

2000



COUNCIL OF EUROPE CONSEIL DE L'EUROPE

Strasbourg, 3 January 2000
[cdbi/cdbi-ph/doc/dirjur2000.2 white paper]

DIR/JUR (2000) 2

"WHITE PAPER"

on the protection of the human rights and dignity
of people suffering from mental disorder,
especially those placed as involuntary patients
in a psychiatric establishment

The present "White Paper", drawn up by a Working Party of the Steering Committee on Bioethics (CDBI) of the Council of Europe, is published for public consultation purposes, with a view to drawing up guidelines to be included in a new legal instrument of the Council of Europe.

The CDBI authorised the publication of the present document, the contents of which only constitute at this stage the result of the work of a group of experts. Consequently, the views contained in it do not necessarily reflect the final position of the CDBI, of the Committee of Ministers of the Council of Europe or of its member States.

Introduction

On 22 February 1983, the Committee of Ministers of the Council of Europe adopted Recommendation No R (83)2 to member States on legal protection of persons suffering from mental disorder placed as involuntary patients (see Appendix 2)¹.

On 12 April 1994, the Parliamentary Assembly of the Council of Europe adopted Recommendation 1235 (1994) on psychiatry and human rights, in which it invited the Committee of Ministers to adopt a new Recommendation based on the rules appearing in the said text (see Appendix 3)².

Following this Recommendation of the Parliamentary Assembly, the Committee of Ministers created a **Working Party on Psychiatry and Human Rights (CDBI-PH)**, which is a subordinate body of the **Steering Committee on Bioethics (CDBI)**.

The terms of reference of the Working Party on Psychiatry and Human Rights (CDBI-PH) read as follows: " Under the authority of the Steering Committee on Bioethics (CDBI) and in the light of Committee of Ministers' Recommendation No R (83)2 on legal protection of persons suffering from mental disorder placed as involuntary patients and of Parliamentary Assembly Recommendation 1235 (1994) on psychiatry and human rights, to draw up guidelines to be included in a new legal instrument of the Council of Europe. These guidelines should aim to ensure protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients, including their right to appropriate treatment."

During its work, the CDBI-PH constantly kept in mind the necessity of protecting the human rights of persons placed in psychiatric establishments, which, in the past, were frequently violated; in this context, the CDBI-PH duly took account, *inter alia*, of the provisions of Article 5, paragraph 4, of the European Convention on Human Rights which reads as follows:"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

During its consideration of the issue of involuntary placement and treatment, the CDBI-PH also underlined that no matter what independent bodies supervise this restriction of freedom, they do not relieve the therapists and professionals in direct contact with people suffering from mental disorder of the ethical and legal considerations which must constantly accompany them in their work. It is the duty of all psychiatrists responsible for taking major decisions for their patient's future to constantly back up their opinions, through dialogue and transparency concerning the approach adopted, vis-à-vis their peers, their patients and the community at large.

The CDBI-PH benefited from the valuable experience of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). In particular, it held an exchange of views with its first Vice-President and with an expert to the CPT. Furthermore, part III of the 8th general report on the CPT's activities covering the

¹ Appendix 2 is only attached for information purposes and **not for consultation purposes.**

² Appendix 3 is only attached for information purposes and **not for consultation purposes.**

period 1 January to 31 December 1997 (document CPT/Inf (98)12) is devoted to involuntary placement in psychiatric establishments.

The present "White Paper" is published for public consultation purposes, with a view to drawing up guidelines to be included in a new legal instrument of the Council of Europe.

The CDBI authorised the publication of the present document, the contents of which only constitute at this stage the result of the work of a group of experts. Consequently, the views contained in it do not necessarily reflect the final position of the CDBI, of the Committee of Ministers of the Council of Europe or of its member States.

The Council of Europe will directly consult organisations representative at European level on the present document. The national authorities, for their part, will organise consultations at national level.

In both cases, comments arising from these consultations must reach the Secretariat of the Council of Europe, in English or French, by the end of October 2000 at the latest.

Consideration of the problem could be structured round the following points:

1. The scope of application of the new legal instrument
2. The categories included in the concept of mental disorder
3. The criteria for the involuntary placement in a psychiatric establishment and for the involuntary treatment
4. The procedures for taking a decision of involuntary placement and of involuntary treatment
5. The procedures for involuntary placement and treatment in cases of emergency
6. Involuntary treatment –specific considerations
7. Special treatments
8. The involuntary placement and treatment of minors
9. The involvement of the police, courts and the prison system in the involuntary placement and treatment
10. Research on people suffering from mental disorder placed as involuntary patients in a psychiatric establishment
11. The human rights of people suffering from mental disorder, especially those placed as involuntary patients
12. The discrimination of people suffering from mental disorder
13. The termination of involuntary placement and treatment
14. The review of the lawfulness of the involuntary placement and treatment
15. The setting-up and monitoring of quality standards for the implementation of mental health legislation.

1. The scope of application of the new legal instrument

It is proposed that:

1. it should deal with both involuntary placement and involuntary treatment, whether or not the latter takes place in the context of the involuntary placement
2. involuntary placement should only take place for therapeutic reasons
3. unless otherwise stated, the new legal instrument should apply to involuntary placement and treatment decided upon in both civil and criminal matters.

Are these proposals acceptable and appropriate?

2. The categories included in the concept of mental disorder

1. In the course of its work, the Working Party noted that the definitions of mental disorder proposed by the World Health Organisation and the American Psychiatric Association specified no precise boundaries. It hence was of the opinion that mental disorders could not be classified with absolute precision and that the term "mental disorder" could cover mental illness, mental handicap and personality disorders (as regards mental handicap, it was noted that some countries used the concept of "learning disability").

2. In respect of personality disorders, account was taken of the judgement of the European Court of Human Rights in the Winterwerp case, which reads as follows "... Article 5.1 obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society."
3. However, it was suggested that involuntary placement or treatment should only be appropriate with regard to certain types of mental disorder, eg. some people suffering from psychoses or severe neuroses , certain types of personality disorder and in significant mental handicap. Persons with a mental handicap sometimes exhibit behaviour which is seriously aggressive and/or irresponsible. Such behaviour may or may not be associated with mental illness. In a situation where mental handicap is associated with mental illness, management of the situation occasionally requires the use of the legislation on involuntary placement and treatment. The term "significant mental handicap" has been used as a description of this disorder.
4. Involuntary placement should under no circumstances be used for political ends. (In this respect, reference could in particular be made to Recommendation No R (83)2 of the Committee of Ministers to member States on legal protection of persons suffering from mental disorder placed as involuntary patients, which states that " Difficulty in adapting to moral, social, political or other values, in itself, should not be considered a mental disorder.").

Are there categories which should be included in or excluded from the concept of "mental disorder" for the purposes of mental health legislation?

5. An alternative proposal to the use of mental disorder is to use the concept of mental incapacity whereby decisions are based on the ability of the individual, as determined by medical and other professional staff, to understand the nature of treatment or admission, weigh up the benefits of such, make a choice and communicate that choice.

Should the concept of mental incapacity be further developed for the purposes of mental health legislation?

3. The criteria for the involuntary placement in a psychiatric establishment and for involuntary treatment

The Working Party considered that deprivation of liberty occurring as a result of involuntary placement or administration of an involuntary treatment should always be accompanied by procedures to protect the rights of the person concerned.

It added that a distinction had to be made between the legal ground for involuntary placement and the legal ground for involuntary treatment. In other words, this means that the involuntary placement as such does not mean that the patient can in any event be treated against his/her will, nor that involuntary treatment should inevitably require involuntary placement.

Is a distinction between involuntary placement and treatment valid and meaningful?

It appeared appropriate to retain the view that even if the patient was admitted involuntarily, the presumption of competence to decide about his/her own treatment prevails, unless inability to decide on his/her own treatment was one of the legal criteria behind placement.

A number of criteria should be met before involuntary placement or treatment occurs:

- a. The existence of a mental disorder must be recognised or assessment required to determine whether a mental disorder is present

Should the grounds for detention for assessment in the absence of definite signs of a mental disorder be defined? If so, how?

- b. This mental disorder must represent

- i. a serious danger to the person concerned (including to his/her health) and/or
 - ii. a serious danger to other persons (provided that the placement or the treatment or both are likely to be beneficial to the person concerned in all cases).

Should proposals for determination and definition of the required level of dangerousness be included in legislation? Is the concept of 'risk' preferable to that of 'danger'?

Should the concept of benefit for the person concerned be further defined?

- c. The person in question is capable of consent and does not consent to the placement or treatment (the person is capable of consent but explicitly refuses or does not react) or the person is incapable of consent and refuses placement or treatment (it was underlined that involuntary placement or treatment could in particular be used in certain cases where, for instance, the person concerned does not persistently agree to the measure and may therefore change his/her mind frequently as to his/her agreement to placement or treatment).
- d. Means of giving the patient the appropriate care which is less restrictive than involuntary placement are not available. In this context, mention has been made of the alternatives to placement, which might include immediate access to the various forms of open care (eg. day hospitalisation, daily nursing support in the home, effective psychosocial treatments, social welfare assistance). Member States must ensure that measures are taken to make alternatives to placement as widely available as possible.

