitalized patients had previous serious violent behavior; the released patients did not.

One hospitalized patient had been charged in the past with attempted murder when he found his wife in bed with another man—he was put in prison for 8 years; one had a history of several violent offenses, including rape and assault; one had vandalized property with a knife; one released patient had been in many fights as a sailor and had a history of arrests and imprisonments, some associated with drinking. Several other patients had been arrested or imprisoned for nonviolent crimes, e.g., being a vagabond, embezzlement, theft, "hooliganism", or for activities similar to the behavior that led the current hospitalization, such as dissident behaviors or crossing the border. A few patients denied behaviors alleged in remote arrests.

Few patients had a history of suicidal behavior; only two had made serious prior suicide attempts.

8. Re-evaluation and Release

Soviet law, present and past, requires that patients in compulsory treatment be re-evaluated by a psychiatric commission every 6 months. Practically all patients indicated that such commissions did meet (one patient was simply asked whether his anti-Soviet views had changed, and when he said "no," the commission was not scheduled). However, the commission meetings were virtually always perfunctory, lasting from a few minutes to 10 minutes at most with each patient. A very large number of patients would be evaluated in a single day by a visiting team, or by the SPH hospital personnel,

(e.g., according to one patient, 63 patients in 1 1/2 hours at one SPH). One Soviet psychiatrist who met with the Delegation indicated that, because of a patient's offense, it is known that the patient is going to spend a long time in the hospital. Therefore, the commission's evaluation can be brief early in the patient's hospitalization.

The release of several patients illustrates the critical role played by the current U.S.S.R. definition of social dangerousness. Their release appeared to have more to do with definitional or political changes than changes in diagnostic practices or the patients' clinical conditions. Thus, one patient was told "perestroika" was the reason for his discharge. Another was told "The situation had changed." Yet another was told, "We have been ordered to find guys like you and fish them out." In another case, a commission suddenly decided that the patient's offense was "nonsense" and recommended him for release. Patients (#04, #23) with no psychiatric diagnosis (in the opinion of the U.S. Delegation) nevertheless were expected to acknowledge their illness before release.

The court ultimately determines the release of the patients. The Delegation did interview two patients, presently residents in a Special Psychiatric Hospital, whose transfer to a less restrictive setting, although recommended by psychiatrists, was not accepted by the court. Such cases appear to be rare, however.

9. Conditions of Release—Community Adjustment

The patients in this sample had minimal contact with the mental health authorities following release. Although six of the released patients were on the psychiatric register, only two patients described regular contacts with psychiatric services. They were periodically sent a post card directing them to come in and talk with a psychiatrist. Others have had occasional contact with a clinic doctor or nurse who visits them. Five of the patients were receiving disability pensions, but two persons wanted no part of a pension. A few patients had guardians. One patient, not on the register, nevertheless had a guardian (his daughter), whom he wished to remove from that role. Some patients were afraid they might be put back into the hospital, but others were reassured by the present political climate.

Several patients were concerned about problems relating to their psychiatric history because this was preventing them from finding a job. One patient found it difficult to find employment in his field of expertise (biology) because his draft card had a notation that he

was a psychiatric case; this notation was in the process of being removed administratively.

Even patients who were not on the register were concerned about their past psychiatric diagnoses and wanted them removed. For such patients, as well, the possibility of employment, career opportunities, and admissions to school can be severely affected by a history of psychiatric hospitalization.

B. Hospital Site Visit Report

The U.S. Delegation's hospital site visit team was organized to provide a broad perspective on the general status of treatment and potential human rights issues in selected psychiatric hospitals in the Soviet Union. Members included three psychiatrists (the team leader, a U.S. State Department psychiatrist, and a Russian-speaking, Soviet-trained, U.S. citizen psychiatrist), two lawyers, a political scientist, and an expert in human rights issues from the American Psychiatric Association.

The hospital team made a thorough visit to the four facilities, which are more fully described in Appendix E, and obtained substantial information from the hospital directors on staffing, budget, and programming. (The categories of information obtained are also outlined in Appendix E.) This section of the report will summarize the hospital team's impressions pertaining to the quality of care, the effect of recent administrative changes, the rights of patients, and legal issues relating to admission and discharge.

Specifically, the hospital site visit team was charged with several objectives, to:

1. Observe and report on the physical plants of the hospitals visited;
2. Gather basic demographic data about patients and staff;
3. Observe and report on the therapeutic environment;
4. Assess change subsequent to modifications in the mental health laws, regulations, and change of auspices of the Special Psychiatric Hospitals from the Ministry of Interior to the Ministry of Health;
5. Review and assess allegations of human rights violations and abuses of psychiatry; and

6. Interview selected patients and respond to patient requests for interviews.

Four psychiatric hospitals were visited: two Special Psychiatric Hospitals (SPHs), Kazan and Chernyakhovsk, locations where many cases of human rights abuse had been alleged; and two Ordinary Psychiatric Hospitals (OPHs), Vilnius and Kaunas, which were close in proximity to Chernyakhovsk. These hospitals were believed to be reasonably representative of their type. Kazan is the oldest SPH in the Soviet Union.

The site visit team sent a request for information to each hospital shortly before the visit and was guided by a list of observations to be made at each hospital as a function of time and relevance (see Appendix E). At the SPHs the team felt an acute shortage of time; future missions should allow about 3 days per hospital for such visits.

1. Hospital Overview and Physical Plant

The Delegation had almost complete access to the hospitals and their patients, although repeated requests that one patient be located for an interview were not satisfied. There was considerable variability in the four hospitals visited, with the physical plant and the general atmosphere of the Special Psychiatric Hospitals considerably inferior to what was found at the Ordinary Psychiatric Hospitals. (A more detailed description of each hospital is contained in Appendix E.)

2. Transfer of the SPHs to the Ministry of Health (MOH) from the Ministry of Interior (MVD)

The administrative transfer of SPHs, which took place in January 1989, is only a partial one, involving mainly nurses and orderlies. The guards remain under the MVD, and their commander reports not to the SPH chief physician but to a higher MVD official. The physicians remain employees of the MVD and retain their uniforms and military rank. When new physicians are hired, they, too, have the option of joining the MVD, an option that officials said they would probably exercise because MVD terms of employment (e.g., salary) are considerably better than those of the Ministry of Health. Thus, all the senior personnel in the SPH continue to be employed by the MVD, even though the regulations governing hospital procedures are now issued by the Ministry of Health, and the Chief Psychiatrist of the region in which each hospital is located has some supervisory role over clinical practices in the hospital. It was

not possible for the U.S. Delegation to predict how the inherent conflict in supervisory jurisdiction over the hospitals and over the staff is likely to affect conditions in the hospitals.

3. Access to Patients and Staff

In addition to having access to the hospitals themselves, the site visit team was able to interview 45 patients of its own choice in the Ordinary and Special Psychiatric Hospitals visited. It was possible to interview patients alone, without Soviet psychiatrists present. The interviews were of varying lengths, and the medical records of many of these patients were also reviewed. Among the patients interviewed were former patients of SPHs who had been transferred to OPHs. Many staff were also interviewed alone and in small groups.

4. Milieu Observations

Patients reported that there was little supervision of the staff of Special Psychiatric Hospitals and that it was dangerous to make complaints. Numerous complaints were voiced to the site visit team that the staff frequently refused patients permission to use the bathrooms and demanded bribes to permit their use. In the Special Hospitals, ward rules are not posted, and patients reported that they often suffered punishment for infractions. Formerly, the use of criminals as orderlies increased the likelihood of physical abuse and bribery. These staff no longer have patient contact at Kazan, and they have been removed entirely from Chernyakhovsk.

However, the civilians who have replaced them received only on-the-job training, and patients varied in their assessment of whether the change had increased or decreased the level of abuse. In both the Special and Ordinary Psychiatric Hospitals administrators said that the low level of pay made attracting quality staff difficult.

In Special Psychiatric Hospitals most patients were not allowed personal possessions in their rooms, and did not have easy access to reading and writing materials. Patients were not allowed to keep diaries, and mail was limited. Visits were usually limited to family members, and all visits were monitored by staff. Family visits were sometimes impossible because the hospitals were too far from the patients' homes. Statistics provided at Chernyakhovsk indicate that the average patient probably received two or three visits per year. Patients were not allowed to use the phone and

complained that they could not mix freely with other patients.

Patients committed to Special Psychiatric Hospitals were rarely, if ever, told of their legal rights, of access to lawyers, or appeals. They were not knowledgeable about the new commitment law that controls their hospitalization, nor were some of the doctors.

Many patients in the SPHs reported that the food improved when the hospital was told that the U.S. team was coming. In addition, the hospital areas were cleaned and painted, uniforms were issued to some patients, the hospital staff and some MVD (militia) guards exchanged their uniforms for civilian clothing, guard dogs were removed to outlying kennels, and the mail allowance was increased. All patients interviewed saw such changes as positive, but many wondered whether they would continue after the visit was completed.

5. Treatment

In both the Special and Ordinary Psychiatric Hospitals, treatment options were quite limited. Psychotherapy, individually or in groups, was not available. Some psychologists spoke of "talking therapy," but the psychiatrists limited their therapy to the prescription of neuroleptic drugs. A few patients had tardive dyskinesia, a severe and irreversible movement disorder produced in some patients by chronic administration of antipsychotic (neuroleptic) drugs, but neuroleptic side effects were mostly muscle spasms and extreme restlessness.

In the SPHs, protesting patients viewed many medication or treatment routines as abusive, and the large number of complaints about punitive injections or forced oral medication added validity to these protests. Patients were almost never consulted about their medications or treatment processes. Further, there appeared to be no rationale or recorded clinical observations to explain changes in medication. Physicians used multiple psychotropic medications, and in a manner that often suggested behavioral manipulation or punishment rather than treatment. For example, following a single behavioral incident, an order would be written to administer a heavily sedating intramuscular neuroleptic for an extended period of 10 to 20 days.

Many patients in the SPHs cited sulfazine as the drug often used for punitive purposes. Some current and former patients demonstrated scars from its injection

into the shoulder and buttocks regions. Some officials said that sulfazine was no longer being used; others said it was.

Insulin treatment was observed in the SPHs. While patients did not report that it was used punitively, they did feel that electroconvulsive treatment (ECT) had sometimes been used as punishment. In the institutions where the punitive use of ECT was reported, however, the treatment was not being administered because the equipment was not available. The staff discussed ECT as a possible treatment modality for resistant depression and inquired about its use in the United States.

In the Special Psychiatric Hospitals many patients were locked in their rooms for a large portion of the day, devoid of scheduled activities except for meals and exercise yard routines. In winter, patients were often not taken for exercise for a month or two at a time because of the cold. (Recreation facilities were poor at all the hospitals visited except for Vilnius.) There were no treatment plans for patients who were judged to be nonimputable. Those participating in workshop activities or in contract work were on less medication and hence seemed more alert than other patients. While the tiered system of moving patients upward to rehabilitation wards seemed appropriate, the rationale for what constitutes improvement was ambiguously defined and poorly recorded in the charts.

In the Ordinary Psychiatric Hospitals, although some wards were locked, patients moved freely through the corridors and had access to recreational spaces. The workshops in Vilnius incorporated training areas, which were light and airy. There were generally fewer complaints about OPHs, where treatment plans seemed to be routinely formulated for the patients.

The training of at least some of the psychiatrists interviewed during the site visit included only 6 months of specialty training in psychiatry after medical school; a forensic specialty for one psychiatrist interviewed was 3 months. Patients varied in their assessment of the physicians—some were described as kind, but at the SPHs some were described as cruel, and at these hospitals the lack of an effective procedure for handling grievances and complaints was most keenly felt.

6. Diagnoses

The diagnosis most often made in both the Special and Ordinary Psychiatric Hospitals was schizophrenia, accounting for approximately 70 to 75 percent of all

diagnoses. The remaining 25 to 30 percent of patients were diagnosed as having retardation, organic brain dysfunction, epilepsy, or psychopathy. The diagnosis of affective (mood) disorder was rarely made. Vague or overly broad diagnostic formulations by hospital personnel were sometimes presented to the team in reference to patients. For example, when a patient was diagnosed by hospital staff as schizophrenic, the formulation relied little on the patient's current symptoms, history, and presenting complaints.

7. Review of Need for Continued Hospitalization

One legal issue explored in some depth in all the hospitals visited was the process of reviewing patients' need for continued hospitalization and their suitability for discharge. In the OPHs, site visitors were told that the average length of stay was about 60 days, and that very few of the patients were "involuntary." After discussing the issue with the Vilnius administration, team members ascertained that most of the patients were initially admitted under emergency conditions, and over their objections, eventually "converted" to voluntary status. Thus, after the initial 24-hour commission reviews, very few 30-day commission reviews (which are required by law upon request by the patient) were actually held. Although the 1988 law provides for appeal by protesting patients, no such appeals had been sought by patients at Vilnius or Kaunas since the law went into effect, perhaps because most patients were ignorant of the law.

In the SPHs, patients are legally entitled to a commission review every 6 months. The standard practice, team members were told, is that the treating physician presents the cases to a commission from the Serbsky Institute, which visits from Moscow every 6 months. One or more of the SPH psychiatrists may serve on this commission. According to the patients, the commission interviews last only a few minutes, rarely more than 10.

8. The Psychiatric Register

Both patients and staff commented on the abuse of the psychiatric register, which influences—and can hinder—patients' re-entry into the community in several areas, including housing, job access, and possession of a driver's license. The register also serves as a vehicle for rapidly readmitting persons to a hospital with little provision for due process.

9. Restrictiveness of Placement

Of great interest to the visiting team was the impression that a significant number of patients in the SPHs did not require hospitalization in such restrictive conditions. According to officially provided statistics, about 30 percent of the patients at Chernyakhovsk had been found nonimputable for relatively minor offenses not involving danger to life or personal safety, and presumably not involving "special danger" to society, if this concept is restricted to risks of violence. Such offenses included nonviolent theft (19 percent), "hooliganism" (7 percent), and other minor offenses (4 percent).

The case of a 50-year-old female physicist illustrates the type of politically unacceptable behavior that can lead to hospitalization, as well as the role of the psychiatric register in facilitating rehospitalization. The woman was in a Special Psychiatric Hospital because she forged a residency document and discussed her religious beliefs publicly. An earlier encounter with psychiatrists for distributing religious leaflets resulted in her name's being placed on the register. This history and her unauthorized lectures on science and religion to her students resulted in her being declared nonimputable and placed in a Special Psychiatric Hospital. An extensive interview with her revealed no apparent psychopathology.

In discussing her case, the treating psychiatrist admitted that such patients were seen less frequently in this era of "perestroika." With some irony, he observed that nowadays the press says things that patients were treated for not too long ago.

In another Special Psychiatric Hospital, team members spoke with a young man who had been involved in nationalist movements. He had threatened a local official who was suspected of corruption. Although a weapon was reportedly brandished during the offense, his psychiatrist at the Special Psychiatric Hospital apparently did not regard the patient as sufficiently dangerous to justify placement in that hospital.

It is important to note that none of the patients in Chernyakhovsk had been committed as a result of arrests under the "political articles" 70 and 190-1. The team found no clear-cut cases of political or religious abuse in this hospital; however, it must be emphasized that due to the limited nature of the visit, such a possibility cannot be ruled out. Some cases raised concerns in this regard and would certainly merit further review.

