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Comments of the CP on the “White Paper” on protection of the human rights and dignity of people suffering from mental disorders proposed by the working party of the Steering Committee on Bioethics (CDPI) of the Council of Europe

Commentaires du CP sur le «Livre Blanc » sur la protection des droits de l’Homme et de la dignité des personnes souffrant de troubles mentaux proposé par le groupe de travail du Comité d’organisation sur la bioéthique (CDPI) du Conseil de l’Europe

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Comments of the Standing Committee of European Doctors (CP) on the

"White Paper" on Protection of the human rights and dignity of people suffering from mental disorders proposed by the Working party of the Steering Committee on Bioethics (CDPI) of the Council of Europe

Raporteur Dr. Kari Pylkkänen (Finland)

The Standing Committee of European Doctors (Comité Permanent des Médicins Européens, CP) represents 1.4 million European doctors. Having appointed Dr. Kari Pylkkänen (Finland) as raporteur and having consulted the European Union of Medical Specialists (U.E.M.S.) and its Section of Psychiatry which represents European psychiatrists, the CP suggests that the following points of view should still be taken for consideration when the Document is finalised:

1. The scope of application of the new legal instrument

CP considers that the "White Paper" addresses an extremely important topic. Its recommendations for new guidelines for legislation are very important initiatives for improvement in patients` rights and the quality of health care delivery for people suffering from mental disorders in Europe. The Working party of the Committee of Bioethics has done a very good work. The scope of the White paper is, however, too limited in its present form to address adequately its very important topic.

We suggest that a new priority should be added to the document in order to address the most important issue in protection of the human rights and dignity of people suffering from mental disorders. We suggest that the scope of the document should be widened to include also the means available for *prevention* of risk for involuntary treatments. For this purpose the *first priority in the document should be given to prevention of the risk for involuntary admission and treatment by advising the governments* ***to give more emphazis on improving the access to and quality of adequate community based psychiatric outpatient care.***

2. The risk for involutary treatment can be decreased by good access to adequate community based psychiatric services

The evidence suggests very strongly that the quality of mental health services outside the scope of involuntary services is reflected on patients rights in terms of increased or decreased risk for episodes of involuntary care. This link is mentioned in the document (Chapter 2 paragraph d), which suggests that if "means of giving the patient appropriate care which is less restrictive than involuntary care are not available" involutary treatment is acceptable.

The evidence suggests that if there is a wider scope and better quality of less restrictive alternatives available, the risk for involuntary placement can be decreased.

This means that *the most important and powerful way of improving the rights and dignity of the people suffering from mental disorders are not only he improvements focused on the quality of the involuntary admission and treatment itself but also those focused on the quality of and access to alternative models of outpatient care.*

This point is very critical and important in the present day Europe for two reasons.

1) The recent restructuring of mental health services all over Europe have introduced massive changes in mental health care delivery. In short the mainstream of these changes has been heavy cuts in avaílability of all forms hospital care and no or minimal changes in access to community based outpatient services. This has changed the balance between involuntary care and alternatives for it.

2) The evidence suggests that the above mentioned changes have heavily increased the proportional number of involuntary episodes in hospitals. While number of hospital beds has come down radically (in some countries down to 30 % from the level 20 years ago) the proportional share of involuntary palacements in hospitals has increased and this has led to deterioration in the quality of care in the hospitals.

The number of patients needing episodes of psychiatric hospital care in general has not changed very much while the number of beds came down very radically. As a result of this the number of hospital admissions has not necessarily changed very much. What changed was the length of stay in hospitals. Due to this many patients are discharged earlier than would be clinically optimal. After discharge they are in need of especially strong outpatient support. For this there is, however, usually not enough resources.

The resources for mental health care did not follow the patients from hospitals to community based outpatient settings. The evidence suggests that after being discharged at an early stage of recovery from hospitals the patients in outpatient care have a great risk of getting worse rather quickly. This often means need for a new episode in hospital - which often takes place in circumstances where involuntary placement cannot be avoided.

