

Protecting the human rights of people with mental disorder: new recommendations emerging from the Council of Europe

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The Declaration of Hawaii by the World Psychiatric Association (1977) was the first general agreement by the psychiatric community on minimum ethical standards. It acknowledged that ethical conflicts can exist between the physician (especially the psychiatrist), the patient and society, and that written guidelines are needed. This was particularly apparent after reports of widespread political abuse of psychiatry (Fulford *et al.*, 1993). A World Psychiatric Association charter on the rights of people with mental illness (World Psychiatric Association, 1989) and United Nations Resolution 46/119 for the Protection of Persons with Mental Illness and for the Improvement of Mental Health (United Nations General Assembly, 1991) followed.

THE COUNCIL OF EUROPE

The Council of Europe, comprising 45 member states, has also focused attention on the human rights of people with mental disorder. Its stated aims are to protect human rights, pluralist democracy and the rule of law; to promote awareness and encourage the development of Europe's cultural identity and diversity; to seek solutions to problems facing European society (such as discrimination against minorities, xenophobia and intolerance); and to help consolidate democratic stability in Europe by backing political, legislative and constitutional reform. The European Convention on Human Rights defines these aims and is relevant to the protection of the rights of people with mental disorder, especially where they are subject to involuntary measures (Bindman *et al.*, 2003). The Parliamentary Assembly of the Council of Europe adopted a recommendation in 1977 which highlighted the need for legal protection of those with mental illness (Council of Europe, 1977). Subsequently, Recommendation (83)2 formulated rules concerning involuntary

admission, including the necessity of judicial review for those detained, the right to appeal and also the right to be treated with the same ethical and scientific conditions as any other ill person (Council of Europe, 1983). In 1994 the Parliamentary Assembly accepted Recommendation 1235 on psychiatry and human rights (Council of Europe, 1994), which was much more specific about the rights of people with mental disorder. Whereas Recommendation 83(2) advised on broad principles, the tone of this document is far more prescriptive. Psychosurgery and electroconvulsive therapy are addressed specifically. Mechanical restraint is forbidden, as is the use of isolation cells. Pharmaceutical restraint should be limited and in proportion to the perceived risk. New recommendations include the obligation to immediately inform people receiving involuntary treatment of their rights, further direction on ethical research and the provision of 'sociotherapy programmes' for detained individuals with personality disorders.

NEW DRAFT RECOMMENDATIONS

In 1996 a Working Party on Human Rights in Psychiatry was appointed by the European Council of Ministers to develop recommendations for member states to further develop those in Recommendation 1235 to 'ensure the protection of the human rights and dignity of people with mental disorder, especially those placed as involuntary patients in a psychiatric establishment'. Such guidelines were considered necessary because of the 'exceptional nature of involuntary procedures that can be used for the placement and treatment of people with mental disorder and therefore the exceptional need for the protection of their rights'. The group included legal and psychiatric experts. A consultation document (Council of Europe, 2000) was

produced and disseminated widely. Draft recommendations have now been developed, covering the topics of non-discrimination and mental health promotion; the protection of vulnerable people; civil and political rights of involuntary patients; environmental and living conditions; professional standards; seclusion and restraint; criteria and procedures for involuntary placement and treatment; procedures for involuntary placement and treatment in an emergency; termination of involuntary placement and treatment; review of lawfulness of involuntary placement and treatment; specific treatments; application to minors; involvement of the police, courts and prison system; and monitoring standards.

The draft recommendations arising out of the consultation process are applicable to patients with a mental disorder, especially those involuntarily placed and/or receiving involuntary treatment. Involuntary placement should include therapeutic purpose. The mental health system therefore should not be used for custodial reasons alone, even when there is significant risk of serious harm to others. Where such potential for harm exists but no therapeutic intervention is indicated, this is a matter for the criminal justice system.