A number of patients interviewed in the SPHs believed they had been hospitalized mainly for political or religious reasons. These patients felt that the essence of their case had been masked by the fact that the formal charges were criminal in nature, or an element of violence was involved in their actions. Physicians interviewed about this point held that while there may have been cases of "hyperdiagnosis" involving dissidents, all such individuals were definitely mentally ill and needed treatment.

10. General Summary Statements

Although a site visit of this nature is impressionistic and does not constitute a scientific study, it provides some basis for assessing changes taking place in Soviet psychiatry. Opening the Soviet psychiatric hospital system to external visit must be considered to be highly worthwhile as an initial step toward improved psychiatric care and better safeguards for human rights. In spite of defensiveness on the part of some staff and officials, the U.S. site visitors' access to hospitals and patients, their records, and their staffs was generally open, and provided with good grace and cooperation. There was an awareness in the hospitals that times were changing, and that the expectation for change cannot be suppressed. It was generally conceded that there is an increased need for collaboration and exchange of information with colleagues abroad.

For the Special Psychiatric Hospitals, the transition to a level of psychiatric care equal to that of the Ordinary Psychiatric Hospitals is likely to be difficult, considering the very limited resources available to them. The SPHs in the U.S.S.R. have recently taken a first step in the direction of change, but it is only a first step. In keeping more with the new legislation's intent, additional, independent review appears warranted. The sense of powerlessness and the restrictiveness imposed on the patients in the Special Psychiatric Hospitals is overwhelming. The U.S. Delegation concludes that even when the criminal charges are taken into account, the assignment of some of these persons to a maximum security facility was not necessary.

As a consequence of the visit, the U.S. hospital site visit team has identified 20 persons for whom some question was raised about the appropriateness of their treatment and placement; these names have been submitted to the U.S.S.R.

Much of the leadership in the change process will need to come from the Soviet psychiatric profession, yet the education of psychiatrists in the U.S.S.R. is limited, brief, and characterized by somewhat rigid adherence to orthodoxy. Psychiatrists must be free to exercise clinical judgment, even in maximum security facilities, and not be overwhelmed by police considerations.

C. Discussion of Soviet Law

This section examines the pertinent features of Soviet law, including recent changes to assess whether (and to what extent) these or other legal reforms can reduce the likelihood of political abuse of psychiatry.

1. Social Dangerousness

When a broad and elastic notion of mental disorder is combined with a broad conception of social danger, the predictable consequence is an expansive use of involuntary psychiatric hospitalization as an instrument of social control. This prediction is confirmed by the Soviet experience.

a. Compulsory Medical Measures in Criminal Cases

Under Article 59 of the Soviet Criminal Code (R.S.F.S.R.), a person found non-imputable is subject to compulsory psychiatric treatment, including hospitalization, if he or she has committed a "socially dangerous act." If the court finds that "by reason of the person's mental condition and the character of the socially dangerous act he has committed, [he] represents a special danger for society," that person may be committed to a maximum security Special Psychiatric Hospital. After commitment, the restrictiveness and duration of hospitalization is supposed to be determined by the patient's degree of dangerousness.

This statutory structure is similar to the law governing responsibility and disposition of mentally disordered offenders in the U.S. and in most other countries. However, administration of this system in the Soviet Union has been problematic due to the expansive concept of social dangerousness that has been applied.

Any violation of the U.S.S.R. Criminal Codes is apparently considered to be a socially dangerous act. Moreover, Soviet courts have apparently regarded violations of any of the "political articles" almost categorically as representing a "special danger for society," thereby

warranting commitment to a Special Psychiatric Hospital. It thus appears that among political offenders found to be nonimputable, their routine placement in SPHs has been based primarily, if not solely, on the nature of the offense committed and not on the individual patient's mental condition. When nonviolent political dissent is considered to be "a special danger for society," and the placement of ostensibly mentally ill patients is determined largely by their conduct rather than their mental condition, political abuse of psychiatry is virtually inevitable.

As noted above, the U.S. Delegation examined many patients, most of whom have now been released, who had been evaluated as posing special danger to Soviet society because of their writings, furthering of nationalist aspirations, defending of rights of others, or furthering of religious ideas. These patients had been hospitalized under court-ordered compulsory treatment despite the fact that their behaviors were nonviolent and were of a political or religious type not prohibited in other countries with different political systems. Their "socially dangerous" behavior constituted prohibited speech or the expression of individual ideas.

During the visits to the SPHs, the Delegation's hospital team explored the rationale for this conception of social dangerousness with the Soviet psychiatrists. In the course of these discussions, the example of General Grigorenko was raised. The Delegation was told that he had been placed in a Special Psychiatric Hospital rather than in an Ordinary Psychiatric Hospital because his ideas had gathered a following. (Upon examination in the West, General Grigorenko was not found to be mentally ill (Reich 1980).)

Along a similar vein, the hospital team was informed by a high official in an SPH:

Freedom in society has moved to freedom in psychiatry. That was a part of our society that was ill, and now it is being corrected. However, we still see these patients as ill, but their illness does not really harm society. Crossing the border is a sign of mental illness, as is distributing religious leaflets, but now we feel that these people can be treated in Ordinary Psychiatric Hospitals or as an outpatient. Definitely crossing the border can be a form of trouble, a form of illness. But we would not have to keep them in a hospital.

In accord with the "new thinking" of Soviet political life, there has been a marked diminution over the past 2 years in criminal prosecutions for violation of the "political articles" in the U.S.S.R. (Articles 70, 142, 190-1, and 227), and the Delegation examined no patient who had been recently hospitalized under these articles. Moreover, many patients who had previously been hospitalized under these articles have now been released. (It should be noted, however, that even at the time of the Delegation's visit, some patients remained hospitalized for pre-arrest behaviors that fit only a very broad conceptualization of social dangerousness—#16, #26, possibly #09, #24.)

The current situation apparently reflects a significant and progressive change in forensic and judicial practice. Nonetheless, there is obviously no assurance that the present situation will endure. What is needed is a change in the law, not merely an apparent change in practice. In the first place, failure to repeal the political articles or to restrict their coverage to violence or incitement to violence would perpetuate the risk of political abuse of psychiatry. During its discussion with Soviet jurists from the Institute of State and Law, the Delegation was advised that the U.S.S.R. Criminal Codes would soon be reformed along these lines. Unfortunately, the changes that were recently enacted do not adequately remove the danger of prosecution for political dissent.

On April 8, 1989, the Presidium of the Supreme Soviet of the U.S.S.R. issued a decree amending Soviet legislation concerning "crimes against the State." Article 190-1 was repealed, but under the successor to Article 70, a person can be punished for "public calls for the overthrow of the Soviet state and social system or for its change by methods contrary to the U.S.S.R. Constitution." These and other recent Criminal Code revisions, such as those apparently aimed at national liberation movements and prohibiting "the public insulting or defamation" of governmental bodies or officials, generated open confusion and controversy within the Soviet Union, leading the Congress of the People's Deputies to cancel some features of the April decree a few weeks later (*New York Times*, June 10, 1989). At present all that can be said is that the situation remains uncertain.

A second area in which legislative change is needed is to define more clearly the criteria for compulsory hospitalization and, especially, for placement in Special

Psychiatric Hospitals. Clearly, placement in such hospitals should be restricted to those mentally ill offenders who have committed serious, violent offenses.

b. Urgent (Civil) Hospitalization

The problem of defining dangerousness is not confined to criminal commitments to mental hospitals. The statute governing "urgent hospitalization" authorizes involuntary hospitalization if the person is a "danger to himself or those around him." Although this concept is commonly used in Western statutes as well, abuses can occur if the language is given an elastic interpretation. This concern is especially evident under the provision of the 1988 statute that permits involuntary psychiatric examination of a "person who commits actions that give sufficient reason to suppose that he has a pronounced mental disorder and at the same time violates public order or the rules of socialist society, and also represents an immediate danger to himself or to those around him." Through its reference to violation of the "rules of socialist society," this provision appears to be open to abuse. Formal instructions issued by the Ministry of Health have not adequately specified the types of patient behavior that could represent a danger to society (Provisional Guidelines 1988).

The patient interviews conducted by the Delegation demonstrate that the possibility of unduly broad interpretation of the concept of dangerousness is not purely hypothetical. The Delegation examined five patients whose most recent hospitalization had been through the urgent hospitalization mechanism involving commitment to Ordinary Psychiatric Hospitals under solely medical/psychiatric review. Two of these patients were hospitalized in 1988 following passage of the new law; one patient was committed in 1987 immediately prior to the new law. While one of these patients was, in the view of the Delegation, clearly mentally ill (#22), the other two were not (#11 and #27). Neither were they clearly dangerous to self, others, or society, unless their recent political behaviors were so evaluated.

Furthermore, the Delegation interviewed informally, without the presence of Soviet psychiatrists, an additional patient described by human rights sources as one of the "political" patients hospitalized during this last year. This patient was a "whistle blower," a physician who objected to financial misdoings at a hospital in accounting for automobiles on an official register. He refused to cover up the diversion of official automobiles for per-

sonal use when they were supposed to be destroyed as scrap metal. He came into conflict with the authorities and subsequently lost his job and standing. He was imprisoned and eventually committed to a psychiatric hospital until he absconded in late 1988 to offer medical help in Armenia. In the Delegation's view, this individual was clearly not mentally ill and he should not have been hospitalized. The Delegation was told by its informal sources that there were other recent questionable cases of civil hospitalization.

The danger that civil hospitalization will be misused can be reduced by clearly and specifically defining the types of harmful behavior that justify hospitalization on grounds of social dangerousness, and by doing so in a way that excludes political or dissident behaviors. This is apparently the intent of a recent statement by the Ministry of Health:

Now a person can be forcibly placed in a psychiatric hospital without his consent only if he represents a direct danger to those around him, as well as to himself (in the form of a suicide attempt) (*Pravda* 1989).

This is positive change. However, these apparent aims should be codified in statute. Until this is done, a significant risk of abuse remains.

2. Criminal Procedure

From the perspective of the person accused of crime, much is at stake in the determination of nonimputability and social dangerousness. In some respects, the consequences of compulsory medical measures can be more severe and more disabling than criminal conviction and punishment. In recognition of this perspective, the trend in U.S. law has been to leave the decision whether to invoke the defense of non-responsibility exclusively within the defendant's prerogative. In other words, neither the court nor the prosecution may impose the defense over the objection of a defendant who is competent to make an informed decision. This is not the rule in the Soviet Union, where the decision to invoke the doctrine of nonimputability and to seek compulsory measures lies with the investigative and prosecutorial authorities.

In this legal context, the fairness of the procedures by which the accused is found nonimputable and socially dangerous is a matter of significant concern from a human rights perspective. Accordingly, this issue was

explored both by the U.S. teams conducting the structured patient interviews and by the team that visited the Special Psychiatric Hospitals.

As noted above, practically all patients and former patients questioned by the Delegation reported that 1) they never met with a defense attorney, even though one may have been appointed in the case; 2) they were not given copies of the report of the forensic examiner or the report of the preliminary investigation as required by law; and 3) they were tried *in absentia*. Typically, the patients reported that they had been arrested, taken to jail, taken to a hospital for forensic examination, and then taken to another hospital under a compulsory treatment order without ever being given an opportunity to be heard in their own behalf and without being informed of the legal basis for their confinement. In short, the accused is not a participant in the process by which his or her fate is determined. To the extent that these reports accurately describe Soviet legal practice, the process is fundamentally unfair.

It is possible that these findings reflect an intentional and systematic policy of ignoring the procedural rights guaranteed by Soviet law and of denying persons accused of political offenses a public opportunity to confront the charges against them. (See Article 246 of the R.S.F.S.R. Code of Criminal Procedure (in Appendix F), which requires accused persons to appear in court save in exceptional circumstances.) If so, these blatant violations of legality should be quickly corrected. It is also conceivable, however, that the practice of excluding ostensibly mentally ill individuals from participation in their own cases has emerged, in a less calculated way, as a byproduct of unwarranted assumptions about the nature and consequences of forensic assessment. To the extent that this is the correct explanation, the problems identified by the U.S. Delegation can be reduced by altering forensic and judicial practice.

Based on the Delegation's interviews with forensic psychiatrists and patients, it appears that forensic evaluations are usually conducted on an inpatient basis, and that if the patient is diagnosed as mentally ill, he or she remains in the hospital while the legal process takes its course. If the accused is hospitalized in a facility outside the jurisdiction where the case will be tried, the defense attorney may have no practical opportunity to meet with the client after being appointed. Further, if the accused person is diagnosed as mentally ill, the courts apparently assume that "the character of his ill-

ness" prevents the person's appearance in court. (See Article 407 of the R.S.F.S.R. Code of Criminal Procedure.)

Forensic evaluation practices have undergone substantial changes in the United States during the past decade, and a substantial body of knowledge has emerged regarding the clinical and legal dimensions of these evaluations. (See generally Criminal Justice Mental Health Standards, 1986.) Based on this experience, the Delegation believes that the standard Soviet practice is based on several erroneous assumptions. First, in a substantial proportion of cases, forensic assessments can be conducted on an outpatient basis. Second, although hospitalization may be necessary in some cases (either because the accused needs emergency treatment or because a period of clinical observation is required for evaluative purposes), it is usually possible to return the accused to the jurisdiction of the court before trial. (Under U.S. procedure, in the few cases in which this is clinically impossible, defendants cannot be tried because they are incompetent to assist in their own defense.) Finally, the apparent assumption that an accused person who has been diagnosed as mentally ill is unable to participate in his or her trial is clinically unfounded in some cases, especially in light of the broad diagnostic constructs used by Soviet psychiatrists.

Much can be learned from recent experience in the U.S. and in other Western countries. The Delegation recommends that the appropriate Soviet authorities invite knowledgeable experts in forensic psychiatry and psychology to provide consultation on ways of improving the process of forensic evaluation. In the meantime, however, several legal reforms should be considered by Soviet judicial authorities. First, defense attorneys should be appointed much earlier in the process, perhaps at the time the preliminary investigation is initiated. The need for such a reform, which has been urged by Soviet legal scholars for many years, is especially evident in cases involving persons referred for forensic evaluation. Second, the accused should have a right to appear at his or her trial, notwithstanding a diagnosis of mental illness. In the absence of any real therapeutic justification for excluding mentally ill persons from their trials, the only effect of doing so is to prevent the accused from presenting a defense or from publicly explaining his or her behavior. In the unusual case in which the accused requires hospitalization for acute treatment, the trial should be delayed.

3. Review of Need for Continued Compulsory Hospitalization

The hospitalization of nonimputable offenders is a controversial social practice in nearly all countries because the offender typically has no "right" to be discharged at any specified time. Instead, the period of hospitalization is indefinite and depends upon clinical assessment of the patient's condition and likely behavior upon release. The length of hospitalization therefore may bear no relationship to the seriousness of the offense, and may exceed the prescribed criminal sentence for the patient's conduct, especially if the offense was relatively minor.

Decision-making procedures in systems of "criminal" commitment are typically very conservative. Under a purely "civil" system of involuntary hospitalization, the hospital psychiatrists may release the patient without approval from anyone else. In contrast, under "criminal" systems of commitment in most countries, including both the Soviet Union and most States in the U.S., the patient may not be released without the approval of a court.

This may lead to situations in which a court refuses to order a patient's discharge or transfer, notwithstanding a favorable psychiatric recommendation. Although this had occurred in two of the Delegation's interview cases, and a number of similar situations were mentioned to the hospital team, these cases are the exceptions in the U.S.S.R., not the rule.