The new legal instrument should give a strong recommendation for governments emphasizing that in order to improve the human rights and dignity of people suffering from mental disorders the governments should pay special attention to new improvements in psychiatric outpatient care in order to overcome the negative outcomes of deinstutialization of psychiatric care in Europe. To reach this aim the governments should consider means of targeting new financial incentives for improvements in community based psychiatric outpatient care. Evidence suggests that promotion of access to adequate community based services is also an effective means for reducing the stigma and discrimination (paragraph 12 in the Document). New systems of quality improvement and follow up of service delivery of mental health care should be developed.

3. Categories included in the concept of mental disorder.

Different countries have different approaches in their legislation here. Some countries limit the clinical criteria for involuntary placement to psychoses only. Some countries have unspecified clinical criteria like “mental disorder”. The enclosed report on Psychiatric legislation in Europe 1998 by the U.E.M.S: Section of psychiatry points out that in 9 countires out of 25 the term mental disorder was not spesified. In 23 countries the psychiatrists included psychosis in the kind of psychiatric illness to be present for commitment to take place.

The clinical criteria in the legislation should be as clear as possible. For this aim both the concepts of “mental incapacity” and “mental disorder” are not clear enough concepts. We suggest that the basic diagnostic criteria should be psychosis. If individual countries want to make exceptions from this basic criteria they may define each of those additional categories in their legislation.

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

The governments are advised quite adequately (3 d.): “The member states must ensure that measures are taken to make alternatives to placement as widely available as possible”.

This aim should be emphasized still further by adding the new chapter emphasizing the necessity of having adequate community based services as suggested in this paper.

Considering what alternatives should be always available, further work is suggested to be done on this. We propose that a guideline including a list of those services that are necessary necessary will be made. The variety of good practice keeps on developing, however, and therefore a list of necessary services can never be comprehensive or final.

Quality systems are needed to ensure an adequate follow up of the service delivery in each country.

5. The distinction between involuntary placement and treatment is not meaningful

The Document suggests distinction between involuntary placement and treatment. This is inconsistent with the argument also presented in the document that involuntary placement should only take place for therapeutic reasons. The idea of involuntary placement with no treatment would give a restrictive, nontherapeutic aim and role for psychiatric services.

The safety of public is an important issue in the society. It is not, however, the duty or role of the health services to provide such safety measures that are not based on medical arguments. Involuntary placement for the purpose of not having any treatment or for cases which cannot be treated medically is not a task of health care. The CP considers psychiatric establishments as integral part of health care organisations. Exercising social control with nonmedical aims is not a health care duty.

6. The procedure and the relevant independent body

CP fully agrees with the points of view presented concerning the process of taking the decision of involuntary treatment. The patient must be first examined by a psychiatrist or medical doctor having requisite experience and competence. The decision should be taken by a relevant authority which may be a psychiatrist authorized to take such a decision and who is independent in relation to the doctor who proposed involuntary treatment. The patient must be medically examined by at least two psychiatrists before a decision concerning involuntary treatment can be made. We regard the decision concerning involuntary treatment as a clinical decision which must be made by a doctor and controlled by the court. The family of the patient should be consulted only if the patient consents or there are wider issues of public safety which mean that the family members or other people close to the patent can be consulted without the consent of the patient.

7. Other comments

The use of physical restraint must be in due proportion to the risks and benefits entailed and always made under supervision of a medical doctor or immediately brought to the knowledge of a medical doctor for approval. Physical restraint must always be used within the framework of treatment only, and the reasons and duration of such measures should always be registered in the patient`s personal file. In addition we suggest that for the purpose of quality control a special register on these measures should be held on each ward to include all uses of psysical restraint.

CP finds that there should be a distinction between legislation concerning admission in hospitals on account of the criteria mentioned in the "White Paper" and legislation concerning criminal acts (forensic psychiatry)

8. The U.E.M.S. Section of Psychiatry study on psychiatric legislation in Europe

The U.E.M.S. Section of Psychiatry has made two follow-up studies on the criteria for and use of compulsory admission and treatment in European countries. The report of the latest study conducted in 1998 is enclosed. The two consecutive studies point out that there have been major developments in this field in Europe during the 1990`s, and most countries have revised or are revising their legislation. The psychiaric legislation dated back to not longer than 1990 in 19 countries of those 25 included in the study.