Given the serious nature of this legislation, should legislation specify certain alternatives which should always be available? If so, which?

Should deprivation of liberty in the criminal field be based on different/more criteria as the criteria described under a. to d. above?

4. The procedures for taking a decision of involuntary placement and of involuntary treatment

1. The procedures described below concern circumstances other than emergencies. The procedures in case of emergency are dealt with under the next heading.
2. In the course of its work, the Working Party expressed the opinion that it was necessary that:
the patient be examined by a psychiatrist or a medical doctor having the requisite experience and competence, in particular as regards risk assessment, in order for a decision on involuntary placement or extension of involuntary placement or for a decision on involuntary treatment or its extension to be taken.

the decision confirming involuntary placement or treatment should be taken by a relevant independent authority, which should base its decision on valid and reliable standards of medical expertise.

3. The Working Party had considered at length the notion of "relevant independent authority". In particular, it took into consideration Recommendation 1235 (1994) of the Parliamentary Assembly on psychiatry and human rights, which advocates that the decision of placement be taken by a judge. It was also informed that in several member States this decision could be taken by bodies other than courts. It noted that case-law of the European Court of Human Rights had never required the initial placement decision to be taken by a court or court-like body. In the opinion of the Working Party, the relevant question was the independence of the body or authority which takes the decision of placement, the independence of which could be verified by the fact that it was a different authority than the one which proposed the measure and by the fact that its decision was a sovereign decision not influenced by instructions from any source whatsoever. It was thus noted that, in some countries, the relevant authority may be a doctor authorised to take such a decision within a psychiatric establishment, for example, who should be independent in relation to the doctor who proposed the placement measure, in others, it may be a social worker or hospital manager, who may work alongside the doctor examining the patient for the purposes of involuntary placement. Furthermore, such an authority should ensure that social care aspects are duly taken into consideration.

What should be the characteristics of the 'relevant independent body'? Who might reasonably fulfil this role and who not?

4. Basing themselves in particular on Article 5, paragraph 2, of the European Convention on Human Rights and the case-law relating to it, the experts considered that the decision of involuntary placement should be taken promptly, be duly documented and state the duration of the said placement. They further considered that the patient should be informed promptly, regularly and appropriately of the reasons for the placement. Lastly, under this procedure, the patient should be able

to state their views and opinions on the placement and this should be taken into consideration by the relevant independent body.

5. When examining this question, the Working Party considered the view that the family and other people close to the patient should be consulted on involuntary placement or treatment and agreed that they should be consulted only if the patient consents, or if there are wider issues of public safety which mean that family members and other people close to the patient can be consulted without the patient's consent. Furthermore, information for the family and other people close to the patient about the reasons on which the involuntary placement or treatment are based should be given promptly and in an appropriate manner which, inter alia, enables the family and other close people to understand it. The Working Group are however aware that, in certain cases, the interests of the members of the family may not be those of the patient.

Should family members always be consulted about an individual patient's detention or about the patient's involuntary treatment? Should others 'close to the patient' take precedence over family members on any occasion?

6. Lastly, it considered that in the case of the involuntary placement or treatment of a person suffering from mental disorder having a legal representative nominated by the patient, the said representative should be informed and consulted, it being understood that it was up to the patient or his/her close family or friends to indicate the existence of such a representative to the relevant authority. It was further noted that, except in cases where the best interests of the person concerned so require (for example in cases where the person suffers from such a serious mental disorder that he/she needs a guardian), the assistance of a legal representative should not be compulsory.

5. The procedures for involuntary placement and treatment in cases of emergency

1. It would seem neither reasonable nor advisable, inter alia because of the immediate danger to the person concerned and/or others in an emergency situation – i.e. a situation in which an immediate danger to the person concerned and/or to others exist and where the opinion of a psychiatrist can not be obtained immediately- to always await the placement or treatment decision of the relevant independent authority. The Working Party has thus considered that, in an emergency situation, the involuntary placement and treatment can take place without the relevant independent authority having taken the decision but on the basis of a valid and reliable medical opinion following medical examination of the patient with a view to the placement and treatment. The Working Party nevertheless underlined that the emergency procedures should not be used with the aim to avoid applying normal procedures.
2. In these circumstances, the relevant independent authority should take a documented and formal decision on the involuntary placement and treatment as soon as possible, on the basis of a valid and reliable psychiatric opinion, after seeking the opinion of the person concerned. It also seemed advisable to consider

that, when taking its decision, the relevant authority should again also bear in mind the other possibilities offered by the community (day hospitalisation, effective psychosocial treatments, social welfare assistance, etc.), having regard to any change in the patient's state of health following the placement.

3. When adopting this position, the experts based themselves in particular on the case-law of the European Convention on Human Rights, which requires no prior decision by the relevant authority in an emergency situation. Indeed, the judgement of the European Court of Human Rights of 5 November 1981 in the X. v. United Kingdom case states in particular the following: " ... the Winterwerp judgement expressly identified 'emergency cases' as constituting an exception to the principle that the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'..."

Are there any other necessary safeguards relating to emergency situations?

6. Involuntary treatment - specific considerations

1. The Working Party approved as a fundamental principle that treatment must in all cases be administered for the benefit of the patient. Treatment should always be applied in response to a recognised clinical symptom, have a therapeutic aim and be likely to entail a real clinical benefit and not only an effect on the administrative, criminal, family or other situation of the patient (Although it was considered that it was important to take into consideration the social situation of the person concerned, it was underlined that the latter did not constitute the first priority. Hence, treatment should have no other aim than the treatment of the symptom. It must correspond to a medical need rather than to a social, family or economic need. It was also underlined that emphasis should be put on therapeutic intent rather than on prior evidence of efficacy of the treatment.)
2. Furthermore, when a person is placed involuntarily, his/her ability to consent should be verified for every form and course of treatment envisaged.
3. The representative of a person should be consulted but where he/she refuses consent to treatment for the person concerned, it should be possible to approach a court or court-like body with the power to respect or overturn the decision of the representative.
4. The Working Party was also of the opinion that a written scheme of involuntary treatment must be drawn up, if possible, in consultation with the patient, his or her representative or, where there was no representative, submitted to an independent authority for decision. The scheme should be reviewed regularly and open to modification at all times in consultation with the patient, his or her representative or an independent authority, as appropriate. Should the patient not consent to the said scheme, he or she should be able to appeal to a court or court-like body.
5. Lastly, written report should be drawn up for each involuntary course of treatment, without the implementation of this procedure however generating too much bureaucracy, and the treatment should always be adapted to the patient. In particular, the involuntary treatment should always be proportionate to the patient's state of health and aim, where appropriate, at administering as soon as possible a treatment

agreed by the patient. It was considered that only officially recognised pharmaceutical products should be used involuntarily and that in view of the extensive, and frequently excessive, use of medication, side effects and dosage regimes should be carefully monitored such that doses could be reduced as soon as therapeutically appropriate. Furthermore, importance should also be accorded to the provision of group therapy, psychotherapy, music therapy, theatre, sport activities, etc., and opportunities for daily physical exercise. Lastly, education was considered to be an important component of daily living activities.

6. When because of an emergency situation the appropriate consent cannot be obtained, the Working Party, on the basis of the relevant provisions of the Convention on Human Rights and Biomedicine, considered that any medically necessary intervention may be carried out immediately.
7. It would be useful that the addressees of the present document indicate the measures which, from their point of view, should not be included in the concept of involuntary treatment.

7. Special treatments

1. These treatments remain controversial. Although it already reached a number of provisional conclusions on this matter, the Working Party would wish to know the views of the addressees of the present document on the subject.
2. Research into electroconvulsive therapy has shown it to be effective in cases of depressive illness, for example. Electroconvulsive therapy is now administered in conjunction with an anaesthetic and muscle relaxants; the use of non modified electroconvulsive therapy should be strictly prohibited. In severe depressive illness, emergency administration in the absence or, rarely, against a patient's consent may be warranted because of the severity of the illness and lack of effective alternatives. Electroconvulsive therapy should be administered in circumstances in which the dignity of the patient is always fully respected.
3. However, the effectiveness of psychosurgery has not been established by appropriate controlled research. Thus, where States continue to sanction the use of it, the consent of the patient should be an absolute prerequisite for its use. Furthermore, the decision to use psychosurgery should in every case be confirmed by a committee which is not exclusively composed of psychiatric experts. The Working Party considered that in each member State the legislators should establish special protocols for the administration of psychosurgery. In so far as there is no clear proof of the effectiveness of psychosurgery, countries which still permit its use should introduce a system for recording full information about any operations carried out. It was also thought that there should be vigilance in regard to the use of hormone implants to alter sexual drive.

What further safeguards are necessary for the administration of:

a. ECT?

b. Psychosurgery?

c. Hormone implants?

