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

DAVID KINGDON, ROLAND JONES and JOUKO LÖNNQVIST

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 excep-
tional 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 representa-
tive;
(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 infor-
       mation;
(g) be accommodated in appropriate envir-
onmental and living conditions, with
provision of sufficient living space, ade-
quate lighting, heating and ventilation,
appropriate decoration and furnishing, reten-
tion of certain personal effects, preserva-
tion 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 circum-
cstances 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 cir-
cumstances; 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 men-
tal 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 admis-
sion, unless the contrary is demonstrated,
and so should be separately considered.
Member states are instructed to ensure that
alternatives to placement – that is, com-
munity treatment – are widely available.
Involuntary admission should occur only
on the basis of an examination by a psy-
chiatrist 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 place-
ment 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 with-
out 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 in-
voluntary treatment to be given, they are
inevitably subjected to it. The argument
for such legislation is that involuntary treat-
ment 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 establish-
ment, 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 disabil-
ity rather than accept medication with its
associated side-effects. This preference
should be respected, and only where cri-
teria are met, for example significant risk
of serious harm, should involuntary treat-
ment 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 sub-
mitted 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 involun-
tary 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 combina-
tion 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 electroconvul-
sive 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 repre-
sentative 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 trea-
ted separately from adults, and have the
right to an individualised public education.

Police should have the powers to inter-
vene, 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 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.

REFERENCES


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

David Kingdon, Roland Jones and Jouko Lönnqvist

Access the most recent version at DOI: 10.1192/bjp.185.4.277

References
This article cites 2 articles, 2 of which you can access for free at:
http://bjp.rcpsych.org/content/185/4/277#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at
/letters/submit/bjprcpsych;185/4/277

Downloaded from
http://bjp.rcpsych.org/ on April 9, 2017
Published by The Royal College of Psychiatrists