From the patient's perspective, a key question is whether he or she has an opportunity to gain transfer or release even if the hospital psychiatrists do not recommend it. Periodic psychiatric review of the patient's status is now required by Soviet legislation: Under the 1988 law and the applicable Health Ministry regulations, patients are entitled to automatic review by a psychiatric commission every 6 months. If the commission recommends transfer or release, the chief psychiatrist of the region is apparently responsible for making the appropriate recommendation to the court. However, if the chief psychiatrist, based on the commission's review, does not recommend transfer or release, the patient has little practical recourse. According to all accounts, the right to appeal an unfavorable decision to court, guaranteed to the patient's relatives or legal representatives before 1988 Health Ministry regulation, has been invoked infrequently, and rarely with success.

As a practical matter, then, a favorable commission recommendation is a necessary, though not sufficient, basis for release. Yet, as noted earlier, the patients interviewed by the Delegation consistently reported that the commissions typically meet with each patient for only a few minutes and do not provide an independent review of the patient's condition. Meaningful review by an independent psychiatric commission and a meaningful opportunity to appeal to court should be required. The absence of an opportunity for such review contributes to the profound sense of powerlessness described, in a common voice, by patients confined in the Special Psychiatric Hospitals.

4. The Process of Urgent Hospitalization

Until January 1988, there was no legislation in the U.S.S.R. governing involuntary psychiatric treatment outside the criminal process. The only source of authoritative directives regarding "urgent hospitalization" was the Ministry of Health, which had issued instructions on the subject, but with limited circulation (*Urgent Hospitalization of the Socially Dangerous Mentally Ill*, 1971). According to all reports, the process of involuntary hospitalization was regarded as largely within the sphere of psychiatric discretion.

It is generally agreed that the law enacted in January 1988 gave the rights of patients subjected to involuntary treatment a legal status that was previously lacking. As Jurist Borodin of the Institute of State and Law stated to the Delegation, the instructions previously promulgated by the Health Ministry were not only unknown to the public, but were not generally followed in practice. Now that the requirements governing this process are specified by legislation, they "have been raised to a new level" and are regarded as mandatory.

The important question is whether the criteria and procedures prescribed in the 1988 statute, and the implementing regulations issued by the Ministry of Health (*Provisional Guidelines*, 1988) provide adequate safeguards against unwarranted hospitalization and particularly against political abuse. In the view of the U.S. Delegation, although the new law represents a progressive step, additional safeguards are clearly needed, for several reasons: First, actual cases of unwarranted hospitalization under the new law were seen by the Delegation. Second, Soviet jurists consulted by the Delegation recommended further reforms. As noted by S.V. Polubinskaya, the 1988 statute is a "compromise be-

tween the interests of the Ministry of Health and those of the organs in defense of the constitutional rights of citizens." (*Komsomolskaya Pravda*, 1988). Finally, further protections are necessary to bring Soviet law into compliance with the applicable guidelines proposed by the U.N. Commission on Human Rights. (See "Draft Body of Principles and Guarantees for the Protection of Mentally Ill Persons, and for the Improvement of Mental Health Care," Economic and Social Council of the United Nations Commission on Human Rights, Sub-commission on Prevention of Discrimination and Protection of Minorities (1988).)

Specifically, the Delegation believes that further reforms would be desirable in two areas: 1) The decision-making process should be structured to assure that exercises of psychiatric discretion are subject to expeditious and meaningful review by either the courts or another independent body; and 2) All persons subject to involuntary hospitalization should be notified immediately in writing of their opportunity to contest the psychiatrist's decision and, if they choose to do so, protesting patients should have access to legal representation.

5. Independent Review of Psychiatric Decisions

The main operative effect of the 1988 law was to codify the decision-making procedures that had been prescribed by the Health Ministry's 1971 guidelines on "Urgent Hospitalization." The statute requires review by a psychiatric commission within 24 hours, and periodic review by a commission no less frequently than once a month for the first 6 months and every 6 months thereafter. In addition, the new law provides mechanisms for external review that did not previously exist. First, the patient or his or her legal representative is entitled to include a psychiatrist of his or her choice on the commission; second, the patient or his or her legal representative may appeal the commission's decision to the chief psychiatrist of the region; third, the decision of the chief psychiatrist may be appealed to court; and finally, supervisory responsibility over the legal aspects of this process is lodged with the procuracy.

Patients hospitalized against their will should have a meaningful opportunity to have their cases reviewed within a reasonable time by an independent body, not only to assure that the psychiatrists followed the proper procedures, but also to assure that the prescribed criteria have been satisfied. At the present time, it appears that

such an opportunity is not provided. In the first place, the opportunity to "appeal to the court," which is guaranteed by statute, is not available sufficiently soon after admission to provide legal protection for the great majority of patients, who are hospitalized for a short time. As a practical matter, the courts are not really accessible because the patients must appeal their cases to the chief psychiatrist before they can appeal to court. (The Delegation was told that the average length of stay in the Ordinary Hospitals was about 60 days, and at the Ordinary Psychiatric Hospitals visited, team members were told that no judicial appeals had yet been taken. Moreover, according to a recent report there were 71,000 hospitalizations in Moscow in 1988, but only 10 cases were appealed to courts (*Pravda* 1989).) Second, although the 1988 statute confers "oversight" responsibility on the procuracy, no system for actually doing so has yet been established, and it is not clear what such oversight will entail.

Under the present system, then, the practical responsibility for substantive review of commission decisions lies mainly with the chief psychiatrist. If the Ministry of Health were to undertake a concerted effort to monitor the process of involuntary hospitalization through the chief psychiatrists, and if the chief psychiatrists were to assure that independent psychiatric commissions were established, this could help reduce the risk of unwarranted hospitalization. Even if these steps were taken, however, the Delegation believes that a meaningful opportunity for review by a court is an essential safeguard in a process involving long-term involuntary psychiatric hospitalization. At a minimum, therefore, judicial consideration should be obligatory after 6 months of involuntary hospitalization, as recommended by Jurist Borodin of the Institute of State and Law, who spoke eloquently to the Delegation about the need for further reform.

6. Notice and Representation

No review procedure is likely to be meaningful unless patients are aware of their right to invoke it and are provided some form of legal assistance in doing so. Based on the Delegation's discussions with patients and staff at Ordinary Psychiatric Hospitals, patients do not appear to be adequately notified of their right to contest hospitalization. Moreover, it also appears that any patient who fails to object to hospitalization is regarded as a voluntary patient, and is not scheduled for com-

mission reviews after the initial 24-hour review. Yet a patient's failure to object may be attributable to ignorance of his or her right to contest hospitalization rather than to willingness to remain in the hospital. Thus, all patients should be informed, both orally and in writing, of their legal rights as soon as possible after admission. (See Article 4 of the Draft Body of Principles and Guarantees of the U.N. Commission on Human Rights, 1988).

The 1988 law guarantees assistance of a defense lawyer to psychiatric patients. It is clear, however, that this guarantee has not yet been operationalized. Because legal assistance is essential to protect patients' legal interests, this aspect of the new law is critically important. (See Article 17-1 of the Draft Body of Principles and Guarantees of the U.N. Commission on Human Rights, 1988).

Twenty years ago, civil hospitalization in the U.S. was essentially a matter of the physician's prerogative. Hospitalization was indefinite, and there were many problems. These same problems now confront the U.S.S.R. In this respect, the political misuse of psychiatry is but one feature of the larger problem of psychiatric practice in the U.S.S.R. that potentially affects all patients.

In summary, the Delegation recommends additional legislation to provide meaningful representation and advocacy for patients as well as early and periodic review of the necessity of hospitalization by bodies other than psychiatrists. The coercive use of psychiatry is too important to be left to psychiatrists. The experience of the U.S. over the last 20 years suggests that although there are tensions and disagreements, psychiatry and law both have important roles to play when hospitalization is involuntary and contrary to the patient's wishes.

7. Punitive Conditions In Special Psychiatric Hospitals

One of the major challenges confronting Soviet psychiatry is to erase the legacy of "punitive psychiatry" associated with the Special Psychiatric Hospitals, a legacy fully documented by the dissident patients interviewed by the Delegation and the hospital team's personal observations. The challenge is to achieve a humane environment for treatment by converting what have been psychiatric prisons into secure hospitals. An important first step was taken in the 1988 law that transferred jurisdiction over these hospitals from the Ministry

of Interior to the Ministry of Health. (The Ministry of Health has now closed seven of the SPHs.) However, the transition from the former regime to the new one will require aggressive action, including major architectural changes, increases in resources and, perhaps most importantly, fundamental changes in philosophy of care and the strengthening of medical authority.

The difficulty of the task confronting the Soviet Ministry of Health was evident in the visits of the U.S. team to the Special Hospitals in Kazan and Chernyakhovsk. (However, the scientific team that visited the Leningrad SPH was favorably impressed by the therapeutic environment there.) If conditions at these two Special Psychiatric Hospitals are representative of those at others, the Ministry of Health is facing a major challenge. The heads of these hospitals appeared to be committed to the goals of the new regime, but the changes that are necessary cannot be accomplished by good will alone. Hospital administrators will need ongoing support from Moscow, both in resources and in resolve.

The Delegation's hospital team was struck by the pervasive sense of powerlessness felt by all patients at Kazan and Chernyakhovsk and by the general restrictiveness of the living conditions. The maintenance of order and control were paramount in these hospitals. Even though the new statute guarantees to patients a right to a "respectful and humane attitude that excludes the abasement of human dignity" (Section 2), the conditions of treatment in the SPHs, past and present, belie this promise.

Earlier in this report, the Delegation enumerated the violations of human dignity observed in SPHs, including restriction of access to writing materials, censorship of mail, close supervision of visits, and the absence of personal possessions. All of these hospital practices are incompatible with the Draft Body of Principles and Guarantees proposed by the U.N. Commission on Human Rights (1988).

Patients reported the punitive use of medication and its episodic use in relationship to rule infractions, particularly the use of the drug sulfazine. The hospitalized and released patients interviewed in depth, as well as a number of patients interviewed by the hospital team, stated unequivocally, and without being asked, that in SPHs antipsychotic drugs were administered by injection for a period of 10 to 15 days for violation of hospital rules. Use of medication for nontherapeutic purposes violates directives issued by the Ministry of Health and

all international codes of human rights and professional ethics.

Many patients reported being severely beaten or seeing other patients severely beaten by patients or by the criminal orderlies working at the SPHs. These patients believe that the staff was aware of, and condoned, these beatings and may have solicited them to punish infractions of institutional rules.

There is no recognized system in the hospitals (SPHs and OPHs) for resolving patient grievances. As a result, patients are fearful of retaliation if they complain about their treatment, about abusive conduct by the staff, or about restrictive hospital rules or practices; patients feel they have no rights.

Furthermore, in both SPHs and OPHs, patients do not participate in treatment decision making. Forensic hospitals in the U.S. suffered some of these problems 20 to 30 years ago, and they persist even now in some States. One of the most important developments in the philosophy of mental health care in the U.S. and other countries over the last 20 years has been the recognition of the role of patients in their own treatment. The older model of psychiatric authoritarianism has yielded, at least somewhat, to a model of patient participation in treatment decision making.

One important mechanism for initiating and nurturing changes in the prevailing hospital conditions would be to establish grievance procedures and programs of advocacy for patients' rights. In the U.S., various procedures have been used. In some States, agencies provide information for patients, advocate for them, and represent their legal and social needs. One of the best known is the Mental Health Information Service in New York State (Weiner 1985). Other models for patient advocacy and for the protection of patients' rights have been described, particularly legal models (Perlin 1986). Recently, a Federal statute, the Protection and Advocacy for Mentally Ill Individuals Act (PL #99-319) (1986) was enacted by Congress following a Federal investigation of abuses and treatment practices in U.S. mental hospitals. This Act provides funds for each State to establish protection and advocacy programs wherein personnel are authorized to enter institutions and to represent patients who are dissatisfied with institutional conditions and their treatment (Weicker 1987; Reatig 1987). It also codifies a patients' "Bill of Rights." Similar approaches should be considered by the U.S.S.R.

8. The Psychiatric Register

Earlier sections of this report described the complaints by released patients about the disadvantages of being on the psychiatric register, including restrictions of legal rights such as voting and driving, the prospect of social and economic discrimination, and the risk of unwarranted rehospitalization. The problems the patients identified because of their psychiatric history were not unique to the sample the Delegation interviewed in depth. Among some 20 additional cases interviewed "informally," there were frequent and bitter complaints about the register and its effect on the patients' comfort, livelihood, and well being. In its informal interviews, the Delegation also received reports that in the past in some cities, persons never hospitalized or examined have been placed on the register without their knowledge by psychiatrists at the behest of an employer because of work-related behavior.

The Delegation commends recent Soviet efforts to decrease the numbers of persons on the register and to restrict use of the register to persons who are dangerous to others. These changes should be fully implemented as soon as possible.

D. Conclusions

1. Social Dangerousness

- a. The U.S.S.R. Criminal Codes prohibit certain types of political and religious expression that liberal democratic societies do not regard as criminal or punishable. Because any violation of the U.S.S.R. Criminal Codes is apparently regarded as a "socially dangerous act," these criminal prohibitions of political and religious dissent have provided the legal basis for compulsory psychiatric hospitalization of dissidents who are diagnosed as mentally ill.
- b. Until recently, Soviet courts appear to have regarded individuals who violate the political articles of the Soviet Criminal Codes (such as Articles 70 and 190-1) almost categorically, as "especially dangerous to society," even though the criminal conduct involved nonviolent expressions of political or religious ideas. As a result, ostensibly "nonimputable" political dissidents have been

routinely placed in maximum security Special Psychiatric Hospitals.

- c. No patient examined by the U.S. Delegation had been hospitalized within the past year as a consequence of arrest under the "political articles."
- d. While the matter of "urgent hospitalization" could not be studied in depth, there is some evidence that within the past 6 months, the involuntary civil process has been used to hospitalize a person whose behavior was essentially political and posed no danger to himself or others. This practice appears to be contrary to the declared policy of the Ministry of Health, which opposes involuntary hospitalization unless the patient "represents a direct danger to those around him, as well as to himself."

2. Procedural Protections

- a. According to virtually every patient and former patient questioned by the Delegation who had been hospitalized after findings of "nonimputability" and "social dangerousness," the patients played no role in the criminal proceedings that resulted in their commitments. With the exception of one case, they never met with a defense attorney, even though one may have been appointed in the case. Of those interviewed on these points, only three patients reported seeing the investigative report; none reported being presented with the experts' findings; and all but one were tried *in absentia*.
- b. Although the status of patients under compulsory hospitalization orders is reviewed by a psychiatric commission every 6 months, as required by law, it appears that these commission reviews are brief (usually less than 10 minutes) and *pro forma*, and do not involve independent decision making. As a practical matter, patients have no meaningful opportunity to challenge the hospital staff's decisions to retain them in the hospital.
- c. Until the new law enacted in January 1988, the civil process of "urgent hospitalization" was regarded as largely within the sphere of psychiatric discretion. There is general agreement that the new statute represents an important reform because it

is known to the public and it brings this process within reach of the rule of law. However, the available evidence suggests that the provisions of the new statute do not provide adequate safeguards against unwarranted hospitalization, and that even the legal protections declared by the new law (including representation by an advocate, periodic psychiatric review, and the opportunity to appeal to court) have not yet become operational.