4. Lastly, no circumstances could be envisaged in which psychosurgery for mental disorder could have any beneficial effects for minors. The addressees of the present document might also wish to express their views on this last point.

8. The involuntary placement and treatment of minors

1. During its discussions, the Working Party considered that protection measures for minors should be more stringent than those for adults. The conditions and safeguards relating to involuntary placement and treatment of adults should also apply to minors to the same extent at the very least.
2. Minors may not be able to defend their own interests, and so in all cases, the assistance of a representative from the beginning of the procedure should be available. Such representation should not necessarily be undertaken by a lawyer, but for example, a family member – providing there is no conflict of interest with the minor – or a social worker.
3. On the basis of the relevant provisions of the Convention on Human Rights and Biomedicine, the Working Party furthermore felt, as regards the consent of minors to a treatment, that the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.
4. As regards more particularly the living conditions of minors subject to involuntary placement, it has been considered that they should be treated and reside in separate premises from those in which adults reside, unless this is against the interest of the minor concerned. This concerns, for example, some exceptional cases in which it might be in the ‘older’ minor's best interest to reside in an adult unit close to home - thus promoting contact with the family - rather than in a paediatric unit a long way from home. Furthermore, the Working Party felt that the new legal instrument being prepared should specify that any minor suffering from mental disorder and placed as an involuntary patient in a psychiatric establishment shall have the right to a public education. In particular, every minor shall be individually evaluated and receive, if possible, an individualised educational or training programme, it being understood that teaching shall be organised by the relevant education departments in consultation with the management of the psychiatric establishment. Reintegration of minors into the general school system should be fully taken into account as soon as it seems appropriate.

Are there other questions and comments as regards involuntary placement and treatment of minors?

9. The involuntary placement and treatment involving the police, courts and the prison system

1. During its work, the Working Party found it necessary to include in the legal instrument being prepared a number of provisions more specifically devoted to the question of the involuntary placement and treatment involving the police, courts and the prison system. During its discussion on this item, it gave particular importance to the views expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which, as

authorised by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment of 1987, makes numerous visits to places where people are deprived of their liberty, in particular prisons and psychiatric establishments, in States Parties to the Convention.

Police

2. The Working Party was of the opinion that the police are the guarantor for the respect of the security of persons and for public order. They should have powers to intervene in situations where the behaviour of a person with mental disorder or reasonably suspected of having mental disorder represents a serious danger for himself/herself or others according to national law. The intervention may include arrest or entry into premises according to national law.
3. It further considered that the police must coordinate interventions with other services- medical or social- in public or private areas with respect to the dignity of the person concerned. This should occur as far as possible with the co-operation and consent of the person concerned. Where arrest is necessary, it must be done by the police with respect for the dignity of the person concerned. Consideration should be given by arresting officers to the vulnerability of persons suffering from mental disorder during police investigation and detention in police stations. Where such arrest has occurred, a medical examination must be done promptly at the site of the incident or a hospital or a police station as appropriate. The medical examination should determine whether the person requires psychiatric care and if so include medical and psychiatric assessment. The medical doctor should determine whether the person can safely remain in the police station and if he/she requires specialist psychiatric care. If an offence is suspected, this should be dealt with promptly, in accordance with Article 5, paragraph 3, of the European Convention on Human Rights. This medical examination should include the assessment of the capacity of the person concerned to reply to the questions raised during the investigation, in accordance with the provisions of Article 5 of the European Convention on Human Rights, and in particular of paragraph 2 thereof which provides that everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
4. Furthermore, the CDBI-PH was of the opinion that the police, within the framework of its general mission, i.e. to be the guarantor for the respect of the security of persons and for public order, may be required to assist in conveying or returning patients subject to involuntary detention to hospital or other care facilities.
5. Lastly, it considered that appropriate training should be given to members of the police as regards assessing and managing situations involving people suffering from mental disorder. Such training should be provided in consultation with local health services and include basic guidance on recognition and management of people suspected of having a mental disorder with regard to relevant legislation.

Courts and prisons

6. The CDBI-PH was of the opinion that criteria under criminal law should follow the same as those applied in civil law with the following exceptions:
 - Consent may be given by the person concerned to placement or treatment but court may nevertheless impose placement or treatment;
 - Restrictions may be placed on termination of placement or treatment by the psychiatrist in charge of the care of the person and/or the independent authority, it being understood that, as with civil proceedings, termination of placement or treatment should occur when criteria are no longer met. Furthermore, the individual may request review of the legality of his placement or treatment and *ex officio* review should occur where they do not .
7. The Working Party also felt that courts and court-like bodies should be able to sentence a person to placement (in a medically appropriate place), and/or treatment or discharge with or without conditions on the basis of expert opinion.
8. The CDBI-PH considered that, in sentencing, the courts should take into consideration the fact that people with mental disorders should be treated in a medically appropriate place. Furthermore, transfers between prison and hospital should occur where necessary for assessment and/or treatment to occur.
9. It was also noted that people with mental disorders may be treated in the community, normal prison facilities or psychiatric establishments, both civil and secure (outside prison or in specialised prison facilities subject to Recommendation No R (98)7 of the Committee of Ministers to member States concerning the ethical and organisational aspects of health care in prison(paragraph 55 of the Appendix thereof)). The indications for treating in different settings include the severity of the mental disorder or its treatability. Substance abuse (of alcohol and/or drugs) or personality disorder may be considered treatable in any of the above settings, but this will be dependent on expert psychiatric opinion following examination of the individual concerned. A prisoner (or his/her legal representative) who considers that the care given in prison is inappropriate to his/her condition or who considers that his/her condition is incompatible with a prison environment should be able to request an expert opinion on his condition. If his/her transfer is denied, an effective appeal system should be made available.
10. As regards prison care facilities, the Working Party considered that medical confidentiality should be guaranteed and respected with the same rigour as in the population as a whole. It also felt that prison should not be authorised to take people who are subject to involuntary placement or treatment under the mental health legislation, except where specially designated hospital units exist. When such units exist within a prison, the national monitoring body should be responsible for their registration and monitoring. Such units should be located in separate prison premises and not under the direction of prison authorities.
11. Lastly, the CDBI-PH was of the opinion that member States should ensure that sufficient provision is made of a range of hospital accommodation with the appropriate levels of security and community-based forensic psychiatric services. In this respect, it

was underlined that many countries have people with mental disorders detained in prisons who require treatment in hospital. The failure to transfer them may involve failure to identify them within the prison population but also insufficient or inappropriate secure hospital accommodation or the reluctance of local mental health services to accept them. The Working Party therefore felt that Member States should put into place mechanisms to overcome these infringements of individuals' human rights.

Are there particular considerations that the Working Party should make with regard to the way in which the police, courts and prisons deal with people with mental disorders?

10. Research on people suffering from mental disorder placed as involuntary patients in a psychiatric establishment

The Working Party on biomedical research of the Steering Committee on Bioethics is currently preparing a draft Protocol to the Convention on Human Rights and Biomedicine, on the subject of biomedical research, and considers, amongst others, the issue of research on persons deprived of their liberty. The Working Party on Psychiatry and Human Rights shall follow the work of this Working Party and examine the text to be drafted on the topic of research on persons deprived of their liberty.

11. The human rights of people suffering from mental disorder, in particular those placed as involuntary patients

1. The Working Party felt that every person suffering from mental disorder should retain those civil and political rights for which he/she has capacity to make decisions ; in addition, the experts thought that when the patient had no capacity to make decisions, suitable provisions should be made to have his/her affairs managed in his/her best interest. Furthermore, every person suffering from mental disorder should have the right, to the extent possible, to live and work in the community (in particular, the person concerned should not automatically be deprived of the right to vote or to make a will, and he or she, whenever possible, should be enabled to enter into legally effective transactions of an everyday nature)..

Are there other considerations that should be made as regards the civil and political rights of people suffering from mental disorder?

2. The environment and living conditions of a person suffering from mental disorder in mental health facilities should be as close as possible, bearing in mind his or her state of health and in accordance with national legislation, to those of the normal life of persons of similar age and culture, and in particular should include vocational rehabilitation measures to promote reintegration in the community. A number of factors which can create a positive therapeutic environment for persons placed as involuntary patients in a psychiatric establishment have been stressed, such as, for example, sufficient living space per patient as well as adequate lighting, heating and ventilation, the provision of bedside tables and wardrobes, individualisation of clothing, to avoid the use of large-capacity dormitories depriving patients of all privacy.