Enclosure:
Psychiatric legislation in Europe 1998. U.E.M.S. Section of Psychiatry, 2000

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1. draft

Psychiatric Legislation in Europe 1998

In 1993 16 member states of UEMS-Section Psychiatry filled in a questionnaire concerning legislation with compulsory admission and other compulsory acts in psychiatry. Forensic admissions on account of criminal behaviour were not included. The survey showed that there were great variations in legislations and also in the way the legislations were applied from country to country. The European states thus seemed far from harmonization concerning the psychiatric legislation.
The same questionnaire was filled in by the delegates of the member states in 1999 (the year 1998 was investigated). The same 16 member states participated (the member state Luxembourg did not answer, but Luxembourg has a legislation resembling the legislation in Belgium). Since 1993 several European countries had either been associate member states of UEMS-section or observer states. Nine of these “new” states also filled in the questionnaire. In total 25 European states participated in the survey.

Participating states 1993 and 1998

Belgium – B, Denmark – DK, France – F, Germany – D, Greece – EA, Ireland – IRE, Italy – I, Netherlands – NL, Portugal – P, Spain – E, United Kingdom – UK, Finland – FIN, Norway – N, Sweden – S, Switzerland – CH, Austria – A

Participating states 1998

Croatia – CRO, Cyprus – CY, Czech Republic – CZR, Estonia – EST, Hungary – H, Malta – MA, Poland – PO, Slovak Republic – SLR, Slovenia – SL

Age of the law

The laws from the different countries ranged in age from 1945 (IRE) to 1999. 12 of the 25 participating states had their psychiatric laws regulated in the period 1993 – 1999. DK, P, N, and SL regulated their laws in 1999. The law in Malta dated back to 1981, and the eight other “new” states had laws from 1993 to 1999.

Criteria for compulsory admission = commitment

Besides having a mental illness all states but Italy accepted the criteria that a patient could be committed to hospital, if he was in acute **danger to himself and/or others**. 16 states accepted the criteria that a patient could be committed, if there was a **danger to his health**, whereas nine states (E, B, S, A, D, NL, H, CZR, EST) did not accept this criteria. Only two member states accepted the criteria that a person could be committed, if he had a behaviour not acceptable in the community.
Concerning the kind of psychiatric illness to be present in a person to be committed nine states did not specify, but used the term “mental disorder” (PO, E, UK, EA, MA, EST, CRO, P, NL).

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In 23 states the psychiatrists included psychosis in the kind of psychiatric illness to be present for commitment to take place. Besides the states with the unspecified “mental disorder” nine states (B, F, IRE, D, CH, H, SLO, CZR, SLR) recognize alcoholism or some orther kinds of addiction.
A voluntarily admitted patient could be compulsorily detained in the psychiatric ward in 17 of the 25 states and could not be compulsorily detained in I, B, F, N, NL, CRO, SLR. In some states the detention could last only a few days, and after decision by a judge.
Mental retardation was in some countries a psychiatric illness, which was accepted and described in the laws as an acceptable illness to be present for placement in a psychiatric hospital. The questionnaire didn’t ask about mental retardation, since the topic of the questionnaire was admission in a psychiatric department/hospital for therapeutic reasons, and not placement of incurable mentally disordered people without medical aims.

Other compulsory acts described in the law

In seven out of 25 states other compulsory acts were not described in the laws. This was a change compared to 1993, where nine of of 16 stated did not mention other compulsory acts.
In 18 states medication was mentioned, and in some states seclusion and restraint and other methods of compulsion for therapeutic reasons were listed in the laws. Several of the laws were unclear and not specific concerning this area. The seven states with no specifications were: B, EA, E, H, CH, SL and SLR.

Decision of compulsory admission

The responsibility for deciding commitment rests with the medical authorities in most of the European states. In 19 states a medical doctor has to examine the patient, decide and apply for commitment. In some countries the physician has to be a psychiatrist, and in some countries two independent physicians are required. Only in FIN, EST, CRO, IRE, and A one or two doctors (psychiatrists) could decide the commitment without accept from another authority. In 16 states a judge will have to confirm the commitment, before it takes place, whereas in e.g. Italy the responsibility for commitment is in the hands of the local health authority. Next of kin should in some countries draw attention of the authorities to the patient’s mental illness and need for admission. But in no countries the next of kin was responsible for the commitment.