3. Patients' Rights

- a. Based on reports of patients and its own observations, the Delegation believes that the conditions in most Special Psychiatric Hospitals, with the exception of the Leningrad SPH, are unduly harsh and restrictive. Notwithstanding the partially implemented transfer of jurisdiction over the SPHs from the Ministry of Interior to the Ministry of Health, and the apparent goodwill of the administrators of the hospitals the Delegation visited, these facilities continue to have many of the characteristics of psychiatric prisons. Patients are denied basic rights, are apparently subject to punitive use of medication, and are fearful of retaliation if they complain about their treatment, about abusive conduct by the staff, or about restrictive hospital rules or practices. In brief, the transition to a more humane regime has just begun.
- b. Although the Delegation's exposure to Ordinary Psychiatric Hospitals was limited, patient interviews and other information indicate that these facilities are decidedly more humane and therapeutic than the Special Psychiatric Hospitals.
- c. One discernible characteristic of all institutional psychiatry in the Soviet Union, especially in the Special Psychiatric Hospitals, is that patients do not participate to any significant extent in decisions about their own treatment.
- d. The Soviet authorities have declared their intention to decrease the number of persons on the psychiatric register and to require registration only of individuals who are a real threat to others. However, this process is in its early phases. At present it appears that large numbers of persons

are encountering social and legal disadvantage because of their psychiatric histories.

E. Recommendations

1. Broad concepts of "social dangerousness" have contributed to the U.S.S.R. practice of hospitalizing people who are not mentally ill. For this and other reasons, the Delegation recommends that additional steps be taken to revise the Soviet Criminal Codes to remove all prohibitions against expression of political or religious beliefs.
2. New legislation and regulation appear necessary to allow the Ministry of Health to implement its announced intention to restrict involuntary civil hospitalization ("urgent hospitalization") to patients who are a direct danger to themselves or others, and thereby to reduce the risk that this process will be invoked to suppress dissent.
3. Defense lawyers should be appointed early in the criminal process prior to the time when patients are evaluated by psychiatric commissions for determination of mental illness and nonimputability. Persons subject to forensic examination in criminal cases should be accorded rights already specified in Soviet Codes of Criminal Procedure (e.g., to play a role in the process of investigation, to learn about the charges against them, to receive the investigative and forensic reports, and to be present at their trial).
4. In light of overly long periods of hospitalization for some patients in SPHs, periodic review of the necessity of continuing hospitalization under compulsory treatment should be strengthened, including meaningful independent review by commissions or other review bodies, with subsequent mandatory court review.
5. In the case of "urgent hospitalization" (civil commitment), additional procedural protections should be implemented. These include mandatory, independent periodic review of the necessity for hospitalization and mandatory court review within at least 6 months of hospitalization. In light of recent statistics documenting only 10 appeals to courts out of 71,000 hospitalizations in

Moscow in 1988, the right to legal representation needs to be made operational, and the appeals process should be rendered less cumbersome. These recommendations appear to have the approval of prominent Soviet lawyers.

6. In keeping with the "Draft Body of Principles and Guarantees for the Protection of Mentally Ill Persons and for the Improvement of Mental Health Care" of the U.N. Commission on Human Rights, the treatment environment of the Special Psychiatric Hospitals should be rendered less restrictive and patients granted more rights and opportunities to engage in normal activities. There should be fewer deprivations and restrictions, such as restriction of access to writing materials, censorship of mail, close supervision of visits, and the absence of personal possessions.
7. Hospitalized patients should be informed of their rights, and these rights should be guaranteed in legislation and regulation. Patients should be invited to participate to a greater extent in treatment decision making. Grievance procedures should be instituted, and patient advocacy services should be implemented through ombudsman or other types of rights protection programs.
8. In keeping with initiatives already begun in the U.S.S.R., the Delegation supports continuing re-evaluation of the medical indications for placing or retaining patients on the psychiatric register. Procedures should be instituted to prevent placement of names on the register without the individuals' knowledge. To prevent their psychiatric histories from stigmatizing persons who are not mentally ill, diagnoses should be removed to facilitate these persons' full reintegration into society.
9. Joint studies between the U.S. and the U.S.S.R. related to forensic practices, determinations of

nonimputability, and the role of law in providing protections for patients rights should be conducted.

F. Prospect

1. To facilitate a continuing dialogue on issues raised during its visit, the Delegation hopes to receive as soon as possible a status report on each of the patients it interviewed in the U.S.S.R.
2. The U.S. hospital team identified 20 patients whose placement and treatment were questionable, even if it was not clear that these were "political cases." The names of these cases have been submitted to the U.S.S.R. The U.S. Delegation has requested follow-up information about the outcome of these cases.
3. The Delegation recommends that the U.S. and U.S.S.R. promptly initiate discussions to:
 - a. Arrange the details of a visit by a Soviet delegation of psychiatrists and other experts to hospitals and forensic facilities in the U.S.;
 - b. Arrange a follow-up visit to the Soviet Union by the U.S. Delegation to allow the Delegation to meet with patients interviewed on the prior visit; and
 - c. Arrange the ongoing collaborative exchanges and joint scientific studies recommended above in this report.
4. The Delegation recommends the formation of an international commission including members from the U.S., the U.S.S.R., and other nations, to review alleged psychiatric abuses in any nation. Where indicated, the commission should have direct access to patients and records for purposes of examination.

APPENDIX A

PARTICIPANTS IN THE U.S. DELEGATION AND CORRESPONDENCE REGARDING D.H.H.S. PARTICIPATION

Leader of the U.S. Delegation

Robert W. Farrand
Deputy Assistant Secretary for
Human Rights and Humanitarian Affairs
Department of State

Psychiatric Team Leader

Loren H. Roth, M.D., M.P.H.
Professor of Psychiatry
University of Pittsburgh School of Medicine

Scientific Director

Darrel A. Regier, M.D., M.P.H.
Director, Division of Clinical Research
National Institute of Mental Health

Hospital Visit Team Leader

Harold M. Visotsky, M.D.
Professor & Chairman
Department of Psychiatry
Northwestern University School of Medicine

SCIENTIFIC TEAMS

Team No. 1

Samuel J. Keith, M.D.—Team Leader
Deputy Director and Associate Director for
Schizophrenia Programs
Division of Clinical Research
National Institute of Mental Health

Vladimir G. Levit, M.D., Med.Sc.D.—
Russian-speaking Psychiatrist
Staff Psychiatrist
Rockland Psychiatric Center

Jonas R. Rappeport, M.D.—Forensic Psychiatrist
Chief Medical Officer
Circuit Court for Baltimore City

Alla Arsenian Klimov—Interpreter

Carolyn Smith—Interpreter

Team No. 2

William T. Carpenter, Jr., M.D.—Team Leader
Professor of Psychiatry
University of Maryland School of Medicine
Director, Maryland Psychiatric Research Center

David Lozovsky, M.D., Ph.D.—Russian-speaking
Psychiatrist
Health Science Administrator
National Institute on Alcohol Abuse and Alcoholism

Joseph D. Bloom, M.D.—Forensic Psychiatrist
Professor & Chair, Department of Psychiatry
Oregon Health Sciences University

William Hopkins—Interpreter

Galina Tunik, Ph.D.—Interpreter

Team No. 3

Robert M.A. Hirschfeld, M.D.—Team Leader
Chief, Affective & Anxiety Disorders Research
Branch
Division of Clinical Research
National Institute of Mental Health

Felix L. Kleyman, M.D.—Russian-speaking
Psychiatrist
Assistant Clinical Professor of Psychiatry
New York Medical College

John Monahan, Ph.D.—Forensic Psychologist
Henry & Grace Doherty Professor of Law
University of Virginia School of Law

John Finerty—Interpreter

Kyrill Borissow, Jr.—Interpreter

Hospital Site Visit Team

Richard J. Bonnie
John S. Battle Professor of Law
Director, Institute of Law, Psychiatry and Public
Policy
University of Virginia School of Law

Joel Klein
Onok, Klein and Farr

Ellen Mercer
Director, Office of International Affairs
American Psychiatric Association

Peter B. Reddaway, M.A.
Professor of Political Science & International
Relations
Institute for Sino-Soviet Studies
George Washington University

Elmore F. Rigamer, M.D.
Deputy Assistant Secretary for
Mental Health Services
Office of Medical Services
Department of State

Leon Stern, M.D.—Russian-speaking Psychiatrist
Medical Director
Rockaway Mental Health Services

Consultants

Nancy C. Andreasen, M.D., Ph.D.
Professor of Psychiatry
University of Iowa College of Medicine

Jack D. Burke, Jr., M.D., M.P.H.
Director, Division of Biometry and Applied Sciences
National Institute of Mental Health

Peter Henry, Ph.D.
Director, Office of Europe and China
Office of International Health
Public Health Service

Edward J. Kelty, Ph.D.
Assistant Director for International Programs
National Institute of Mental Health

Darrell Kirch, M.D.
Medical Director
Neuropsychiatric Research Hospital
National Institute of Mental Health

Armand Loranger, M.D.
Associate Professor of Psychiatry
Cornell Medical Center

Rosalind Mance, M.D.
Assistant Professor of Psychiatry
Emory University

Susan Matthews
Coordinator, National Plan for
Schizophrenia Research
Division of Clinical Research
National Institute of Mental Health

Michael Novakhov, M.D.
Research Fellow
Downstate Medical Center

William Potter, M.D., Ph.D.
Chief, Section on Clinical Pharmacology
National Institute of Mental Health

Anne H. Rosenfeld
Public Affairs Specialist
Office of the Director
National Institute of Mental Health

Saleem A. Shah, Ph.D.
Senior Research Scholar
Division of Biometry and Applied Sciences
National Institute of Mental Health

David J. Sternbach, M.M., L.C.S.W.
Silver Spring, Maryland

Senior Policy Consultants

Ambassador Richard Schifter
Assistant Secretary of State for Human Rights and
Humanitarian Affairs
Department of State

Lewis L. Judd, M.D.
Director
National Institute of Mental Health

Frederick K. Goodwin, M.D.
Administrator
Alcohol, Drug Abuse and Mental Health
Administration

Harold Thompson
Director, Office of International Health
Public Health Service

Melvin Sabshin, M.D.
Medical Director
American Psychiatric Association

THE SECRETARY OF STATE
WASHINGTON

December 15, 1988

Dear Otis:

As you know, human rights has been one of the four principal facets of our dialogue with the Soviet Union in recent years. In that dialogue we don't just speak in generalities. We get down to specifics. Among the specific human rights topics has been the issue of abuse of psychiatry, the commitment to psychiatric institutions of persons who are perfectly sane, but who have displeased the authorities because of their political views or religious activities.

The Soviet authorities have tacitly conceded that abuse of psychiatry really occurred in their country and have pointed out to us that they have taken corrective action, which included a review of all doubtful commitment cases, followed by the release of those whose commitment was deemed unjustified. We responded by pointing to a list of names of persons still in psychiatric hospitals as to whom we were told that they were committed on political grounds. The Soviets then offered to let American psychiatrists see these patients and come to their own conclusion.

This Soviet offer is of importance not only in terms of our own relations with the U.S.S.R., but also in the context of a review session of the Conference on Security and Cooperation in Europe which is now meeting in Vienna. To make it possible for us to agree to a conclusion of the Vienna meeting, we need a mechanism to be in place to deal with such doubtful cases as those of psychiatric patients concerning whom we have information that they might have been committed for political reasons.

Obviously, this Department is not equipped to deal with this problem. We have, therefore, turned for help to the National Institute of Mental Health, specifically its Director, Dr. Lewis Judd. I have been told that Dr. Judd has been extremely helpful in devising a thoughtful program for bringing the Soviet mental health care system under effective professional review. With Dr. Judd's support and guidance, an advance team of U.S. psychiatrists recently held discussions under State Department auspices in Moscow. These preliminary talks resulted in Soviet agreement to conditions for a two-week visit in early 1989 of 20 U.S. forensic psychiatrists, mental health specialists and Russian language interpreters to evaluate under strict professional standards a select group of Soviet citizens either currently in or recently released from mental hospitals. Dr. Darrel Regier, Director of NIMH's Division of Clinical Research, was a key contributor to the advance team's success.

I therefore wish to express my thanks not only for Dr. Judd's good work and NIMH resources which have already gone into this initiative but for the major effort yet to come. It is difficult to exaggerate the potentially positive effect which this unique undertaking could have on what is a promising new stage in our relations with the Soviet Union. It will be crucial, in this regard, that the delegation of U.S. psychiatric professionals travel to the Soviet Union within the very near future.

The NIMH presence in this undertaking has been and will be important in assuring Soviet psychiatrists that objective, scientifically sound interviews will take place. We, therefore, hope for the continued involvement of HHS, including support of the NIMH assessment team, whose presence assures interested groups in the United States as well as in the Soviet Union that this work is being done in keeping with rigorous professional standards.

We are grateful for the great contribution which HHS has made thus far in helping to achieve this major step forward in the cause of human rights.

Sincerely yours,

/s/
George P. Shultz

The Honorable
Otis R. Bowen,
Secretary of Health and Human Services.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

December 14, 1988

TO: Administrator, ADAMHA

FROM: Assistant Secretary for Health

SUBJECT: PHS Participation in Visit to Soviet Psychiatric Institutions

As a follow-up to our recent discussion, I want to let you know that I share the view of the Department of State that PHS participation in the joint effort to inspect Soviet psychiatric institutions is a very important step in the process of establishing better relations between our two countries. I am sure that this effort will have long-term benefits not only for U.S. foreign policy, but also for establishing a better foundation upon which to base U.S. Soviet cooperation in mental health and the neurosciences under our bilateral health agreement.

The cooperation, support, and personal participation of the Director, National Institute of Mental Health (NIMH), has been a very important element in the success of our efforts to date. His provision of key staff for this very time-consuming activity, and his willingness to provide the necessary financial support, are deeply appreciated.

I think it is important to proceed expeditiously with the planning for the main visit in February. In that regard, as I noted in our discussion, the continued participation of Dr. Darrel Regier and Dr. Samuel Keith is critical for the success of the second visit.

Attached, for your information, is a copy of the memorandum I sent to The Secretary forewarning him of a State Department request for support, which I now understand is being transmitted to us in letter format.

Please keep me informed of progress on this important effort.

Robert W. Windom, M.D.