3. The Working Party also considered that as soon as the patient's health permits, he or she should be transferred to a less restrictive care facility.
4. Furthermore, the treatment and care of the patient should be based on an individually prescribed scheme, discussed with the patient, reviewed regularly, revised as necessary, and provided by adequately qualified staff (in this respect, it was thought that staff qualifications should be registered with professional bodies and staff, themselves , should participate in programmes providing continuing professional development). Except under exceptional circumstances, i.e. in the interests of public safety or as agreed for the purposes of medical research (see section 10 above), information on the patient's health, including medical data, should remain confidential (in this respect, reference was made to Article 8 of the European Convention on Human Rights which enshrines the respect for people's private lives , to Article 10 of the Convention on Human Rights and Biomedicine which states that "Everyone has the right to respect for private life in relation to information about his or her health" and to the Appendix to Recommendation No R (97) 5 of the Committee of Ministers to member States on the protection of medical data, and in particular principles 3 and 7). It was also considered that, with due respect to the above-mentioned instruments, relevant medical information on the patient's health, including medical data, could be transmitted to the medical doctor or appropriate health and social care workers who may request it.
5. The Working Party also examined the issue of the means of physical restraint and of seclusion. It considered that the use of short periods of physical restraint and of seclusion should be in due proportion to the benefits and the risks entailed. Thorough training in techniques of physical restraint should be provided to staff. In this context, it was underlined that the response to violent behaviour by the patient should be graduated, ie that staff should initially attempt to respond verbally; thereafter, only in so far as required, by means of manual restraint; and only in a last resort by mechanical restraint. It was also underlined that physical restraint must always be used within the framework of the treatment. In other words, when it is used, physical restraint should be seen as being a part of the treatment.
6. It was furthermore felt that seclusion and mechanical or other means of restraint for prolonged periods should be resorted to only in exceptional cases and where there is no other means of remedying the situation; furthermore, such measures should be used only on the express order or under the supervision of a medical doctor or immediately brought to the knowledge of a medical doctor for approval; the reasons and duration of these measures should be mentioned in a proper register and in the patient's personal file.

What safeguards should be provided to govern restraint or seclusion of patients?

7. The Working Party also examined the question of the temporary and permanent infringement of individual's capacities to procreate and considered that, should this issue be mentioned in the new legal instrument being prepared, it would be appropriate that the Recommendation provide that except in the most exceptional cases, there must be no permanent infringement of an individual's capacities to procreate without the individual's consent. Furthermore, the permanent infringement of an individual's capacities to procreate should always take place in the best interest of

the person concerned; in other words, the clinical aim of such an infringement should always be the protection of the person concerned. It should then certainly be appropriate to specify that the mere fact that a person suffers from a mental disorder does not constitute a sufficient reason for causing permanent infringement to that person's capacities to procreate. Where permanent infringement of individual's capacities to procreate is envisaged, the matter should be examined by a court or court-like body.

Are there exceptional circumstances permitting permanent infringement of procreation capacities of people suffering from mental disorder? If so, what are these circumstances?

Should the exceptional circumstances where permanent infringement of procreation is deemed permissible be specified?

What safeguards should exist to ensure that permanent infringement of procreation capacities only occurs in exceptional circumstances?

8. The Working Party expressed the opinion that the right of the person suffering from mental disorder and placed as an involuntary patient in a psychiatric establishment to correspond with any appropriate authority, his or her representative and his or her lawyer cannot be restricted. In this respect, it was specified that no restrictions on correspondence with the lawyer or the appropriate authority, including the European Court of Human Rights or the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) would ever be necessary or appropriate.
9. As regards the right of the patient to communicate with persons other than those referred to above, it has been considered that it should not be unreasonably affected. It was pointed out, however, that in certain cases and in compliance with the relevant provisions of the house rules of the psychiatric establishment concerned, it might prove necessary to restrict these rights where failure to do so could be harmful to the patient's health or future prospects or to the rights and freedoms of other people (for example, repeated unpleasant telephone calls or letters, suspicion of drug-trafficking; another example might be where someone affected by manic depression writes and intends to send a letter of resignation to their employer). It was also underlined that measures such as searching of patients and their rooms, random urine drug tests and listening to patients' phone calls should be applied in compliance with the house rules of the psychiatric establishment concerned.

What circumstances would justify restriction of the right to communicate? What safeguards should exist to protect this right?

10. The Working Party furthermore felt that in this field special rules could be established for persons in involuntary placement, provided that these rules were not in contradiction with the provisions of Article 8, paragraph 2, of the European Convention on Human Rights which deals with the issue of the respect for private and family life.
11. With regard to communication from outside, it was stressed that nothing should hamper communication between the outside and the psychiatric establishment on

the one hand or the patient's right to receive information from outside on the other hand.

12. Lastly, the Working Party was of the opinion that the freedom of the persons suffering from mental disorder and placed as involuntary patients in a psychiatric establishment to receive visits should not be unreasonably restricted. However, due consideration should be taken of the protection of vulnerable patients or minors placed in or visiting a psychiatric establishment who might be exploited during visits and of the existence of limited visiting rights for certain patients and in certain care facilities. It was felt that the freedom of the patient to communicate with visitors should be exercised in keeping with the house rules of the establishment concerned and that in this respect no distinction should be made between psychiatric establishments and other hospital establishments.
13. The Working Party was also of the opinion that the protection of patients' situation should be ensured pursuant to the national legislations of member States. In this framework, it was underlined that when a person suffered from mental disorder, he/she might endanger his/her future economic situation. National legislations of member States should consequently provide measures aiming at guaranteeing and protecting the economic situation of people suffering from mental disorder, e.g. through guardianship or other appropriate means . National legislations of member States should also make available measures to protect the interests of people suffering from mental disorder as regards their future situation in the field of employment and family life.

12. **Discrimination against people suffering from mental disorder**

When considering this problem, the experts felt that member States should take measures to eliminate discrimination against people suffering from mental disorder, including within health services.. Member States should also encourage the holding of campaigns aiming at increasing the awareness of the public about discrimination against people suffering from mental disorder. Here the importance of Article 14 of the European Convention on Human Rights (prohibition of discrimination) and of the case-law of the European Court of Human Rights were stressed. Certain examples have been highlighted by the experts, in particular the incorrect and stigmatising use of terms such as schizophrenia in the media, discriminatory practices concerning employment of patients or former patients, discriminatory practices concerning assurance, less financial and technical means in favour of psychiatric establishments or services of general hospitals where people suffering from mental disorder are treated, etc.. .. Furthermore, member States should more specifically draw the attention of governments and relevant public and State institutions to the role of the State in promoting mental health and improving and maintaining the treatment and life quality of people suffering from mental disorder.

What concrete measures should member States be expected to take to reduce discrimination?

13. **The termination of involuntary placement and treatment**

1. The Working Party felt that involuntary placement or treatment should be terminated when criteria for involuntary placement or treatment are no longer met; the medical

doctor, the establishment and the independent authority should have the competence to put an end to the involuntary placement in view of the criteria mentioned under point 3. above. It was underlined that the psychiatrist in charge of the care of the patient should be responsible for assessing whether the patient still meets the criteria for involuntary placement or treatment.

2. As regards after-care of those who have been subject to involuntary placement, the experts considered that appropriate after-care provision should be put in place by member States, linking hospital and community services, inter alia, to ensure that termination of involuntary placement occurs as soon as possible and to avoid, as far as is reasonable, resorting to the involuntary placement of the person concerned in the future. But they felt that the lack of such services outside the establishment should not in itself be sufficient reason to prolong detention.

14. The review of the lawfulness of the involuntary placement and treatment

1. The Working Party considered that patients should be able to request at reasonable intervals the review of the lawfulness of involuntary placement or treatment by a court or court-like body; the court or court-like body, pursuant to Articles 5 and 6 of the European Convention on Human Rights and the case-law of the European Court of Human Rights thereon, should decide as soon as possible and use adversarial procedure; if a patient does not request the review of the lawfulness of the involuntary placement or treatment, an ex officio review of the lawfulness by the independent authority (preferably a court or court-like body) should take place at regular and reasonable intervals; furthermore, in the proceedings following the request to a court or court-like body the person placed or treated as an involuntary patient should have the right to be heard either in person or, where necessary, through a representative.
2. The experts felt that where appropriate, the person placed or treated as an involuntary patient should have the right to have legal counsel if he/she is not fully capable of acting for himself/herself, without the need himself/herself to take the initiative in obtaining legal counsel. Free legal aid should be available for the providing of legal counsel, according to national law.
3. Consideration should be given to providing legal counsel automatically in all procedures before a court or court-like body with regard to involuntary placement and treatment.
4. It would be appropriate that the person placed or treated as an involuntary patient or his representative have access to all the materials before the court or court-like body, and have the right to challenge the evidences before the court or court-like body. Furthermore, it was thought that the patient's treating doctor should be informed of the proceedings brought before the court or court-like body and of his right to participate in them.
5. The judicial review by a court or court-like body should ensure the lawfulness of the procedure followed throughout and check whether the criteria for involuntary placement or treatment continue to be met. The court or court-like body should have full knowledge of the factual and legal elements and should be able to freely review the decision taken by the relevant independent authority.

Are these review arrangements appropriate? Should lay persons be entitled to participate in the proceedings before the court or court-like body?