Mental disorder is defined broadly, with reference to international classification systems. Difficulty adapting to moral, social, political or other values in itself is specifically excluded from the definition. The involuntary admission of patients for treatment of substance misuse is not absolutely prohibited, but should only occur in exceptional circumstances and for treatment by doctors who specialise in this field. Such treatment may be offered as an alternative to other sentences by a court.

Measures aimed at eliminating discrimination through mental health promotion programmes are considered in accordance with article 14 of the European Convention on Human Rights, under which people have the right to live free from discrimination. Member states are encouraged to develop mental health promotion programmes aimed at increasing the awareness of the public about mental disorder, especially its prevention, recognition and treatment.

As with preceding recommendations (Council of Europe, 1994), physical restraint and seclusion should be proportional to the benefits and risks entailed. However, contrary to the earlier recommendations, the use of mechanical restraint

is not prohibited: 'isolation and mechanical or other means of restraint for prolonged periods should be resorted to only in exceptional cases where there is no other means of remedying the situation', under the supervision of a doctor. The rights of people with mental disorder include the rights to communication, individualised treatment and appropriate environmental conditions; specifically, they include the rights to:

- (a) retain those civil and political rights for which they have the capacity to make decisions;
- (b) be informed of their rights as a patient;
- (c) communicate with any appropriate authority and with their legal representative;
- (d) have protection of their economic interests;
- (e) live and work in the community to the extent possible;
- (f) receive individualised treatment:
 - (i) discussed with the patient
 - (ii) reviewed and revised regularly
 - (iii) provided by adequately qualified staff
 - (iv) in the least restrictive environment and using the least restrictive means appropriate to the patient's health and the need to protect the safety of others
 - (v) with confidentiality of information;
- (g) be accommodated in appropriate environmental and living conditions, with provision of sufficient living space, adequate lighting, heating and ventilation, appropriate decoration and furnishing, retention of certain personal effects, preservation of privacy, individualisation of clothing, provision of adequate food, and allowing reasonable communication and visiting.

Specific provision should be made for children and vulnerable adults.

Consideration is given to the placement and treatment of vulnerable people with mental disorders. This includes circumstances in which the person can consent, but does not; cannot consent, but resists treatment; and cannot consent, but does not resist treatment. The following recommendations refer to the first two circumstances; however, many people (often those in nursing or residential homes) fall into the third category, and specific

provision should be made to protect their interests.

Involuntary placement and treatment should only occur on the grounds that mental disorder is recognised (or that a mental health assessment is required) and that the condition represents a significant risk of serious harm to self or others. Competency of patients to decide on their own treatment is presumed even after involuntary admission, unless the contrary is demonstrated, and so should be separately considered. Member states are instructed to ensure that alternatives to placement – that is, community treatment – are widely available. Involuntary admission should occur only on the basis of an examination by a psychiatrist or medical doctor with requisite experience. Consultation with the family or other people close to the patient should be made as far as possible, unless the patient objects, but where significant issues of public safety exist, consultation should take place despite the patient's objections. The decision to invoke involuntary placement or treatment should be confirmed by an independent competent body; it should be taken promptly, documented and the duration specified. A competent body is defined as 'an independent authority, person, or body provided for by law which is independent of the person or body proposing the measure and that can make an independent decision'. Emergency involuntary placement can take place without independent consideration, although such consideration should be sought as soon as possible. Emergency procedures should not be used with the aim of avoiding application of normal procedures.

The recommendations also apply to people who are treated involuntarily as out-patients. At present such patients incur a double jeopardy, whereby even if they do not need involuntary admission for involuntary treatment to be given, they are inevitably subjected to it. The argument for such legislation is that involuntary treatment in hospital could be avoided for many people if involuntary out-patient treatment were given. However, the use of physical restraint to administer treatment should never occur outside a medical establishment, and involuntary treatment should only be used (as in the *Winterwerp* [1981] judgment) while objective signs of mental disorder exist. When signs of disorder such as hallucinations do continue, the right of the person to self-determination should be taken into consideration. Some people

may prefer to experience distress or disability rather than accept medication with its associated side-effects. This preference should be respected, and only where criteria are met, for example significant risk of serious harm, should involuntary treatment be considered and then carefully monitored. A written treatment plan should be agreed as appropriate with the patient and the patient's personal advocate, or submitted to an independent authority for approval.