Attachment

APPENDIX B

MEMORANDUM OF UNDERSTANDING AND CONSENT FORMS

U.S./SOVIET MEMORANDUM OF UNDERSTANDING December 19, 1988

1. THE DELEGATION WILL BE ABLE TO VISIT SPECIFIC PATIENTS AS DESIGNATED BY THE DELEGATION
 - A. The U.S. delegation will interview at least 20 patients in the U.S.S.R.
 - B. The list of names from which the U.S. Delegation will choose persons to interview will be given to Soviet colleagues not later than six weeks prior to the Delegation's visit.
 - C. Inpatients may be interviewed in Special Psychiatric Hospitals or Ordinary Psychiatric Hospitals. Patients who are no longer in the hospital and who are either registered or not registered will be interviewed at suitable locations provided by the Soviet side and agreed to by the patient and the U.S. Delegation.
 - D. At least one of the patient's relatives (or, if the patient has no available relative, at least one of his friends) will be transported at Soviet expense to the location of the patient's examination.
 - E. Inpatients who are remote from central locations will be transported to convenient hospitals, either Special Psychiatric Hospitals or Ordinary Psychiatric Hospitals in the vicinity of Moscow or Leningrad; in other words, several hospitalized patients will be examined at one location.
 - F. The following will be the sampling procedure:
 - i. The U.S. Delegation will provide the names of 45 persons in the U.S.S.R. who may be interviewed and who may have their psychiatric records reviewed.
 - ii. The Soviet side will locate each of these persons and determine their willingness to talk to the U.S. Delegation and to consent to have their psychiatric records reviewed by the U.S. Delegation.
 - iii. The Soviet side will ask persons who have been released from the hospital whether they are willing to travel to Moscow or Leningrad to talk with the U.S. Delegation.
 - iv. A similar procedure will take place with the relatives or friends whom patients wish to have talk with the U.S. Delegation.
 - v. The Soviet side will then inform the U.S. Delegation about the status of each of the 45 persons on the U.S. list, i.e., whether the person is willing to talk with the U.S. Delegation, have records released, or travel to a central location to be interviewed. A similar status report will be provided the U.S. Delegation regarding patients' relatives or friends.
 - vi. Based on the information, the U.S. side will then designate 20 patients who are "priority patients" to be interviewed, along with their relatives or friends, by the U.S. Delegation. These 20 patients and their relatives or friends will then be gathered at central locations to meet the U.S. Delegation.
 - vii. The remainder of the 45 patients on the U.S. list and their relatives or friends will be deemed "alternates." They will not need to be transported by the Soviet side for interview by the U.S. Delegation unless the 20 "priority patients" are unwilling to consent to psychiatric examination when they are interviewed by the U.S. Delegation after it arrives in the Soviet Union.
 - viii. The U.S. Delegation will review the psychiatric records of all 45 persons on its initial list who permit record review (see below).
- G. The U.S. Delegation will include three clinical teams. Each team will include a clinician-interviewer trained in administering a

structured psychiatric examination, who will be a Russian-speaking psychiatrist; a research psychiatrist who will assure accurate diagnosis; a senior forensic psychiatrist or psychologist; and an interpreter furnished by the U.S. Delegation.

- H. A team will examine one patient and his relatives or friends per day. If at this time, the examination is incomplete, the patient or his relatives or friends will be seen the next day. The clinical teams will have sufficient time to examine patients and to interview relatives.
 - I. Patients will be asked to provide a urine sample for toxicology screen.
 - J. With patients' permission, examinations will be audio- and videotaped. The U.S. Delegation will provide the necessary audio-visual equipment.
 - K. The U.S. team will obtain informed consent from the patient for the examination, audio- and videotaping, and study and use of records (see accompanying consent forms). If a patient on the U.S. list reportedly refuses to be seen, the U.S. team, nevertheless, will make a reasonable effort to meet the patient to determine whether he wishes to consent or refuse. Such effort may include having the patient's relative or friend explain the purpose of the examination to him.
 - L. With the patient's consent, a Soviet psychiatrist will be present at the examination. If a patient refuses to consent to the presence of a Soviet psychiatrist at the examination, the Soviet psychiatrist will furnish questions to the U.S. clinical team that it will ask the patient. The patient's responses to these questions will be videotaped.
2. FAMILY MEMBERS OF THE PATIENTS (OR IF THE PATIENT HAS NO RELATIVES, AT LEAST ONE FRIEND) MAY BE PRESENT DURING THE EXAMINATION, IF THE PATIENT DESIRES. THESE PERSONS WILL BE ALLOWED TO MEET

WITH THE DELEGATION SEPARATE FROM THE PATIENT.

- A. Family members or a friend will be asked to give accounts of what happened to the patient, why he was hospitalized, what his signs and symptoms of mental illness were, how he was or is being treated, etc.
 - B. Family members or a friend will be asked to give informed consent for interview and for audiotaping.
3. THE DELEGATION AND THE PATIENTS WILL BE ABLE TO USE THEIR OWN INTERPRETERS.
 4. THE DELEGATION WILL HAVE ACCESS TO ALL PATIENTS' RECORDS, INCLUDING THOSE FROM THE COURTS, FINDINGS OF PSYCHIATRIC COMMISSIONS, AND RELEVANT LEGAL RECORDS.
 - A. Photocopies of the complete original patient records (i.e., in the original Russian), as well as English translations of specified items, will be provided to the U.S. Delegation (given to the U.S. Embassy) at least two weeks prior to its visit to the Soviet Union. The items to be translated into English will be: i) the first psychiatric commission report ever done on the patient; ii) the last psychiatric commission report (relating to the patient's last hospitalization; iii) the patient's medical orders; iv) the discharge or release summary (if the patient has been discharged); and v) the relevant court records (see Item B below).
 - B. The complete photocopied patient records should include all treatment notes and records, forensic reports, reports of all psychiatric commissions, and relevant legal records, including statement of criminal charges against the patient, findings of courts regarding guilt or innocence, criminal responsibility, placement, release, and discharge.
 - C. Current medication will be listed for each patient on the day of examination.
 5. THE PATIENTS WILL NOT RECEIVE MEDICATIONS OR OTHER TREATMENTS DESIGNED TO ALTER THEIR BEHAVIOR SPECIFICALLY

FOR THE PERIODS WHEN THEY WILL BE SEEN BY THE DELEGATION. IN OTHER WORDS, THE DELEGATION WILL HAVE AN OPPORTUNITY TO SEE PATIENTS IN AS TYPICAL A PERIOD AS POSSIBLE. [IF PATIENTS ARE ON MEDICATION, THEY WILL REMAIN ON MEDICATION; IF PATIENTS ARE NOT ON MEDICATION, THEY WILL NOT BE PLACED ON MEDICATION.]

6. THE SOVIET AND U.S. PSYCHIATRISTS AND EXPERTS WILL HAVE AN OPPORTUNITY TO DISCUSS EACH PATIENT FOLLOWING THE EXAMINATION OF THE PATIENT AND INTERVIEWS WITH RELATIVES OR FRIENDS. THE PATIENTS' DIAGNOSING AND TREATING PSYCHIATRISTS WILL BE AVAILABLE TO DISCUSS THE PATIENT WITH THE U.S. DELEGATION.
7. THE U.S. DELEGATION WILL VISIT AT LEAST TWO SPECIAL PSYCHIATRIC HOSPITALS AND TWO ORDINARY PSYCHIATRIC HOSPITALS IN THE U.S.S.R. OTHER THAN THE HOSPITALS WHERE PATIENTS ARE EXAMINED. THE ADDITIONAL HOSPITALS TO BE VISITED WILL BE DESIGNATED BY THE DELEGATION AFTER ITS ARRIVAL IN THE U.S.S.R. THE VISIT TO THESE HOSPITALS WILL INCLUDE ACCESS TO PATIENT WARDS AND OTHER TREATMENT AREAS, AND PATIENTS MAY BE QUESTIONED ABOUT THEIR VIEWS OF THEIR CARE.
8. THE U.S. DELEGATION'S VISIT TO THE U.S.S.R. WILL LAST APPROXIMATELY TWO WEEKS.
9. THE U.S. DELEGATION WILL NUMBER ABOUT 24 PERSONS.
 - A. The list of members of the U.S. Delegation will be furnished to the Soviet Union one month prior to the Delegation's arrival in the Soviet Union.
- B. Upon receipt of the names of the U.S. Delegation, the Soviet side will furnish to the U.S. Embassy in Moscow the names of its psychiatrists and others who will be participating in the clinical evaluations of patients (viz. the Soviet psychiatrists responsible for the care of the patients) and in the two days of discussions.
10. THE U.S. DELEGATION WILL PAY FOR ALL ITS OWN EXPENSES IN THE U.S.S.R. THE SOVIET SIDE WILL ARRANGE APPROPRIATE TRAVEL RESERVATIONS AND HOTEL ACCOMMODATIONS.
11. A JOINT U.S./U.S.S.R. STATEMENT THAT THE VISIT HAS OCCURRED WILL BE ISSUED AT THE CONCLUSION OF THE VISIT.
12. THE U.S. DELEGATION WILL WRITE A WRITTEN REPORT ABOUT ITS VISIT.
 - A. The U.S. Delegation will compose a Final Report when it returns to the U.S. This Final Report will not be released until the Soviet colleagues have had an opportunity to comment on it. Any Soviet response will be distributed by the U.S. Delegation.
 - B. The Final Report, including relevant findings from patient and family interviews, and record reviews, will not be confidential. However, patient and family names will be omitted in the Final Report.
 - C. The audiotapes and videotapes of patients and their relatives/friends will be used only to aid the U.S. Delegation and its consultants in developing their report. These tapes will remain confidential and will not be further distributed unless questions are raised about the validity of the interview process itself.

ADDENDUM TO AGREEMENT

As the result of a later discussion in the U.S.S.R. on February 15, 1989, between the Soviet and U.S. psychiatrists, there were changes made in the December 19, 1988 Memorandum of Understanding.

Because the Soviet side was unable to provide English translations of the requested items from the records, it was agreed that the Soviets would instead provide the full patient record in Russian, a table of contents, tabulations identifying key documents, and English capsule summaries.

It was also agreed that patients would be given the option of having a Soviet psychiatrist present during the U.S. psychiatric examination. If the patient wished to be

interviewed alone by the U.S. Delegation, there would be an opportunity for a Soviet psychiatrist to interview the patient at the conclusion of the U.S. interview (see consent forms).

It was furthermore agreed that if the patient permitted the U.S. side to videotape the patient's examination, a copy of this videotape would later be provided the Soviet psychiatrists. In such instances, the patient also would receive a copy of the videotape if he or she wished. There would be no videotaping unless the patient agreed to this condition.

Finally, it was agreed that the U.S. Delegation would attempt to interview more than 20 patients in the U.S.S.R., if possible.

CONSENT FORM FOR PERSON INTERVIEWED (A)

This document has been prepared in connection with the visit to the Soviet Union of a group of American psychiatrists and other experts who are affiliated with the United States Government. As part of an understanding between the Soviet and United States Governments, these mental health experts are studying the system of psychiatric care in the U.S.S.R.

Because you are, or have been, hospitalized in a psychiatric facility, the records of your treatment have been made available to this visiting group. They wish to study these records and to conduct a psychiatric interview with you, including provision of a urine sample. They may also want to talk with your relatives or a friend and diagnosing and treating physicians about your psychiatric care and experience.

These U.S. psychiatrists will not in any way become involved in treating you. Their purpose, instead, is to evaluate your mental state, the justification for your hospitalization, and the treatment you have been provided. The subsequent report of the American psychiatrists will be made publicly available.

If you agree to participate in this process, the facts of your case may be included in the report of the American psychiatrists, but your name will *not* be used.

The visiting psychiatrists would also like to make videotapes and audiotapes of their interview with you. These videotapes and audiotapes will be used by the American team and its consultants to aid them in

developing their report. The American team will not distribute these tapes among any other persons not related to this examination, unless questions are raised about the validity of the interview process itself. Copies of these tapes will also be made available to a Soviet psychiatrist and you, if you so wish. There will be approximately six persons present for the interview, which will take place over the course of one day.

I hereby consent to be interviewed in the presence of a Soviet psychiatrist, and to have my medical records studied by the American psychiatric team, which is affiliated with the United States Government.

I hereby consent to have my family or a friend interviewed by the American psychiatric team, which is affiliated with the United States Government.

I hereby consent to have my interview videotaped and audiotaped.

Date:

CONSENT FORM FOR PERSON INTERVIEWED (B)

This document has been prepared in connection with the visit to the Soviet Union of a group of American psychiatrists and other experts who are affiliated with the United States Government. As part of an understanding between the Soviet and United States Governments, these mental health experts are studying the system of psychiatric care in the U.S.S.R.

Because you are, or have been, hospitalized in a psychiatric facility, the records of your treatment have been made available to this visiting group. They wish to study these records and to conduct a psychiatric interview with you, including provision of a urine sample. They may also want to talk with your relatives or a friend and diagnosing and treating physicians about your psychiatric care and experience.

These U.S. psychiatrists will not in any way become involved in treating you. Their purpose, instead, is to evaluate your mental state, the justification for your hospitalization, and the treatment you have been provided. The subsequent report of the American psychiatrists will be made publicly available.

If you agree to participate in this process, the facts of your case may be included in the report of the American psychiatrists, but your name will *not* be used.

The visiting psychiatrists would also like to make videotapes and audiotapes of their interview with you. These videotapes and audiotapes will be used by the American team and its consultants to aid them in developing their report. The American team will not dis-

tribute these tapes among any other persons not related to this examination, unless questions are raised about the validity of the interview process itself. Copies of these tapes will also be made available to a Soviet psychiatrist and you, if you so wish. There will be approximately six persons present for the interview, which will take place over the course of one day.

I hereby consent to be interviewed, but not in the presence of a Soviet psychiatrist, and to have my medical records studied by the American psychiatric team, which is affiliated with the United States Government. At the conclusion of this interview, there will be an opportunity for the American and Soviet psychiatrists to interview me together.

I hereby consent to have my family or a friend interviewed by the American psychiatric team, which is affiliated with the United States Government.

I hereby consent to have my interview videotaped and audiotaped.

Date:

CONSENT FORM FOR RELATIVES OR FRIENDS (A)

This document has been prepared in connection with the visit to the Soviet Union of a group of American psychiatrists and other experts who are affiliated with the United States Government. As part of an understanding between the Soviet and United States Governments, these mental health experts are studying the system of psychiatric care in the U.S.S.R.

Your friend or relative, _____ has consented to be interviewed by these visiting psychiatrists. He or she has also agreed that the psychiatrists may talk with you about your friend or relative's hospitalization. The purpose of these interviews is for the American experts to evaluate your friend or relative's mental state, the justification for his/her hospitalization, and the treatment he/she has been provided. The report of the American psychiatrists will be made publicly available.

If you agree to participate in this process, the facts you relate may be included in the report, but no patient, friend, or family member names will be used. The visiting psychiatrists would also like to make an audiotape

of their interview with you. These audiotapes will be used by the American team and its consultants to aid them in developing their report. The American team will not distribute these tapes among any other persons not related to this examination, unless questions are raised about the validity of the interview process itself. Copies of these tapes will also be made available to a Soviet psychiatrist and you, if you so wish. There will be approximately six persons present for the interview, which will take place over the course of one day.

I hereby consent to be interviewed in the presence of a Soviet psychiatrist by the American psychiatric team, which is affiliated with the United States Government.

I hereby consent to have my interview audiotaped.

Date: _____

CONSENT FORM FOR RELATIVES OR FRIENDS (B)

This document has been prepared in connection with the visit to the Soviet Union of a group of American psychiatrists and other experts who are affiliated with the United States Government. As part of an understanding between the Soviet and United States Governments, these mental health experts are studying the system of psychiatric care in the U.S.S.R.

Your friend or relative, _____ has consented to be interviewed by these visiting psychiatrists. He or she has also agreed that the psychiatrists may talk with you about your friend or relative's hospitalization. The purpose of these interviews is for the American experts to evaluate your friend or relative's mental state, the justification for his/her hospitalization, and the treatment he/she has been provided. The report of the American psychiatrists will be made publicly available.