6. Furthermore, the court or court-like body should give its decision speedily, after the moment when the application for release or termination of treatment was lodged ,should identify any violations of national legislation in force in the field of involuntary placement and treatment and send these to the relevant body ; it was underlined, in particular, that if the relevant body finds that placement or treatment was made in contravention of the legislative provisions in force, the person concerned should have the right to compensation as provided for in Article 5. paragraph 5 of the European Convention on Human Rights which states: “Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.”.
7. It was also thought that in the case of a person subject to both involuntary placement and treatment, the review of the involuntary placement and treatment should occur at the same time.
8. Lastly, the Working Party considered whether a right of appeal against the court or court-like body should be considered..

Should an appeals process be established and, if so, what form should it take?

15. The setting-up and monitoring of quality standards for the implementation of mental health legislation

1. In the framework of the consideration of this question, the Working Party considered that the systems for the setting-up and monitoring of quality standards for the implementation of mental health legislation should:
 - a. be provided with sufficient financial and human resources to perform their tasks;
 - b. be organisationally independent from the management of the Mental Health Services or premises which are being monitored;
 - c. be co-ordinated between themselves and with other audits and quality assurance services;

In addition, professionals, both psychiatrists and non-psychiatrists, as well as lay-persons and users should be involved in the system for the setting up and monitoring of quality standards for the implementation of mental health legislation.
2. Furthermore, the experts were of the opinion that arrangements for the setting-up and monitoring of quality standards should include:
 - a. ensuring that persons with mental disorders are not detained in premises which are not registered by the appropriate authority;
 - b. notifying to the appropriate authority the death of persons subject to involuntary placement or treatment; ensuring that powers exist to order an investigation into the

death of a patient and that an independent investigation of the local mental health services into the death of the person concerned has occurred;

c. visiting and inspecting such premises to establish their suitability for the care of patients with mental disorder, at any time and, where deemed necessary, without prior notice;

d. users of services should be involved in visiting and inspecting local Mental Health Services to establish that suitable alternatives to detention in hospital are provided for the care of patients with mental disorder;

e. the managers of the mental health services or premises and staff who treat, nurse or care for those persons subject to mental health legislation provide any information required in so far as this may reasonably be deemed necessary for the purposes of setting-up and monitoring quality standards;

f. meeting privately with patients subject to provisions of Mental Health legislation and accessing their medical and clinical file at any time;

g. receiving complaints confidentially from any such patients and ensuring that local complaints procedures are in place and that complaints are appropriately replied to;

h. reviewing situations in which restrictions to communication have been applied;

i. ensuring that relevant professional obligations and standards are met, in accordance with article 4. of the Convention on Human Rights and Biomedicine and the relevant paragraphs of its explanatory report (articles 28 to 32);

j. ensuring that statistical information on the use of Mental Health legislation and complaints is collected reliably and systematically;

k. providing a report regularly (usually annually) to those, up to and including the Minister, responsible for the care of patients with mental disorder, who should consider publishing the report; in case the report itself is not published, information should nevertheless be given to the general public by the chief official of the State on such matters as the mental health of the society, activities for improving the life quality of people suffering from mental disorder and the conditions of their treatment.

l. advising those, up to and including the Minister, responsible for the care of patients with mental disorder, on the conditions and facilities appropriate for such care;

m. ensuring that those, up to and including the Minister, responsible for the care of patients with mental disorder, respond to questions raised during the visits and, at a later stage, to advice and reports arising from the arrangements for the setting-up and monitoring of quality standards. The arrangements for the setting-up of quality standards should ensure that follow-up action is taken.

What monitoring arrangements would be appropriate? Are the arrangements proposed likely to be effective and sufficient for this task?

Are there other fields of interest to you and on which you would like to make comments?

Conclusion

The CDBI-PH will continue its work on the subject, in the light in particular of the views expressed by the addressees of the present document. It is foreseen that it will submit a preliminary draft Recommendation to the CDBI in 2001. The text thus approved by the CDBI will be presented by the CDBI in the form of a draft Recommendation to the Committee of Ministers of the Council of Europe, with a view to its adoption.

APPENDIX 1**GLOSSARY**

ADVERSARIAL PROCEDURE: Means that no one can be judged without having been heard by the court or called before it. The provisions of Article 6 of the European Convention on Human Rights could be used as guidelines in this context.

COURT OR COURT-LIKE BODY (TRIBUNAL): Article 6 of the European Convention on Human Rights refers to "an independent and impartial tribunal established by law". The "right to a court" can be seen to have three elements to it. There must be a "tribunal" established by law and meeting the requirements of independence and impartiality; it must have sufficiently broad jurisdiction to determine all aspects of the dispute or charge to which Article 6 applies; the individual concerned must have access to the tribunal. According to the European Court of Human Rights, the "tribunal" is characterised by the fact that it is a body with a judicial function, namely determining matters within its competence on the basis of rules of law and after proceedings conducted in a prescribed manner. It must have power to give a binding decision on the matter before it.

DANGER: Danger can be interpreted as the chance that damage will occur

INVOLUNTARY PLACEMENT: Involuntary placement means the admission and detention for treatment of a person suffering from mental disorder in a hospital, other medical establishment or appropriate place, it being understood that the person in question is capable of consent and does not consent to the placement or the person in question is incapable of consent and refuses placement.

INVOLUNTARY TREATMENT: This term covers the management of a person suffering from mental disorder and any intervention- whether of a physical, psychological or social nature- having a therapeutic aim, it being understood that the person in question is capable of consent and does not consent to the treatment or the person in question is incapable of consent and refuses treatment.

MEDICAL DOCTOR HAVING THE REQUISITE EXPERIENCE AND COMPETENCE: Medical doctor who is not necessarily a psychiatrist , as this may well be the case in emergency situations, but who has sufficient experience to deal with the medical and administrative issues raised in the case of involuntary placement or treatment.

MENTAL DISORDER: This term covers mental illness, mental handicap (or learning disability) and personality disorders.

MENTAL INCAPACITY: Concept whereby decisions are based on the ability of the individuals, as determined by medical and other professional staff, to understand the

nature of treatment or admission, weigh up the benefits of such, make a choice and communicate that choice

PSYCHIATRIST: Medical doctor with special expertise in assessment , diagnosis and treatment of mental disorder

REASONABLE TIME: Whether the period in question is "reasonable" depends on the particular circumstances. Account must be taken of the complexity of the case and the conduct of the applicant and the authorities.

RELEVANT INDEPENDENT AUTHORITY: This term covers either a court or court-like body, or another independent authority. The independence of the authority is verified by the fact that it is a different authority than the one which proposes the measure and by the fact that its decision is a sovereign decision not influenced by instructions from any source whatsoever.

TREATMENT: This term covers the management of a person suffering from mental disorder and any intervention- whether of a physical, psychological or social nature- having a therapeutic aim.

APPENDIX 2

RECOMMENDATION No. R (83) 2 CONCERNING THE LEGAL PROTECTION OF PERSONS SUFFERING FROM MENTAL DISORDER PLACED AS INVOLUNTARY PATIENTS³

(Adopted by the Committee of Ministers on 22 February 1983 at the 356th meeting of the Ministers' Deputies)

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members, in particular through harmonising the laws on matters of common interest;

Having regard to the Convention for the Protection of Human Rights and Fundamental Freedoms and to its application by the organs established under that convention;

Having regard to Recommendation 818 (1977) of the Consultative Assembly of the Council of Europe on the situation of the mentally ill;

Considering that common action at European level will promote the desired better protection of persons suffering from mental disorder,

Recommends that the governments of the member states should adapt their laws to the rules annexed to this recommendation or adopt provisions in accordance with those rules when introducing new legislation.

³ When this recommendation was adopted and in application of Article 10.2.c of the Rules of Procedure for the meetings of the Ministers' Deputies, the Representatives of the following member states reserved the right of their governments to comply or not with the provisions indicated below of the rules appended hereto :

The Federal Republic of Germany: Articles 3.a and 6.b;

Ireland: Articles 4.2 last sentence and 3 last sentence, and 9.2;

Liechtenstein: Articles 4.2 last sentence and 3 first sentence, and 6.b;

The Netherlands: Articles 3.a, 4.4 and 6;

Sweden: Article 6.b

Switzerland: Articles 4.1 last sentence, final phrase, and 2 last sentence, and 6.b;

The United Kingdom: Articles 4.2 last sentence and 3 last sentence, and 6.b.

Rules

Article 1

1. These rules concern the involuntary placement of persons suffering from mental disorder. Placement decided pursuant to criminal proceedings is not covered by these rules; however, Rules 5,9,10 and 11 apply to such a placement.
2. Involuntary placement (hereinafter referred to as "placement") means the admission and detention for treatment of a person suffering from mental disorder (hereinafter referred to as "patient") in a hospital, other medical establishment or appropriate place (hereinafter referred to as "establishment"), the placement not being at his own request.
3. The admission of a patient to an establishment for treatment at his own request does not fall within the field of application of these rules. However, these rules apply to cases where a patient who has originally been admitted at his own request is to be detained in an establishment in spite of his wish to be discharged.

Article 2

Psychiatrists and other doctors, in determining whether a person is suffering from a mental disorder and requires placement, should do so in accordance with medical science. Difficulty in adapting to moral, social, political or other values, in itself, should not be considered a mental disorder.