Complaint procedures – commitments

In seven states the complaint goes to the court, in eight states to a judge or a judiciary person, and in 10 states to another institution, e.g. a mental health review tribunal (UK) or the Ministry of Health (IRE). In 17 states the patient will get an answer concerning the complaint within two weeks whereas in eight states it will take more than two weeks. The maximum time limit for getting an answer after having complained was not specified in all countries, and statistics were not available.

Complaint procedures – other compulsory acts

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The complaints about the compulsory acts were sent to the court in seven states, to the judge in seven states, and to other special persons, hospital directors, boards or commissions, in the rest of the states. Since other compulsory acts were not specified in several countries' laws neither was there specified a complaint procedure for these acts. In some countries the complaint procedure varied depending on which kind of compulsory act there was complained of. The time span for the patient to wait for an answer varied between one day and "eternity", and for some states the time span was not known. In 13 states the patient waited less than 15 days, included ten states (I, B, F, DK, A, IRE, NL, CH, H, SLR), where the patient waited less than seven days to get an answer about the complaint. Compared to the survey in 1993 the time span had minimized in several countries, possibly because there was established a description of complaint procedures and time limits, when the laws were regulated. .

Time to be detained involuntarily

In 12 states there were no answers, possibly because the relevant statistics were not available. The average number of days involuntarily in hospital ranged from 1 (D) to 73 (FIN) in the states with statistics, and the maximum ranged from 90 to 730. It was possible to keep the patient in hospital for "eternity" in I, S, UK, DK, IRE, D, and NL. In some of the countries where it was possible to detain a person involuntarily for "eternity" the legality of the compulsory detainment was renewed at certain intervals by a judge or some other judiciary system.

Number of compulsory admissions in relation to all admissions

As in the 1993 survey it was difficult to get exact data concerning the percentage of compulsory admissions out of total number of admissions in each member state. We know that in the last 15 years the number of psychiatric beds has diminished dramatically in most of the European states. In the same period the length of hospital stays has also decreased because a lot of patients are treated in out-patient settings. In six member states there were no data. In the rest of the states the percentage of compulsory admissions was in median 11%, range 2,3% (EST) - 80% (EA). The states with percentages of 11% or less were: B, UK, F, DK, IRE, D, NL, CH, H, PO, SL, CZR, SLR, and EST.

Conclusion

In the nineties there seems to have been great interest in either regulating or creating new legislation concerning compulsory admission and other compulsory acts in psychiatry. If the four regulations of laws performed in 1999 are included 19 out of 25 states have laws dating from 1990 as the oldest ones. Only Italy, United Kingdom, Ireland, Germany, Switzerland, and Malta have older laws. Concerning Germany and Switzerland several of the local states have newer and more specified regulations.

From 1993 to 1998 several of the states had specified complaint procedures for other compulsory acts, and also time limits for patients to get an answer have been specified. The states very

seldom in their legislation included clause on level of hospital facilities for patients involuntarily staying in psychiatric departments and hospitals. The survey shows that legislation is one thing and reality another, since a legislation has to be both interpreted and implemented. Besides the fact that different ideologies inflect on the legislation, the local culture and the local way of

organizing psychiatry might influence on the way the legislation will be in each member state. The economic situation for each state and the political decision, where to allocate resources in the health care system, will also inflect on compulsion in psychiatry. In spite of the variations in the legislations and the way the legislations are applied, the European states seem in a process of harmonization concerning psychiatric legislation. To continue this process and to diminish the amount of compulsion to the necessary minimum and to secure human rights for persons admitted involuntarily the following is crucial:

I. Psychiatric treatment shall be offered in a comprehensive setting including both high quality in-patient and high quality out-patient treatment
II. Sufficient financial resources shall be allocated to make it possible to have high standard of buildings and a qualified staff in both hospitals and community psychiatric services.
III. Complaint procedures shall be specified and with time limits.
IV. Statistical information concerning number of compulsory admissions, other compulsory acts, and complaints shall be available.
V. Systems for monitoring quality standards shall exist in all member states.
VI. It is essential to secure the human right to treatment for mentally disordered individuals with a treatable psychotic illness.