If you agree to participate in this process, the facts you relate may be included in the report, but no patient, friend, or family member names will be used. The visiting psychiatrists would also like to make an audiotape of their interview with you. These audiotapes will be

used by the American team and its consultants to aid them in developing their report. The American team will not distribute these tapes among any other persons not related to this examination, unless questions are raised about the validity of the interview process itself. Copies of these tapes will also be made available to a Soviet psychiatrist and you, if you so wish. There will be approximately six persons present for the interview, which will take place over the course of one day.

I hereby consent to be interviewed but not in the presence of a Soviet psychiatrist, by the American psychiatric team, which is affiliated with the United States Government. At the conclusion of this interview, there will be an opportunity for the American and Soviet psychiatrists to interview me together.

I hereby consent to have my interview audiotaped.

Date: _____

APPENDIX C

STUDY METHODS

1. Types of Interviews and Interview Teams

Two types of interviews were conducted in the formal interview schedule: abbreviated and full. The abbreviated interview was to determine if there was any detectable psychopathology of a major mental illness present or if there had been any clear-cut violations of the patient's rights. The process of the abbreviated interviews was variable, depending on the length of time available, the reasoning behind the selection of the particular individual for the interview, and the availability of medical record material to examine. In no case was the abbreviated interview less than 2 hours in duration, and in most cases it was much longer (the description given below is for the full interview only).

Each interview team was composed of a research psychiatrist (team leader); a forensic psychiatrist or psychologist; a Russian-speaking, Soviet-trained, U.S. citizen psychiatrist; and two interpreters.

2. Chart Review

According to the original plan (per negotiations by the U.S. Advance Team, November 1988), prior to the interview two documents were to have been provided to the U.S. team: a copy of the complete psychiatric record and an English translation of specified items in the record. These materials were to have been reviewed by the Russian-speaking U.S. psychiatrists and abstracted onto a detailed record summary instrument developed for this purpose. It was proposed that each team would meet late at night or early in the morning to review this material for the day.

In practice, this worked only incompletely, for several reasons: the charts were not provided on schedule and were lengthy and difficult to review in advance (see Appendix D re: Soviet Compliance); the records were sometimes missing critical reports (e.g., the psychiatric commission from the Serbsky Institute); cancellations and rescheduling of interviews as a function of interviewee availability made adequate preparation difficult; and a brief English summary of each case prepared by the Soviets sometimes was not done or, rarely, was given to the U.S. team after the interview, and in Russian. Al-

though on occasion the incompleteness of these preparatory documents compromised the process, no interview was cancelled because of this. These deviations from prior agreement were problematic, but it was felt that the most critical aspect of this process was the direct access to the interviewees.

3. Introduction

At the start of the interview day, the designated interviewee was introduced to the U.S. team in most instances by the Soviet psychiatrist for hospitalized interviewees and by the U.S. Delegation's leader for released interviewees. The Soviet psychiatrist was asked to absent him- or herself from the room while informed consent was explained to the interviewee and the accompanying relative or friend, if present.

4. Informed Consent

In very general terms, all people to be interviewed were already aware of the purpose of the visit of the U.S. Delegation. Many had agreed to travel to either Leningrad or Moscow to meet the Delegation. For most of the hospitalized interviewees, the procedure had been briefly explained by the Soviet psychiatrists; for the released interviewees the procedure was explained by either the U.S. psychiatric team leader or through a third party.

The formal informed consent procedure involving oral disclosure as well as written signing of Russian-language consent forms followed the initial introduction. All options concerning the conduct of the interview were explained in a neutral manner, with the choice left entirely to the interviewee. Even in those situations in which the interviewee said the U.S. Delegation could decide, it was explained that it was the patient's decision alone to make.

Informed consent options included the following:

- A. The interview procedure was explained in detail, including the videotaping and audiotaping of the entire procedure. It was explained that a Soviet psychiatrist would have the opportunity to ask questions of the patient at the conclusion of the U.S. team's examination if the interviewee consented to be interviewed by the U.S. team.
- B. The interviewee was given the opportunity to have the Soviet psychiatrist present throughout the inter-

view, but only with the interviewee's consent. About half of the interviewees chose this option.

- C. The interviewee was asked whether videotaping of the interview was acceptable. It was explained that if videotaping was permitted, three copies would be made, with one held by the U.S. team, one given to the Soviets, and one given to the interviewee. If there was an objection to the three tapes being made and shared, no videotaping would be done.
- D. The interviewee was asked whether there was a relative or friend present that he or she would like to have interviewed by the U.S. team. If so, the interviewee was asked to identify that person.
- E. The relative or friend was given the same set of choices as the interviewee, with one exception: no urine specimen was requested.

The consent forms and the information in them were mutually agreed upon by the U.S. and U.S.S.R. during the November 1988 visit of the U.S. Advance Team with modifications agreed upon in February 1989 (see Appendix B).

5. Clinical/Psychiatric Interview

A. Overview

Three structured interview schedules were selected for use in obtaining psychopathologic or symptomatic information about the interviewees: the Structured Clinical Interview for DSM-III-R, Psychotic Disorders; the International Personality Disorders Examination; and the Mini-Mental Status Examination. In addition, the DSM-III-R Checklist was used for difficult-to-resolve diagnostic problems.

B. Instruments

1. Structured Clinical Interview for DSM-III-R, Psychotic Disorders (SCID-PD)

This version (1985) of the instrument was developed by Robert Spitzer and Janet Williams, in collaboration with Miriam Gibbons, Jack Burke, Samuel Keith, and Nina Schooler for use in the N.I.M.H. Treatment Strategies in Schizophrenia Collaborative Study in which it has been used on over 500 patients. In addition, other versions of the SCID have been used internationally in China, France, Greece, Japan, Portugal, Spain, the Netherlands, and Italy. The instrument's orientation is toward the

most recent hospitalization. Minor revisions of this instrument were made following a training session in the U.S. to make it more "user-friendly." The interview elicits clinical information to make the following DSM-III-R diagnoses:

Schizophrenia
Schizophreniform
Schizoaffective
Brief Reactive Psychosis
Delusional Disorder
Psychotic Disorder NOS
Major Depressive Syndrome
Manic Syndrome

All interviews began by eliciting a brief overview of the person's psychiatric history and most recent psychiatric hospitalization using the introductory material from this instrument.

2. International Personality Disorders Examination (IPDE)

This instrument was developed by Armand Loranger (1988) as a structured clinical interview for personality disorders. Its orientation is toward persistently present psychopathology over the past 5 years, and it is considered less valid under the age of 25. A version of this instrument is currently under extensive international field trials. Following a training session in the U.S., the instrument was significantly revised in order to shorten the length of the interview itself and to reduce the number of diagnoses to those of highest relevance.

DSM-III-R disorders:

Paranoid
Schizoid
Schizotypal
Borderline
Narcissistic

ICD-10 disorders:

Dyssocial
Impulsive

3. Mini-Mental State Examination

This instrument was developed by Marshall Folstein and colleagues (1975) to assess rapidly the degree of any organic (brain) impairment. Its orientation is toward the current interview and status. It has been used in many studies, including the N.I.M.H. Epidemiologic Catchment Area Study, in which it has been standardized on thousands of people with and without psychiatric diagnoses. There are 30 questions with the following grading scale:

| Number Correct | Cognitive Status |
|----------------|-----------------------------|
| 0-17 | Severe Cognitive Impairment |
| 18-24 | Mild Cognitive Impairment |
| 25-30 | Normal |

The Mini-Mental State Examination was omitted in some structured interviews when there was no question of organic impairment being present.

6. Social/Legal Evaluation

a. Purpose

The purpose of the forensic interview was to determine whether relevant Soviet laws, regulations, and administrative directives had been properly followed in these areas:

- Involuntary civil commitment (urgent hospitalization)
- Involuntary criminal commitment
- Hospitalization process, treatment, discharge, and community adjustment

The forensic assessments were not for the usual legal purposes or for assisting legal or other decision makers.

b. Instrument

The Forensic Interview Schedule (FIS) was designed as a semi-structured instrument to enable the Russian-speaking psychiatrists administering the interview to remain sensitive to the socio-cultural context of the interviewees, and to allow them to use their own best judgment when probing for needed clarification or elaboration of responses. The various questions sought to obtain some basic description of the key events, situations, and experiences of the patients. With appropriate modifications, the FIS was also designed to be used with

the patients' relatives or friends in order to check and verify information obtained from patients, their psychiatric records, and the structured diagnostic interviews (SCID-PD and IPDE).

The FIS items were grouped under several sections that essentially followed the usual legal process. The following are the major sections of the Forensic Interview Schedule:

- I. Introduction: The introduction provided some basic information about the interview, and made sure that the interviewees understood the purpose and could ask for any needed clarification.
- II. Precipitating Behavior and Events: This section sought to uncover what actually happened that served to precipitate the most recent arrest and involuntary hospitalization.
- III. Detention and Commitment Process: This section followed the sequence of events to learn about the reasons and bases for the urgent hospitalization or criminal investigation and commitment process for the current or most recent hospitalization.
- IV. Episode of Hospitalization: This section sought to learn about the general conditions of the person's hospitalization and the nature of the treatment program and care received by the patient in the current or most recent hospitalization.
- V. History of "Social Dangerousness": This section provided an opportunity to fill in any gaps and/or to obtain additional relevant information about the patient's history of dangerous behavior.
- VI. Process and Conditions of Release and Community Adjustment: The title of the section is self-explanatory.
- VII. Psychiatric Hospitalization History: This section provided an opportunity to obtain any additional essential missing information.
- VIII. Conclusion: This section simply provided an opportunity for interviewees to ask questions and to share any additional information.

The overall analysis and evaluation regarding the forensic psychiatric issues were based not only on a review of results from this interview, but also on information obtained from the patients' psychiatric records, the

interviews with relatives or friends, and the diagnostic interviews.

c. Relative/Friend Interview

In addition to the material collected through the Social/Legal Evaluation, an attempt was made to resolve discrepancies between the recorded symptomatology and that observed in the interviewee and to note any additional personal observations the friend or relative chose to make.

7. Soviet Psychiatric Interview and Formulation

In general, the Soviet psychiatric interview was brief (about one-half hour or less) and did not use any structured format with the patient. The U.S. Delegation had hoped to have the Soviet diagnosing and/or treating psychiatrist present for this interview. With a few exceptions, the treating psychiatrist was not present, and in no instance was the diagnosing psychiatrist present. Thus, questions addressed by the U.S. Delegation to the Soviet psychiatrists were of little use in clarifying specific patients' earlier diagnoses since these psychiatrists were also unfamiliar with the patients. The Soviet psychiatrists had access to all records, including those parts that were not available to the U.S. Delegation. For some of the interviews they observed the entire process; in other interviews they had been absent at the patient's request. They were invited to make any comments

about each case and to state any formulation they would like. The U.S. team did not offer their final diagnosis since it was felt that, given the problems noted above in preparation of the cases, the team members had insufficient time to integrate the information gained from multiple sources.

There was also an opportunity to discuss the patients (in terms of general conclusions, with a few individual patients highlighted), at the end of the visit. At that time, the U.S. and the Soviet teams met together with other experts for 1 1/2 days for a general discussion about Soviet forensic psychiatry.

Following the conclusion of the interview for the day, case summaries were either dictated or typed for each interview.

8. Audiotaping and Videotaping

In an effort to have a complete record of the patient interviews and to allow for subsequent review following the actual interviews, audio- and videotaping of each patient interview were conducted, provided consent was obtained. Of the 27 cases examined, videotapes were obtained for 21 patient interviews, with audiotapes of 3 additional cases, thus providing the U.S. Delegation with audio and/or videotapes of 24 (89 percent) of the total 27 cases.

APPENDIX D

SOVIET COMPLIANCE—STUDY LIMITATIONS

Despite unprecedented Soviet cooperation in giving the U.S. Delegation access to patients, many problems were encountered in efforts to complete the evaluations satisfactorily. Some of the problems were quite serious.

First, there was a problem with the records. During the visit to Moscow of the U.S. Advance Team in November 1988, the Soviets had agreed to provide copies of the entire medical record and to make available English translations of specified portions—namely, the first and last psychiatric commission reports, all medical orders, the discharge summary, and relevant court records. A few weeks before the visit, however, the Soviets indicated they could not provide the English translations because of the constraints of time and resources. It was then agreed 1 week before the visit that the Soviets would provide copies of the entire record, a table of contents, tabulations to identify key documents, and English capsule summaries of each record. It was also agreed that they would in other ways facilitate the U.S. Delegation's ability to review the records prior to the time that the patients were seen. Regrettably, however, the Soviets did not comply with all aspects of this agreement.

One week before the visit, the U.S. Delegation was promised that all records (either the originals or photocopies) would be available for review on the day of its arrival in the Soviet Union. (This would have provided a much shorter period for the U.S. Delegation's review of the materials than the 2 weeks discussed and agreed upon earlier.) But even this altered schedule was not fulfilled by the Soviets; most of the records were not available upon the Delegation's arrival, necessitating intense efforts to obtain the promised materials. The records for all patients to be interviewed actually became available only 3 or 4 days prior to the beginning of the patient examinations. Obviously, this put a great strain on the U.S. Russian-speaking psychiatrists who were to review these records. And, contrary to the agreement, for the 44 patients who were on the revised list, the Soviets failed altogether to provide copies of seven records.

The full range of problems associated with the records began to be evident only later. Some portions of the records came late; forensic psychiatric reports

prepared by the Serbsky Institute for General and Forensic Psychiatry were at times missing; other key portions of the hospital records (e.g., the accounts of patients' treatment during the most recent hospitalization at an SPH or OPH) were missing for a few patients. In some instances, the relevant missing sections were later provided by the Soviets, although not in time for the patient interviews. These problems with the records greatly complicated the Delegation's work. The Delegation did, however, return to the U.S. with photocopies of records for virtually all patients who were interviewed.

Second, contrary to the agreement negotiated in November 1988, the Soviets generally failed to facilitate access to relatives or friends of the patients who were to be interviewed. The U.S. clinical teams were able to interview relatives and friends of about half the patients. Except for the relatives and friends of three patients interviewed in Leningrad, the rest became available largely because of the U.S. Delegation's own efforts after it arrived in Moscow. In some instances, especially regarding hospitalized patients, it became evident during the interviews that the patients had wanted their relatives to be seen, but the Soviets had neither requested that these persons be present, nor assisted the patients' relatives and friends in this regard.

Third, in November 1988 there had been agreement that the Soviets would have the patients' treating and diagnosing psychiatrists present at the interviews to discuss these cases with the U.S. clinicians. Indeed, the Soviets had emphasized the importance of such discussions as a way of providing the U.S. clinicians with all relevant information about the patients. For the most part this, too, did not happen—with the exception of the useful discussions with the treating psychiatrists for the patients seen in Leningrad. Instead, the Soviets provided experts in forensic psychiatry from the Serbsky Institute or research psychiatrists who were experts in diagnosis but who were not very familiar with the particular cases. Although it was useful to discuss the patients with these experts, a valuable opportunity was lost for more specific discussions with the patients' treating psychiatrists.

There were some rather complicated problems with the consent/refusal status of some patients. These difficulties overlapped with various other Soviet pressures and manipulations, which were evidently designed to discourage or prevent certain patients from meeting with the U.S. Delegation. Through later discussions

with the patients or through other means, the U.S. clinical teams learned about at least five such instances. For example, the patients revealed that they had been discouraged by their local psychiatrists from seeing the U.S. Delegation or were told that they would not be interviewed. Based on efforts by the U.S. Delegation, however, virtually all of the identified patients were seen.