Article 3

In the absence of any other means of giving the appropriate treatment:

- a. a patient may be placed in an establishment only when, by reason of his mental disorder, he represents a serious danger to himself or to other persons;
- b. states may, however, provide that a patient may also be placed when, because of the serious nature of his mental disorder, the absence of placement would lead to a deterioration of his disorder or prevent the appropriate treatment being given to him.

Article 4

1. A decision for placement should be taken by a judicial or any other appropriate authority prescribed by law. In an emergency, a patient may be admitted and retained at once in an establishment on the decision of a doctor who should thereupon immediately inform the competent judicial or other authority which should make its decision. Any decision of the competent judicial or other authority mentioned in this paragraph should be taken on medical advice and under a simple and speedy procedure.

2. Where a decision for placement is taken by a non-judicial body or person, that body or person should be different from that which originally requested or recommended placement. The patient should immediately be informed of his rights and should have the right of appeal to a court which should decide under a simple and speedy procedure. Moreover, a person whose duty it is to assist the patient to decide whether to appeal should be designated by an appropriate authority, without prejudice to the right of appeal of any other interested person.
3. When the decision is taken by a judicial authority or when an appeal is made before a judicial authority against the decision of placement by an administrative body, the patient should be informed of his rights and should have the effective opportunity to be heard personally by a judge except where the judge, having regard to the patient's state of health, decides to hear him through sole form of representation. He should be informed of his right to appeal against the decision ordering or confirming the placement and, if he requests it or the judge considers that it would be appropriate, have the benefit of the assistance of a counsel or of another person.
4. The judicial decisions referred to in paragraph 3 should be open to appeal.

Article 5

1. A patient put under placement has a right to be treated under the same ethical and scientific conditions as any other sick person and under comparable environmental conditions. In particular, he has the right to receive appropriate treatment and care.
2. A treatment which is not yet generally recognised by medical science or presents a serious risk of causing permanent brain damage or adversely altering the personality of the patient may be given only if the doctor considers it indispensable and if the patient, after being informed, has given his express consent. If the patient is not capable of understanding the nature of the treatment, the doctor should submit the matter for decision to an appropriate independent authority prescribed by law which should consult the patient's legal representative, if any.
3. Clinical trials of products and therapies not having a psychiatric therapeutic purpose on persons suffering from mental disorder, subject to placement, should be forbidden. Clinical trials having a psychiatric therapeutic purpose are a matter for national legal provisions.

Article 6

The restrictions on the personal freedom of the patient should be limited only to those which are necessary because of his state of health and for the success of the treatment; however, the right of a patient:

- a. to communicate with any appropriate authority, the person mentioned in Article 4 and a lawyer, and
- b. to send any letter unopened,

should not be restricted.

Article 7

A patient should not be transferred from one establishment to another unless his therapeutical interest and, as far as possible, his wishes are taken into account.

Article 8

1. A placement should be for a limited period or, at least, the necessity for placement should be examined at regular intervals. The patient can request that the necessity for placement should be considered by a judicial authority at reasonable intervals. The rules in Article 4, paragraph 3, apply.
2. The placement may be terminated at any moment on the decision:
 - a. of a doctor, or
 - b. of a competent authority,acting on his own initiative or at the request of the patient or any other interested person.
3. The termination of the placement does not necessarily imply the end of treatment which may continue on a voluntary basis.

Article 9

1. The placement, by itself, cannot constitute, by operation of law, a reason for the restriction of the legal capacity of the patient.
2. However, the authority deciding a placement should see, if necessary, that adequate measures are taken in order to protect the material interests of the patient.

Article 10

In all circumstances, the patient's dignity should be respected and adequate measures to protect his health taken.

Article 11

These rules do not limit the possibility for a member state to adopt provisions granting a wider measure of legal protection to persons suffering from mental disorder subject to placement.

EXPLANATORY MEMORANDUM

I. General considerations

1. In 1977, the Parliamentary Assembly of the Council of Europe adopted its Recommendation 818 (1977) on the situation of the mentally ill. This Recommendation, *inter alia*, underlined the need for better legal protection of the mentally ill, especially those who are subject to measures relating to involuntary placement.
2. On the proposal of the European Committee on Legal Co-operation (CDCJ), the Committee of Ministers asked a committee of experts responsible to the CDCJ to study a number of problems in the field of medical law with a view to identifying specific issues lending themselves to legislative harmonisation at European level. The committee met in the spring of 1979 and proposed, among other subjects, the question of the legal protection of the mentally ill. The CDCJ, aware of the fact that the *Winterwerp* case had entered its final phase before the European Court of Human Rights, recommended to the Committee of Ministers that, among other legal matters in the medical field, priority should be given to the legal protection of the mentally ill and a committee of experts should be entrusted with the task of preparing an international legal instrument.
3. The Committee of Experts on Legal Problems in the Medical Field held four meetings at which it proposed a draft recommendation. The opinion of the European Public Health Committee (CDSP) was sought on the text, which was then revised by the CDCJ and adopted by the Committee of Ministers on 22 February 1983 as Recommendation No. R (83) 2.

II. Comment on the Recommendation

4. The problem of the legal protection of the mentally ill raises a series of human rights issues relevant to several articles of the European Convention for the Protection of Human Rights and Fundamental Freedoms (particularly Articles 3, 5, 6 and 8). The case-law of the organs established under the convention is developing. Among the relevant decisions in this field two in particular should be mentioned.
5. The European Court of Human Rights delivered judgment in the *Winterwerp* case on 24 October 1979. The Court, interpreting paragraph 4 of Article 5⁴ of the convention in the case before it, *inter alia*, stated:

“ ... it is essential that the person concerned (mentally ill patient who undergoes involuntary placement) should have access to a court and the opportunity to be heard either in person or, where necessary, through some form

⁴ "4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

of representation..." (see paragraph 60 of the *Winterwerp* judgment of the European Court of Human Rights).

In its judgment, the Court made it clear that it was a requirement of the European Convention on Human Rights that the mentally ill person concerned had a right of access to a court. A careful study of the *Winterwerp* judgment was made and special attention was given to this conclusion when the recommendation was prepared.

6. On 5 November 1981 the Court, in the case *X against the United Kingdom*, decided, *inter alia*, that there was a breach of Article 5, paragraph 4, of the convention. The Court found that, although *X* had access to a court which ruled that his detention was "lawful" in terms of English law, a judicial review as limited as that available in the *habeas corpus* procedure, while adequate for emergency measures for the detention of persons on the grounds of unsoundness of mind, was not sufficient for a continuing confinement such as the one undergone by *X* until 1976.
7. These judgments were taken into consideration and it was also noted with particular interest that in all member states there was a wish to improve the treatment and legal protection of persons suffering from mental disorder who are subject to involuntary placement. It was considered that this wish, apparent in all member states, would best be implemented by harmonisation of laws at European level. It was thought, furthermore, that states might also re-examine the facilities available to doctors for treatments as well as hospital conditions in order to introduce further improvements in the interest of persons suffering from mental disorder.
8. Therefore, taking into account, on the one hand, recent judgments of the European Court of Human Rights and, in the other hand, the legislative trends in member states, giving better legal protection to persons suffering from mental disorder who require placement, a series of rules appended to this Recommendation were drawn up.

III. Comments on the rules

Article 1

9. This article defines the scope of application of the rules and excludes placement measures decided pursuant to criminal proceedings. This means that the Recommendation shall not apply to measures decided by a court in the course or at the end of criminal proceedings. However, it was considered that questions relating to treatment, legal capacity and dignity of patients (Rules 5, 9 and 10) did not fall within the field of criminal law and, therefore, the rules of the Recommendation should apply even to placement decided pursuant to criminal proceedings. In the countries where criminal proceedings can, by reason of the mental disorder of the accused person, lead to the application of placement

provided for by the ordinary law, the rules appended to this Recommendation shall apply.

10. The term "persons suffering from mental disorder" was preferred to that of "mentally ill persons" since certain persons, although they are not considered as "mentally ill", suffer from such mental disorders that they might require placement. It was therefore thought that these persons, when subjected to involuntary placement, also need the legal guarantees and protection offered by the rules.
11. Paragraph 2 of this article defines "involuntary placement" as meaning the admission and detention for treatment in a hospital, other medical establishment or another appropriate place of a person who is suffering from mental disorder and who has not himself requested such treatment. It was preferred not to use exclusively the term "hospital" as this term may have a more or less restrictive meaning depending on the health legislation of each state. In some states, placement can be at the patient's home or in a host family. The expression "other...appropriate place" covers such cases.
12. Paragraph 3 of Article 1 is added to cover a particular situation. As the field of application of the rules is restricted to involuntary placement, the admission of persons suffering from mental disorder to a medical establishment at their own request is excluded from it and such a patient should be treated in the same way as any other patient admitted to hospital. However, it is also possible that a patient originally admitted at his own request might need placement later, despite his wish to be discharged, because of a deterioration in his mental health. In this case, if a patient is to be detained against his wish, the legal protection provided for by the rules shall apply to that patient to the same extent as to any other patient undergoing placement.