Involuntary treatment or placement should be terminated as soon as the criteria for such treatment are no longer met, and after-care for people released from involuntary placement should be provided by member states. Free legal representation should be available according to national law, and regular legal review should take place to evaluate the lawfulness of the involuntary placement.

The individual's consent in combination with appropriate ethical scrutiny and independent second medical opinion is an absolute prerequisite for procedures that have irreversible physical consequences, such as psychosurgery. Protection where intrusive procedures such as electroconvulsive therapy are concerned includes obtaining informed, written consent, or specific procedures to ensure independent scrutiny where this cannot be obtained.

The treatment of minors is considered, although the definition of a minor is deemed a matter for national law. A representative should be available to the minor from the beginning of the procedure, and this person's opinion should be taken into account when making decisions on the patient's behalf, depending on the minor's degree of maturity. Minors should be treated separately from adults, and have the right to an individualised public education.

Police should have the powers to intervene, in coordination with other services, when they suspect a person has a mental disorder and represents a serious risk of harm to him- or herself or to others. Legal representation should be available to the person when interviewed, and following arrest a medical examination (including assessment of capacity) should be done promptly. Appropriate training should be given to members of the police in assessing and managing situations involving people with mental disorder. The guidelines on involuntary placement and treatment in civil situations apply also to people with a mental disorder in contact with courts and

prisons, with the following exceptions: although consent may be given by the person concerned to placement or treatment, a court may impose such direction irrespective of consent, and a court can impose restrictions on termination of the placement or treatment by the psychiatrist. However, people subject to such court decisions should be treated in a medically appropriate place, and be transferred between prison and hospital as necessary.

A system for monitoring quality standards in mental health service provision is fundamental, and procedures for setting up and monitoring quality standards are recommended. For example, an inspection team that includes mental health service users should be established, with the power to inspect premises regularly without prior notice. The team should be able to talk to patients privately, inspect clinical files and receive complaints from patients confidentially, ensuring that local complaints procedures are in place and are appropriately responded to. The team should review any situations in which restrictions to communication have been applied, and ensure that professional obligations and standards are met.

IMPLICATIONS

The Council of Europe Expert Working Group's recommendations are important for the protection of people with mental illness and, if implemented, will have significant implications for the way in which European mental health services develop, deliver and monitor care. The recommendations are comprehensive and are designed to promote a minimum standard of care for patients, especially those subject to involuntary procedures, in all member states. They not only protect against potential abuses, such as detention for purely political reasons, but also encourage nations to

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change current bad practice such as the use of unmodified electroconvulsive therapy and the excessive use of physical restraint and seclusion, which still occur in some parts of Europe (Council of Europe, 1998). The proposals have inevitably been most detailed in their consideration of situations in which involuntary measures are imposed, but the importance of providing appropriate resources for care and measures to destigmatise mental disorder cannot be overstated. Member states are encouraged to provide sufficient financial resources to fund environmental improvement and trained personnel to implement the guidelines. This will be a matter for prioritisation; nevertheless, the guidelines highlight the importance of protecting a group of people whose rights have been and continue to be seriously infringed.

The draft recommendation is being discussed further by the Bioethics Committee of the Council of Europe before a final recommendation is made to the Council of Ministers. If that recommendation is accepted, countries will not be obliged to implement it, but it will provide guidance in many areas, including national legislation, that could advance and harmonise mental health care substantially.

DECLARATION OF INTEREST

D.K. and J.L. were members of the Working Party of the Council of Europe described in this editorial. The views

expressed should not be taken to represent the views of the Council of Europe.

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