One formerly hospitalized patient was again hospitalized (urgently) in December 1988 and indicated that he was told during his recent hospitalization he would not be permitted to meet with the U.S. Delegation. He was, however, interviewed. The Delegation had kept track of the patient through the U.S. Embassy and other sources and was able to provide his precise location when the Soviets initially indicated his whereabouts was unknown.

In two instances, the Delegation was told by the Soviets that patients had refused to be interviewed. In one instance, when this statement was challenged on the basis of other information known to the Delegation, it proved not to be true, and the patient was interviewed. In the case of another patient who had been discharged around the time of the Delegation's visit and who had reportedly refused, it was possible for the Delegation to locate the person. The patient confirmed his desire to be interviewed and said that when he was discharged he was told that American journalists (not psychiatrists) were coming to the hospital.

In yet another case, the Delegation was told that the patient was too sick to travel and could be interviewed

only in a distant city. Subsequently, this proved to not be the case. Indeed, the patient, who had consented to be interviewed, had never been asked whether he felt too sick to travel. Interestingly enough, this patient, who appeared well to the U.S. clinical team, traveled on his own to Moscow, accompanied by his wife, and was interviewed.

It must be noted that very few patients indicated during their interviews with the Delegation that they were either fearful of later consequences or of any reprisals. Most were quite determined to have the interviews and indicated great pleasure at being given this opportunity.

Finally, and also contrary to the agreement worked out previously, in a few cases the patients' medications had been changed—either stopped or, in one case, increased. One patient was so heavily and obviously overmedicated that he could not provide a urine specimen. This patient's clinical state clearly reduced the validity of his evaluation; hence, a follow-up examination by independent psychiatrists under more favorable conditions is recommended.

In sum, if the U.S. Delegation had not been active in keeping track of the patients and if it had not had its own sources of information within the Soviet Union, clearly a number of key cases would not have been interviewed. The aforementioned experiences indicate that the Soviets did, in fact, attempt to "shape the sample" in ways that strike the Delegation as inconsistent with the extent of progress that is claimed by Soviet psychiatry.

APPENDIX E

HOSPITAL VISIT ADDENDA

1. Pre-visit Questions Forwarded to Each Hospital

1. The census of the hospital for the years ending 1987 and 1988
2. Bed component, occupancy in each hospital, number of square footage, and number of wards
3. Admissions and discharges for 1988
4. Catchment area
5. Number of people voluntarily committed
6. Number of people involuntarily committed
7. Number coming from criminal system
8. Number of buildings in which patients are housed
9. Number of psychiatrists, other staff—nurses, mental health workers, dentists, etc. ("mental health workers" are people with special training)
10. How many prisoners do you have working as orderlies? Have you ever had them?
11. Have you added or deleted staff this year?
12. List of security staff, rank, and seniority
13. Medical records—what constitutes a chart? Obtain blank charts
14. Hospital budget
15. Primary diagnosis putting patient into hospital
16. The five most common diagnoses
17. Types of medication used—which are most common?
18. Layout of the hospital
19. Manuals of operations for hospital staff
20. Organizational chart
21. To whom does the Chief of the hospital report?

2. Outline for Visit to "Special" and "Ordinary" Hospital Facilities

1. Physical Plant

- A. Size: Total number of beds, total number of occupants, of square footage per bed
- B. Appearance: Cleanliness, appropriate space for hospital programs or procedures
- C. Wards: Seclusion rooms, isolation rooms, space for hospital programs or procedures
- D. Heating systems, safety systems, exercise spaces, yards

Note: Attempt to draw layout of the institutional floor plan. The floor plans and plant drawings will be supplemented by pictures.

2. Records

- A. Medical records: Admission forms and notes, physical exam notes, previous hospital notes, treatments and procedures notes, progress notes, medication notes, physician and therapy notes; frequency of entries into the medical and social records; discharge notes and follow-up records; special incidents reports

Note: A general description of the medical records and the record room should be noted. If possible, sample copies of record forms should be obtained.

- B. Legal records, e.g., involuntary commitments, legal explanation for hospitalization, court orders

3. Staff and Employee Rosters

- A. Names and numbers of medical personnel: physicians, psychiatrists, dentists, and other medical personnel, physicians in training
- B. Nursing personnel: nurses by certificate, nursing aides, attendants, helpers, etc.
- C. Social workers, clinical psychologists or therapists and how they are addressed
- D. Dietary staff, housekeeping, laundry, secretarial, administrative
- E. Guards, security or army personnel

Note: For all professions, some review and assessment of the training, certification, or credentials should be requested, reviewed and noted.

4. Organizational

- A. Organization charts or, if unavailable, create a table of organization by inquiry
- B. Patient-staff ratios

5. Structure and Programs

- A. Therapy and treatment resources available; how are treatment plans determined?
- B. Review process for efficacy of treatment plans
- C. Discharge planning and follow-up planning
- D. Rehabilitation planning and resources

6. Procedures

- A. Manuals and regulations for the hospital management and staff routines
- B. Patient procedures, e.g., seclusion, restraints, suicide precautions
- C. Visitors and visiting privileges, mail, packages

7. Budgets

- A. Size of hospital budgets
- B. How are budgets determined?
- C. How is staff size determined, selected, recruited?
- D. Workshops, work programs

8. Issues of Competence

- A. Serious medical complications, emergency procedures
- B. How is consultation required and received for psychiatric conditions, for medical conditions, for cognitive or intellectual functioning?

Other Items to Check

Personnel policies and procedures written and published (local/central)

Patient care monitoring—records of monitoring

Patient rights written policies

Intake, assessment, treatment plans, special treatment procedures

Consultation services: Are there manuals available or forms? (See request for copies of forms above.)

Dental services: Dentists or dental equipment available

Dietetic services: Any arrangements for special diets?

Emergency services: Emergency equipment, resuscitation equipment, fire and safety policies, and equipment

Library, recreational, exercise services: Any space or equipment?

Pharmacy: Space, arrangement, variety of drugs and medication, pharmacist

Radiology: Equipment and training technicians

Education: Resources, space, books, teachers

Building and Grounds:

Functional safety and sanitation

Therapeutic environment

Housekeeping services

Infection control

Sterile supplies and equipment

Cooperativeness of staff, general and specific observations and comments on the attitudes and responses of staff, relationships among staff, and relationships between staff and patients

3. Description of the Hospitals Visited

A. Kazan Special Psychiatric Hospital

The Kazan Special Psychiatric Hospital, which was transferred to the jurisdiction of the Ministry of Health from the Ministry of Internal Affairs (MVD) in January, 1989, has 1,020 beds. The 1987 census was 1,069 patients, whereas the January 1, 1989, census was 956 patients, a decline of 11 percent. The budget provides for approximately \$8.48 (at the official exchange rate of approximately 1 ruble-U.S. \$1.64) per patient per day including all expenses for personnel, food, and other items. There are 25 senior psychiatrists on the staff and 13 department heads. About 20 percent of the psychiatrists have worked 5 years or less at this hospital.

The physical facility of the hospital consists of old buildings that are poorly maintained, although the buildings had been newly painted. The atmosphere is more that of a prison than of a hospital. The grounds are surrounded by brick walls 16 to 18 feet high with guard towers occupied by guards from the MVD situated throughout. Some of the outer walls are topped with barbed wire and electrical wiring. Each entry to the wards has steel-grilled or solid-steel doors. Doors to rooms and patient units are steel with glass observation slots. The beds are positioned close to each other, and many rooms have six or more beds with little or no space between them. Each unit has an exercise yard designated for its own use. The exercise period is from 1 1/2 to 2 1/2 hours per day but this allowance is not possible if the weather is too cold. The yards are surrounded by solid fences to deter communication between wards.

There are 13 wards or units in the hospital: Wards 1-7 for men are all closed wards. (In this hospital, this means that every door is locked.) Wards 8 and 9 are for medical treatment and rehabilitation. Ward 10 is the closed ward for female patients; however, the women are allowed workshop privileges. (Kazan SPH is one of two SPHs in the U.S.S.R. that have female patients.) Wards 11 and 12 are the men's work units. They are considered open in that the doors to the rooms and dormitory wards are unlocked; however, permission to walk in the corridors must be requested. There is a closed unit for females who are acutely ill or have behavioral problems.

According to data supplied by the hospital administration, the average length of stay in this hospital is 2 1/2 to 3 years, and 78 percent of the patients are diagnosed as schizophrenic. Other diagnoses include epilepsy and organic brain disease. In addition to treatment with neuroleptic drugs, insulin coma is used for 15 or 16 patients. Electroconvulsive therapy (ECT) is only used for exceptional patients who are "highly charged" and for whom other forms of treatment are ineffective.

B. Vilnius Ordinary Psychiatric Hospital

The Vilnius Hospital, which has always been under the jurisdiction of the Ministry of Health, was built in 1903. There are 2,010 beds in the hospital, although 120 are in locations that were under renovation at the time of the visit. The catchment area of this hospital is 1,135,000, or one-third of Lithuania. There were 1,817 patients in the hospital on March 3, 1989, most of whom were voluntary patients. Those who were there for compulsory (court-ordered) treatment were in wards with the voluntary patients. Of 85 people who were admitted for evaluation in 1988, 34 were admitted on an involuntary basis and were facing criminal charges. For civil procedures used for emergency admittance, there were no statistics and less than 20 involuntary "civil" cases per year. The average length of stay was about 60 days, although between 200 and 300 patients admitted stayed for longer than 1 year. There was no security department in this hospital.

The physical facility of the hospital is similar to public hospitals in the United States. The old two-story buildings are situated on large wooded grounds. At the entrance to the administration building there is an attractive modern marble sculpture. There are six wards for adult male and female patients, a 60-bed adolescent unit, and a 120-bed children's unit, in addition to the 120-bed unit being renovated. The units are clean, although somewhat overcrowded. The bathrooms are very old and outdated; many of the toilets are holes in the floor. The offices of the ward physicians and nurses are on the same corridors as the patient rooms; the corridors are furnished with chairs and benches. The patients, dressed in colorful pajamas and robes, are permitted to move about freely, and many are given ground privileges. There is a cafeteria, for example, which is open for staff and patients who are of a certain regimen, if they choose not to eat in the dining room on the wards

and are willing to pay for their meals there. There is also a shop that sells magazines, newspapers, and incidentals.

Extensive occupational workshops are available in this hospital, including seven large and productive greenhouses. The patients and ex-patients participate in a special union, which allows them to earn money for the hospital. The union, which has members throughout Lithuania, has a factory that produces the hospital's linens, white coats, and dresses, as well as articles to be sold outside of the hospital. These workshops produce approximately 50 different items. Patients who work here are paid, and they receive a pension for disability benefits. (Children from the age of 8 can begin working in these workshops.) For those patients who are unable to participate in these programs, there are common rooms with televisions; patients also socialize in the hallways.

C. Kaunas Ordinary Psychiatric Hospital

The Kaunas Ordinary Psychiatric Hospital has been under the jurisdiction of the Ministry of Health since its inception in the 1950s. The building itself dates from the 17th Century, when it was a monastery. There are 300 patients in the main facility which is in the old city of Kaunas, and approximately 350 in other facilities for treating alcohol and substance abuse, which are outside the old city.

Buildings in the main facility are small and difficult to maintain due to age. Those outside the old city are newer and in better condition. The administration of the hospital hopes to build a more modern hospital in the near future. There are four wards in the main facility: two for men (90 beds each) and two for women (60 beds each), with an age range from 18 to 70 years. The units are crowded, with little space between beds. The staff would like to have mixed wards, but present physical conditions prohibit this. The exercise yards are severely limited and bare; however at times, the hospital personnel take the patients for walks in the city. There are no organized sports, and the patients are limited to films, television, and piano for recreation. It appears that this is due to the lack of space on the hospital grounds.

The unit for treatment of alcohol and drug addiction, the construction site unit, and the factory unit have a total of approximately 350 beds for both male and female patients. The average age is 30 years for drug ad-

dicts and 30 to 45 years for alcoholics. The average length of stay is 26 days for narcotic addicts, 45 days for alcoholic psychosis, 78 days for male alcoholics, and 87 days for female alcoholics. For the entire hospital, the average length of stay is several months.

There are three visiting days and no restrictions on incoming and outgoing mail and parcels. Some family therapy is offered to help patients return to the community, but staff feel that there is not enough time for this type of work. It appears that the hospital has not used ECT since 1974, and that insulin coma has been used only occasionally. Neuroleptic medication is used, but sulfazine reportedly has not been used since 1970 due to the difficulty in obtaining the ingredients.

Kaunas Hospital is limited in its treatment program in part because of its physical setting. Many of the problems of this hospital could be improved by the new hospital, which hospital administrators hope will be built in 1993.

D. Chernyakhovsk Special Psychiatric Hospital

The Chernyakhovsk Special Psychiatric Hospital, built by the Germans in East Prussia as a maximum security prison, was converted into a hospital in 1965. This SPH was transferred from the jurisdiction of the Ministry of Internal Affairs to the Ministry of Health in January 1989. There were 650 beds in the hospital and 446 patients at the time of the visit. Of these patients, 338 were diagnosed as schizophrenic. In 1978, there were 740 patients (the highest number recorded), and the patients had to sleep in bunk beds. The census in 1987 was 579; in 1989 it was 446, a decline of 23 percent.

The hospital has 18 psychiatrists in all, and a total of 90 guards report to the MVD. These guards serve shifts of 12 hours on and 24 hours off; 15 guards are on duty at all times, with 1 being assigned to each ward. The annual budget of the hospital is 1,296,000 R.

In the transition from prison to hospital, none of the prison atmosphere was lost. The buildings, entry ways, guard towers, surrounding walls, and steel doors to patients' rooms and wards show the heavy emphasis on control. There is little to characterize this facility as a hospital or treatment environment. The hospital is built in an area behind a wood working factory and surrounded by high brick walls with wire strung between metal posts. Watchtowers are placed at intervals around the walls and grounds. Separate recreational buildings

are being built for staff, and there will be a new unit for patients. The buildings are old and the facilities are poor, although newly painted. There are six wards, and the rooms are overcrowded even though the census is declining. The beds are side by side with no space between them, and bathrooms are primitive. The patients are locked in their rooms and must ask permission to go to the bathroom by turning on a light outside the door of the cell.

Workshops, which the patients run, are producing millwork for the new patient unit; other patients work in sewing and electrical product workshops. The hospital support areas (laboratories, offices, visitor areas, pharmacy) seemed inappropriately small for a hospital of this size, although there is a library of 12,000 books.

Exercise yards are walled off from each other, and patients are taken out for 2 to 3 hours per day in the summer, but exercise in the winter depends on the weather.

The diagnosis of schizophrenia is used for over 75 percent of the patients. Other diagnoses include alcoholism, reactive psychosis, paranoid personality disorder, epilepsy, mental retardation, organic brain disease, and psychopathy. In 1988, the crimes of forensic patients included 63 crimes against state property, 297 crimes against life, 255 crimes against public order, and 55 other crimes. Treatment consists mainly of neuroleptic drugs, although ECT is used on occasion, and sulfazine is used in rare instances when the hospital is able to obtain it.

APPENDIX F

EXCERPTS FROM SOVIET LAW

1. Relevant Articles from R.S.F.S.R. Criminal Code¹

Article 11. Nonimputability. A person shall not be subject to criminal responsibility who at the time of committing a socially dangerous act is in a state of nonimputability, that is, cannot realize the significance of his actions or control them because of a chronic mental illness, temporary mental derangement, mental deficiency, or other condition of illness. Compulsory measures of a medical character may be applied to such a person by order of the court.