Article 2

13. This article recognises that it is a matter for doctors (psychiatrists and/or other doctors according to the national law) to determine, for the purpose of placement, whether a person is suffering from a mental disorder. It provides moreover that the diagnosis must be made strictly in accordance with medical science. By medical science in this article is meant medical science recognised as such by the medical profession at the time of diagnosis of a mental disorder.
14. The second sentence of this article aims at ensuring that the placement serves no other purpose than the need to safeguard the health of the patient and to protect his person or that of others.

Therefore, difficulty of adapting to moral, social, political or other values of society must not be considered as a mental disorder justifying placement when it is not accompanied by other important elements which would permit, in accordance with the first sentence of the article, the diagnosis of the existence of a mental disorder according to medical science.

This provision does not rule out that such a difficulty may be considered, according to medical science, as a symptom of mental disorder but it must not be the only symptom.

Article 3

15. Article 3 lays down the conditions for placement. By starting with the words "In the absence of any other means of giving the appropriate treatment", the article emphasises that placement may be used only when no other means of treatment is available or is likely to be effective. That is to say that if there is a reasonable expectation that a treatment without placement (for instance, by prescription of medicaments to him, or by care given in the community where he lives) might be effective, placement should not be used.
16. Paragraph *a* sets down the fundamental principle as regards placement, that is a patient may undergo placement only if he presents a serious danger to himself or other persons.
17. It should be noted that the term "danger", covers not only the case where the danger is actual but also where there is a serious possibility of injury being caused to the patient himself or to another person. This makes it possible to take an appropriate decision in cases where, although the mental disorder does not reflect harmful behaviour, the doctor has every reason to believe, in accordance with medical science, that injury to persons may be caused.

Destruction of property may, in certain limited cases, be taken into consideration, insofar as it gives every reason to believe that the mental disorder might evolve to the point that the person concerned may be dangerous also for human beings.

18. However, under paragraph *b* of this article, states may also allow placement, subject to certain conditions, solely for the benefit of the health of the patient. Accordingly, states may allow placement without the serious danger required by the first sub-paragraph only in cases where, because of the serious nature of the mental disorder, the absence of treatment would lead to the deterioration of the patient's mental disorder or prevent the appropriate treatment being given to him.

Article 4

19. This article is based on the consideration that a decision for placement must be the result of co-operation between judicial or administrative authorities and the medical profession. In fact, the medical profession, depending on the different legislations, might be involved either as an authority deciding on placement (it would then be the "appropriate authority" mentioned in Article 4, paragraph 1) or as an expert for the judge or administrative body responsible for deciding insofar as it gives them the medical advice required by paragraph 1 of Article 4.

Whatever the case, since placement is not only a medical measure but also a restriction of the patient's freedom, it is important that, when the decision is taken by a judge, medical advice be obtained and, when the decision is taken by another

appropriate authority (administrative body on medical opinion or medical authority alone), the right be given to the patient to appeal against the decision of that authority to a court. In order to avoid hardship to the patient, the procedure must in all cases, be simple and speedy.

20. In the case of an emergency, the patient may be admitted into an establishment at once on the decision of a doctor, but the latter is required to inform immediately the competent judicial or other authority which will decide whether a placement of that patient is necessary and justified in accordance with Article 3.

There is an emergency when the mental disorder of the patient requires immediate admission to an establishment and it is not possible to obtain a previous decision by the competent authority.

21. Paragraph 2 relates to the procedure in those member states where the decision for placement is taken by a non-judicial body or person.

It was thought that in this case, since a judge does not intervene from the beginning in the procedure, special safeguards should be granted to the patient.

22. The first safeguard is the requirement that the person or body deciding on placement must be "different" from the one requesting it. This rule uses this term instead of the adjective "independent" since, in many states, the administrative organisation is such that the person or body requesting placement might be hierarchically subjected to the authority taking the final decision. It was thought however that the requirement that the person or body requesting placement and the one deciding it should not be the same constitutes a guarantee of objectivity for the patient.
23. The second safeguard consists of the patient's right of appeal to a court. This is a reflection of the principle upheld by the European Court of Human Rights applying the European Convention on Human Rights in the *Winterwerp* case. Therefore once a decision of placement is made the patient must immediately be informed of his rights and may, in any case, make an appeal against that decision to a court.
24. The third safeguard is designed to take into account the fact that the patient, because of his state of health or the treatment administered to him, may not be in a position to understand and defend his interests and his next of kin or legal representative might have an interest in the placement which is contrary to the patient's interest. It is provided therefore that an appropriate authority will designate a person for the sole purpose of assisting the patient to decide whether to lodge an appeal against the decision of placement or not. The person who would be designated to assist the patient should not necessarily be a lawyer. It should also be emphasised that such a person can be appointed to assist a given patient, or an appropriate authority or person can be appointed with the general competence of assisting all the patients, for instance on a given territory. Of course, the right of appeal of other interested persons remains and it is for the law of each member state to determine this concept (for example, members of the patient's family, persons living with the patient, etc.).

25. The fourth safeguard is provided by paragraph 3 of Article 4 which applies also when the initial decision is taken by a judicial authority. This paragraph requires that whenever the patient's case, either at first instance or on appeal against a decision of a non-judicial body, is brought before a court or other competent body, the patient must have the opportunity to be heard.
26. The aim of this safeguard is to avoid a placement decision being taken solely on the basis of medical reports. Therefore the patient must have the opportunity of being heard personally by the judge. This opportunity must be "effective", that is to say it must not simply be laid down by law but all the measures (information etc.) must be taken so that the patient can be heard by the judge. Such a provision does not mean that the patient must be taken before a judge in all cases. It will be for the latter to decide, together with the doctor responsible, whether the patient should come to the judge or if the judge must go to him, unless national legislation lays down this last solution in all cases.

For example, if the judge, in spite of the wish expressed by the patient to be heard personally, should consider that the patient's state of health would not allow a hearing, he will have to take measures which allow a representative of the patient to express his point of view.

27. Paragraph 3 also provides that the patient must benefit from the assistance of a counsel or of another person. Such assistance - which is different from that provided for in paragraph 2 of Article 4 - might be either of a legal or other nature. In any case, such a provision should not be interpreted as giving an absolute right to free legal aid. This will depend on national legislation. Moreover, such assistance should be given only if the patient requests it expressly or if the judge (in the countries where he has such a power) considers it fit.
28. As all judicial decisions concerning placement of a patient inevitably affect his personal freedom, it is essential that all these decisions should be open to appeal to a higher court. Paragraph 4 simply states this principle. It should be noted that the term "appeal" is not used in its legal technical meaning but indicates only the necessity for two levels of jurisdiction.

Article 5

29. This article provides that patients suffering from mental disorder and subject to placement should have a right to receive treatment under the same ethical and scientific conditions as any other patient suffering from an illness other than mental disorder. Moreover, it ensues from paragraph 1 of Article 5 that placement must never serve simply as a means of isolating the patient, but must enable him to receive the treatment indicated for the state of his health by medical science. In order to ensure equality between persons suffering from mental disorder and other sick persons, paragraph 1 refers also to the environmental conditions of treatment with a view to emphasising the importance of providing premises and equipment which are comparable to those available to other medical departments.

30. For the protection of patients, paragraph 2 of this article concerns some treatments which, in spite of their particular characteristics which might raise some doubt as to the advisability of their being administered to involuntarily placed patients, are considered indispensable in the care of the patient by reason of the state of the patient's mental health. These particular treatments are: those which are not yet generally recognised by medical science; those which present a serious risk of causing permanent brain damage or adversely altering the personality of the patient. Before administering one of these treatments the doctor must obtain the consent of the patient. If the patient refuses his consent, no such treatment can be given to him. In cases where the patient is unable to give his consent because he is not capable of understanding and evaluating the nature and the consequences of the treatment, the doctor will submit the matter to an independent authority prescribed by law and only after an authorisation has been given by that authority may such treatment be administered to the patient. If there is a legal representative of the patient, he must be consulted by the above-mentioned authority.
31. By using the expression "permanent brain damage", it is intended to indicate that the patient's consent must be obtained when there is a serious risk that the treatment will cause damage which is permanent.

The expression "adversely alter the personality of the patient" should be interpreted as meaning any alteration other than the amelioration of the patient's pathological behaviour which is a symptom of his mental disorder because this amelioration is itself the aim of the treatment.

The expression "legal representative" does not mean, as it usually means in common law countries, a "lawyer". In paragraph 2, it is used in the sense of the civil law countries where it covers all the persons who, by operation of the law or by virtue of a court's or other authority's decision, exercise legal rights on behalf of other persons who are legally incapacitated (for example guardian).

32. Paragraph 3 deals with clinical trials. Without prejudice to the legal regulation of trials having a therapeutical purpose which is specific for mental disorder (this is a matter for national law), it was considered that any other clinical trial involving such persons, whether having a therapeutical purpose or not, should not be permitted. It was thought that the patients should be protected against such trials even if they consent to them.

Article 6

33. This article concerns the limits to the patient's personal freedom.

The basic idea is that the patient must, as far as possible, receive the same consideration as any other person and that restrictions on his personal freedom must be confined to measures necessary in the interest of his health and of the treatment. Placement must never be used to punish or isolate without treatment.

34. Thus, some freedoms must not be subject to restrictions other than those that ordinary law applies to people in general. The freedoms in question are the freedom to communicate (in writing or orally) with any appropriate authority,

with the person referred to in Article 4 or with a lawyer, and the right to send letters. The limits on these rights are set by criminal law, whose purpose is to protect the freedom of others by preventing or punishing offences. If, for example, the patient uses letters in a way which is contrary to criminal law (for example to blackmail), then criminal law shall apply with any restrictions to personal freedom that it might imply.

35. The expression "appropriate authority" was used in order to cover a number of authorities with which the patient might wish to correspond in order to have his situation reviewed, for example a health authority or other authority supervising hospitals, a court or the European Commission of Human Rights in the case of states which, under Article 25 of the European Convention on Human Rights, recognise the right of individual petition.

Article 7

36. Article 7 is to avert a patient's transfer from one establishment to another solely for administrative reasons and regardless of his therapeutic interests. A patient may, however, be transferred if his therapeutic interests so require (if, for example, the required treatment necessitates his placement in a better equipped hospital). Before any transfer, the patient's wishes must also as far as possible be taken into account.

Article 8

37. This article concerns the length and the termination of the placement.

It establishes two fundamental principles.

38. The first is that placement must normally be decided for a limited period or for a period not exceeding the period fixed by law. Whenever no limited period is specified in the placement order or prescribed by law, the authority ordering the placement must review at regular intervals the necessity for placement.
39. Paragraph 1 adds to these safeguards the right of the patient to appeal, at reasonable intervals, to a court for the termination of his placement. This ensures compliance with the rule stressed by the European Court in the case of *X against the United Kingdom*, that Article 5, paragraph 4, of the convention implies that a patient compulsorily confined in an institution for an indefinite or lengthy period is entitled "at any rate where there is no automatic periodic review of a judicial character, to take proceedings at reasonable intervals before a court to put in issue the "lawfulness" (...) of his detention".
40. The second principle admits that there are no special procedures for the termination of the placement. It empowers the doctor (competent according to national law) and the judicial or other competent authority to terminate the placement where the patient's state of health no longer justifies it. This decision can be taken either at the instigation of the doctors or authorities concerned or on the application of the patient or any other interested person.

This principle does not prevent states, in which placement is decided by a judicial authority, from requiring that the decision to terminate the placement taken by a doctor is to be submitted to that authority.

41. Paragraph 2 does not refer to the other grounds for termination of the placement implicit in paragraph 1, namely the expiry of the period specified in the placement order or prescribed by law, without renewal of the placement order, or a decision to terminate the placement being taken by the competent authority when carrying out one of its regular reviews of the necessity for the placement.
42. Since placement is a means of giving treatment, a patient who is entitled to leave the establishment may no longer require placement, yet still need further treatment. Termination of the placement therefore does not preclude the doctor's treating the patient on a voluntary basis. This rule, embodied in paragraph 3, is particularly designed to emphasise that the termination of placement is not necessarily conditional on the patient's full recovery and to encourage the establishment of a voluntary doctor-patient relationship whenever possible.

Article 9

43. The purpose of paragraph 1 is to ensure that placement is not regarded as a ground for restricting the patient's legal capacity *ipso jure*. Any such restriction must comply with the principles (and procedures) of ordinary law, which generally provides that legal capacity may be restricted only where the person concerned is unable to understand or defend his interests.
44. Paragraph 2 concerns the measures which may be taken by the authority ordering the placement. Placement often gives patients neither time nor opportunity to settle their affairs. While not imposing a duty on the authority ordering the placement to take safeguarding action itself, paragraph 2 accordingly makes it responsible for alerting the competent authorities (for example the social welfare authorities) so that, if no one else (family member, employee, etc.) is available to look after the patient's affairs, they can step in to perform services which do not presuppose restrictions in the patient's legal capacity or the appointment of a legal representative (for example for managing property).

Article 10

45. This article stresses the principle that a patient undergoing a placement is as entitled as any other sick person to respect for his dignity, whatever the reasons for his placement. The words "in all circumstances" are intentionally included to cover not only the placement in a medical establishment but also every stage of the placement (for example transport, court proceedings, etc.). The article likewise states that adequate measures shall be taken to protect the patient's health. This implies that the patient's general health must not be endangered by the treatment or his mental health impaired by continuation of the placement even when there is no longer any prospect of effective treatment.

Article 11

46. This article recognises that states have the power to accept the principles of the recommendation while adopting, in particular instances, provisions which are different but which they consider more favourable to patients. If it deems it appropriate, a state may, for example, in the context of Article 5, completely prohibit a treatment not yet generally recognised by medical science or a treatment which adversely affects the personality, even where the patient consents to such treatment.

APPENDIX 3RECOMMENDATION 1235 (1994)¹ on psychiatry and human rights

1. The Assembly observes that there is no overall study on legislation and practice with regard to psychiatry covering the member states of the Council of Europe.
2. It notes that on the one hand, a body of case-law has developed on the basis of the European Convention on Human Rights and that on the other, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has made a number of observations with regard to practices followed in the matter of psychiatric placements.
3. It notes that, in a large number of member countries, legislation on psychiatry is under review or in preparation.
4. It is aware that, in many countries, a lively debate is currently focused on problems associated with certain types of treatment such as lobotomies and electroconvulsive therapy as well as on sexual abuse in psychiatric care.
5. It recalls Recommendation No. R (83) 2 of the Committee of Ministers to member states concerning the legal protection of persons suffering from mental disorder placed as involuntary patients.
6. It considers that the time has come for the member states of the Council of Europe to adopt legal measures guaranteeing respect for human rights of psychiatric patients.
7. The Assembly therefore invites the Committee of Ministers to adopt a new recommendation based on the following rules:
 - i. Admission procedure and conditions:
 - a. compulsory admission must be resorted to in exceptional cases only and must comply with the following criteria:
 - there is a serious danger to the patient or to other persons;
 - an additional criterion could be that of the patient's treatment: if the absence of placement could lead to a deterioration or prevent the patient from receiving appropriate treatment;
 - b. in the event of compulsory admission, the decision regarding placement in a psychiatric institution must be taken by a judge and the placement period must be specified. Provision must be made for the placement decision to be regularly and automatically reviewed. Principles established in the Council of Europe's forthcoming convention on bioethics must be respected in all cases;

- c. there must be legal provision for an appeal to be lodged against the decision;
- d. a code of patients' rights must be brought to the attention of patients on their arrival at a psychiatric institution;
- e. a code of ethics for psychiatrists should be drawn up inter alia on the basis of the Hawaii Declaration approved by the General Assembly of the World Psychiatric Association in Vienna in 1983.

ii. Treatment:

- a. a distinction has to be made between handicapped and mentally ill patients;
- b. lobotomies and electroconvulsive therapy may not be performed unless informed written consent has been given by the patient or a person, counsellor or guardian, chosen by the patient as his or her representative and unless the decision has been confirmed by a select committee not composed exclusively of psychiatric experts;
- c. there must be an accurate and detailed recording of the treatment given to the patient;
- d. there must be adequate nursing staff appropriately trained in the care of such patients;
- e. patients must have free access to a "counsellor" who is independent of the institution; similarly, a "guardian" should be responsible for looking after the interests of minors;
- f. an inspection system similar to that of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment should be set up.

iii. Problems and abuses in psychiatry:

- a. the code of ethics must explicitly stipulate that it is forbidden for therapists to make sexual advances to patients;
- b. the use of isolation cells should be strictly limited and accommodation in large dormitories should also be avoided;
- c. no mechanical restraint should be used. The use of pharmaceutical means of restraint must be proportionate to the objective sought, and there must be no permanent infringement of individuals' rights to procreate;
- d. scientific research in the field of mental health must not be undertaken without the patient's knowledge, or against his or her will or the will of his or her representative, and must be conducted only in the patient's interest.

iv. Situation of detained persons:

- a. any person who is imprisoned should be examined by a doctor;

b.a psychiatrist and specially trained staff should be attached to each penal institution;

c.the rules set out above and the rules of ethics should be applied to detained persons and, in particular, medical confidentiality should be maintained in so far as this is compatible with the demands of detention;

d.sociotherapy programmes should be set up in certain penal institutions for detained persons suffering from personality disorders.

1. Assembly debate on 12 April 1994 (10th Sitting) (see Doc. 7040, report of the Committee on Legal Affairs and Human Rights, Rapporteur: Mr Stoffelen; and Doc. 7048, opinion of the Social, Health and Family Affairs Committee, Rapporteur: Mr Eisma).

Text adopted by the Assembly on 12 April 1994 (10th Sitting).