Also, a person shall not be subject to punishment who commits a crime while in a state of nonimputability but before the rendering of judgment by the court contracts a mental illness which deprives him of the possibility of realizing the significance of his actions or of controlling them. Compulsory measures of a medical character may be applied to such a person by order of the court, but upon recovery he may be subject to punishment [Page 126].

[This Article appears under **General Part**, Chapter 3: Crime.]

Article 70. Anti-Soviet Agitation and Propaganda.

Agitation or propaganda carried on for the purpose of subverting or weakening the Soviet regime [*vlast'*] or of committing particular, especially dangerous crimes against the State, or the circulation, for the same purpose of slanderous fabrications which defame the Soviet state and social system, or the circulation or preparation or keeping, for the same purpose, of literature of such content, shall be punished by deprivation of freedom for a term of six months to seven years, with or without additional exile for a term of two to five years, or by exile for a term of two to five years.

The same actions committed by a person previously convicted of especially dangerous crimes against the State or committed in wartime shall be punished by deprivation of freedom for a term of three to ten years, with or without additional exile for a term of two to five years. [Pages 153-154]

[This Article appears under **Special Part**, Chapter 1: Crimes Against the State. I. Especially Dangerous Crimes Against the State.²]

Article 83. Illegal Exit Abroad and Illegal Entry into the U.S.S.R. Exit abroad, entry into the U.S.S.R., or crossing the border without the requisite passport or the permission of the proper authorities, shall be punished by deprivation of freedom for a term of one to three years.

Operation of the present article shall not extend to instances of arrival in the U.S.S.R. of foreign citizens, without the requisite passport or permit, for exercise of the right of asylum granted by the Constitution of the U.S.S.R. [Page 156]

[This Article appears under **Special Part**, Chapter 1: Crimes Against the State. II. Other Crimes Against the State.]

Article 142. Violation of Laws on Separation of Church and State and of Church and School. The violation of laws on the separation of church and State and of school and church shall be punished by correctional tasks for a term not exceeding one year or by a fine not exceeding 50 rubles.

The same acts committed by a person previously convicted of violation of laws on the separation of church and State and of school and church, as well as organizational activity directed to the commission of such acts, shall be punished by deprivation of freedom for a term not exceeding three years. [Page 169]

[This Article appears under Chapter 4: Crimes Against Political and Labor Rights of Citizens.]

Article 190-1. Circulation of Fabrications Known to be False Which Defame Soviet State and Social System. The systematic circulation in an oral form of fabrications known to be false which defame the Soviet State and social system and,

¹Source: Berman, H.J. *Soviet Criminal Law and Procedure. The R.S.F.S.R. Codes.* (2nd Ed.) Cambridge, MA: Harvard University Press, 1972.

²Under a decree of the Presidium of the Supreme Soviet of the U.S.S.R., issued on April 8, 1989, Article 70 has been revised.

likewise, the preparation or circulation in written, printed or any other form of works of such content shall be punished by deprivation of freedom for a term not exceeding three years, or by correctional tasks for a term not exceeding one year, or by a fine not exceeding 100 rubles. [Pages 180-181]

[This Article appears under Chapter 9: Crimes Against the System of Administration.¹]

Article 209-1. Malicious Evasion of Performance of Decision Concerning Arrangement of Work and Discontinuance of Parasitic Existence.² The malicious evasion, by a person leading an antisocial form of life, of the performance of a decision of a district (or city) executive committee of a Soviet of working people's deputies concerning the arrangement of work and the discontinuance of a parasitic existence shall be punished by deprivation of freedom for a term not exceeding one year or correctional tasks for the same term.

The same act committed by a person previously convicted in accordance with paragraph one of this Article shall be punished by deprivation of freedom for a term not exceeding two years. [Page 187]

[This Article appears under Chapter 10: Crimes Against Public Security, Public Order, and Health of the Population.]

Article 227. Infringement of Person and Rights of Citizens Under Appearance of Performing Religious Ceremonies. The organizing or directing of a group, the activity of which, carried on under the appearance of preaching religious beliefs and performing religious ceremonies, is connected with the causing of harm to citizens' health or with any other infringements of the person or rights of citizens, or with the inducing of citizens to refuse social activity or performance of civic duties, or with the drawing of minors into such group, shall be punished by deprivation of freedom for a term not exceeding

five years or by exile for a similar term with or without confiscation of property.

The active participation in the activity of a group specified in paragraph one of the present Article, or the systematic propaganda directed at the commission of acts specified therein, shall be punished by deprivation of freedom for a term not exceeding three years, or by exile for the same term, or by correctional tasks for a term not exceeding one year.

Note: If the acts of persons stated in paragraph two of the present Article, and the persons themselves, do not represent a great social danger, measures of social pressure may be applied to them. [Page 192]

[This Article appears under Chapter 10: Crimes Against Public Security, Public Order, and Health of the Population.]

2. Relevant Articles from R.S.F.S.R. Code of Criminal Procedure Concerning the Rights of Accused Persons and Defendants³

Article 46. The Accused. ... The accused shall have the right to know what he is accused of and to give explanations concerning the accusations presented to him; to present evidence; to submit petitions; to become acquainted with all the materials of the case upon completion of the preliminary investigation or inquiry; to have defense counsel from the moment provided for by Article 47 of the present Code; ... [Page 217]

[This Article appears under Chapter 3: Participants in the Trial, Their Rights and Duties.]

Article 47. Participation of Defense Counsel in Criminal Proceedings. Defense counsel shall be permitted to participate in a case from the moment the accused is informed of the completion of the preliminary investigation and is presented with all the proceedings of the case to become acquainted with them.

¹This Article was repealed as of April 8, 1989. [See FN 2 previous page.]

²This Article was repealed and the referenced criminal activity incorporated into Article 209.

³Source: Berman, H.J. *Soviet Criminal Law and Procedure. The R.S.F.S.R. Codes.* (2nd Ed.) Cambridge, MA: Harvard University Press, 1972. (There are numerous provisions in this code pertaining to the rights of defendants; only those most directly relevant for purposes of this report are listed here.)

In case of minors, as well as of persons who by reason of their physical or mental defects are not themselves able to exercise their right to defense, defense counsel shall be permitted to participate in the case from the moment the accusation is presented. [Page 218]

[This Article also appears under Chapter 3.]

Article 49. Obligatory Participation of Defense Counsel. The participation of defense counsel in a judicial examination shall be obligatory in cases:

- (1) In which a state or social accuser is participating;
- (3) Of dumb, deaf, blind, and other persons who by reason of their physical or mental defects are not themselves able to exercise their right to defense; [Page 219]

[This Article also appears under Chapter 3.]

There are numerous provisions in this Code pertaining to the rights of defendants; only those most directly relevant for purposes of this report are listed here.

Article 58. Duty to Explain and Secure Rights to Persons Participating in Case. A court, procurator, investigator, and person conducting an inquiry shall be obliged to explain to persons participating in a case their rights and to secure the possibility of exercising such rights. [Page 222]

[This Article appears under Chapter 3.]

Article 148. Presentation of Accusation. The presentation of an accusation must follow within 48 hours from the moment the decree to prosecute as the accused is rendered, or in the event of compulsory appearance, on the day of the compulsory appearance . . .

After ascertaining the identity of the accused, the investigator shall announce to him the decree to prosecute him as the accused, and shall explain the nature of the accusation. The performance of such actions shall be certified by the signature of the accused on the decree to prosecute him as the accused and by the signature of the investigator, with an indication of the time of presentation of the accusation. [Page 250]

[This Article appears under Chapter 11: Presentation of the Accusation and Interrogation of the Accused.]

Article 149. Explanation to Accused of His Rights in Preliminary Investigation. When presenting an accusation, an investigator shall be obliged to explain to an accused his rights as provided by Article 46 of the present Code, and a note to such effect shall be made on the decree to prosecute him as the accused and shall be certified by the signature of the accused. [Page 250]

[This Article also appears under Chapter 11.]

Article 201. Acquainting Accused With All Materials of Case. If an investigator deems the evidence gathered to be sufficient for drawing up a conclusion to indict and has fulfilled the requirements of Article 200 of the present Code, he shall announce to an accused that the investigation in his case has been terminated and that he has the right to become acquainted with all the materials of the case both personally and with the help of defense counsel, as well as to file petitions to supplement the preliminary investigation. [Page 266]

[This Article appears under Chapter 17: Conducting an Expert Examination.]

Article 246. Participation of Person Brought to Trial in Judicial Examination. The examination of a case in a session of the court of first instance shall proceed with the participation of the person brought to trial, whose appearance in court shall be obligatory.

The examination of a case in the absence of the person brought to trial may be permitted only in exceptional instances, if this does not obstruct the establishment of the truth in the case: ... [Page 279]

[This Article appears under Chapter 21: General Conditions of Judicial Examination.]

Article 264. Record of Judicial Session. The person presiding shall be obliged to secure to participants in the trial an opportunity to become acquainted with the record. [Page 285]

[This Article also appears under Chapter 21.]

Article 405. Participation of Defense Counsel. In cases of persons who have committed socially dangerous acts while in a state of nonimputability as well as of persons who have contracted a mental illness after committing a

crime, the participation of defense counsel shall be obligatory.

Defense counsel shall be permitted to participate in a case from the moment the fact of the mental illness of the person who has committed the socially dangerous act is established.

[Pages 327-328]

[This Article appears under **Section 8: Proceedings for the Application of Compulsory Measures of a Medical Character**. Chapter 33: Proceedings for the Application of Compulsory Measures of a Medical Character.]

REFERENCES

- American Psychiatric Association. *Diagnostic and Statistical Manual—DSM-III-R*, Third Edition, Revised. Washington, D.C.: American Psychiatric Association, 1988.
- Babayan, E.A. Legal Aspects of Psychiatry in the Soviet Legislation. Mimeo (undated), p. 22.
- Berman, H.J. *Soviet Criminal Law and Procedure. The RSFSR Codes*, 2nd ed., Cambridge, MA: Harvard University Press, 1972.
- Buyanov, M.I. Heal Thyself, Medicine. *Uchitelskaya gazeta*, November 19, 1988.
- Bloch, S. and Reddaway, P. *Russia's Political Hospitals: The Abuse of Psychiatry in the Soviet Union*. London: Victor Gollancz Ltd., 1977.
- Bloch, S. and Reddaway, P. *Soviet Psychiatric Abuse: The Shadow over World psychiatry*. Boulder, Colorado: Westview Press, 1985.
- Centre for Human Rights. *Human Rights: A Compilation of International Instruments*. New York: United Nations, 1988.
- Churkin, A. Interview in "Psychiatry and Politics." *New Times* #43, pp. 41-43, October 1988.
- Cooper, J.E., Kendall, R.E., Gurland, B.J., Sharpe, L., Copeland, J.R.M. and Simon, R. *Psychiatric Diagnosis in New York and London*. New York: Oxford University Press, 1972.
- Criminal Justice Mental Health Standards, American Bar Association, Washington, DC., 1986.
- Draft Body of Principles and Guarantees for the Protection of Mentally Ill Persons and for the Improvement of Mental Health Care, Economic and Social Council of the United Nations Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, 1988.
- Folstein, M.F., Folstein, S.E. and McHugh, P.R. "Mini-Mental State:" A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 12: 189-198, 1975.
- Holland, J. and Shakhmatova-Pavlova, I.V. Concept and classification in the Soviet Union. *Schizophrenia Bulletin* 3: 277-287, 1977.
- Kazanetz, E.P. Differentiating exogenous psychiatric illness from schizophrenia. *Archives of General Psychiatry* 36: 740-745, 1979.
- Koryagin, A. Unwilling patients. *Lancet*, p. 821-824, April 11, 1981.
- Loranger, A.W. *Personality Disorder Examination (PDE) Manual*. Yonkers: DV Communications, 1988.
- Melekhin, G. In: Yakovlev, Others View Human Rights Roundtable, *Tass*, April 7, 1988. In: *Worldwide Issues*, FB15-SOV-88-068, April 8, 1988.
- Morozov, G.V. and Kalashnik, I. M. (eds). *Forensic Psychiatry*. White Plains, New York: International Arts and Sciences Press, 1970.
- National Institute of Mental Health. *Mental Health, United States*, 1985. Taube, C.A., Barrett, S.A., eds. DHHS Pub. No. (ADM) 85-1378. Washington, D.C., Superintendent of Documents, U.S. Govt. Printing Office, 1985.
- Novikov, A., Razin, S., and Mishin, M. "Does Soviet Psychiatry Need a Tighter Rein?" *Komsomolskaya pravda*, November 11, 1987, p. 4. Condensed in *The Current Digest of the Soviet Press*, December 16, 1987.
- Perlin, M.L. Patients' Rights, Chapter 25 in: Klerman, G.L., Weissman, M.M., Appelbaum, P.S., Roth, L.H. (eds). *Psychiatry, Social, Epidemiologic and Legal Psychiatry*, Vol. 5. Philadelphia: J.B. Lippincott, 1986, pp. 402-422.
- Polubinskaya, S.V. Quoted in *Komsomolskaya Pravda*, July 16, 1988, Reproduced: *International Association on the Political Use of Psychiatry Information Bulletin*.
- Pravda*, Psychiatry: Law and Practice, March 1, 1989.
- Protchenko, B., and Rudyakov, A. Painful Theme #3. *Kommunist Magazine*, 1989.
- Provisional Guidelines on the Procedure for Immediate Hospitalization of the Mentally Ill, Appendix #17 to Decree #225 of the U.S.S.R. Ministry of Public Health, March 21, 1988.
- Reatig, N. Fiscal Year 1987 Report on Activities under P.L. 99-319. The Protection and Advocacy for Mentally Ill Individuals Act, Mimeo: Available from the National Institute of Mental Health, 1987.
- Reich, W. The case of General Grigorenko: A psychiatric reexamination of a Soviet dissident. *Psychiatry* 43: 303-323, 1980.
- Schooler, N., Keith, S., Severe, J. and Matthews, S. Treatment strategies in schizophrenia. *Psychopharmacology Bulletin* (in press).

Spitzer, R.L. and Williams, J.B.W. *Structured Clinical Interview for DSM-III-Psychotic Disorders Version*. New York, N.Y.: Biometrics Research Department, 1985.

Statute on Conditions and Procedures for the Provision of Psychiatric Assistance, Ratified by a Decree of the Presidium of the U.S.S.R. Supreme Soviet, January 5, 1988.

Urgent Hospitalization of the Socially Dangerous Mentally Ill. Instruction of the Ministry of Public Health of the U.S.S.R., August 26, 1971, No. 06-14-43.

U.S. Department of State Country Reports on Human Rights Practices for 1988, Union of Soviet Socialist Republics, p. 1215.

Washington Post, Associated Press. "2 Million to Quit Soviet Mental-Patient Rolls," February 12, 1988.

Weicker, L. Federal response to institutional abuse and neglect: The Protection and Advocacy for Mentally Ill Individuals Act. *American Psychologist* 42: 1027-28, 1987.

Weiner, B.A. Rights of Institutionalized Persons, Chapter 5, in: Brakel, S.J., Parry, J., Weiner, B.A. *The Mentally Disabled and the Law*. Chicago: American Bar Foundation, 1985, p. 287.

