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Editorial

Council of Europe recommendation on human rights and psychiatry: a major opportunity for mental health services

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The Council of Europe was founded in 1949 with 10 member, has grown to a membership of 46, including 21 countries from Central and Eastern Europe, and has in 2005 a budget over 180 million euros (2005). The Council is made up of four tiers of organisation: The main decision making body is the Committee of Ministers which comprises the Foreign ministers (or their deputies) from each of the 46 member states. Beneath the Committee of Ministers is the parliamentary assembly which is made up of 630 members drawn from the 46 national parliaments. It has influence on decision-making, but the final say is with the Committee of Ministers. *The other tiers* are comprised of the Congress of Local and Regional Authorities, and finally the secretariat comprising 1800 representatives.

The protection of human rights has been central to the Council's aims since its inception. It was originally set up to defend human rights and to standardise social and legal practices across borders. An important contribution made by the Council is the European Convention on Human Rights [1], adopted in 1950. This led to the establishment of the European Court of Human Rights to hear complaints about human rights violations in member states. The political landscape of Europe has changed in recent years and a new role for the Council is to act as a human rights regulator for Europe's post-Communist democracies. During a Summit meeting in 1997 a plan was adopted to focus work on four key areas: security of citizens, democratic values and cultural diversity, social cohesion, and, much in keeping with the Council's founding aims, human rights and democracy.

1. The Council of Europe and psychiatry

In keeping with its mission to protect the rights of individuals, the Council has been involved in the protection of people who have a mental disorder. In 1977, it adopted a recommendation that identified the need for the legal protection of people with a mental illness [3], followed in 1983 by a recommendation regarding the rights of patients detained involuntarily for treatment in 1983 [4]. Further, in 1994, recommendation 1235 on psychiatry and human rights was made [2].

In 1996 a working party on psychiatry and human rights was established by the European Council of Ministers to develop the earlier recommendations. The aim was "to enhance the protections of the dignity, human rights and fundamental freedoms of persons with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment." In 2000 a White Paper was published to consult on draft recommendations, and on 22nd September 2004 a final recommendation (2004/22) [5] was agreed by the Committee of Ministers. These initiatives have been accepted by all member states with the exception of the United Kingdom, which 'reserved the right to comply or not with the recommendation as a whole'.

The recommendations are intended to be a common minimum standard with which states should comply, although it is recognised that legislation in some countries may be more rigorous in some areas. The recommendations are broad in scope and aim to "enhance the protection of the dignity, human rights and fundamental freedoms of persons with a mental disorder, in particular those who are subject to involuntary placement or involuntary treatment". The recommendations comprise 38 articles divided into five chapters. Spanning the articles, there are four broad principles which are evident throughout the recommendations. They are equality, principle of least restriction, objectivity, and the separation of involuntary placement and therapy. We will discuss these principles in turn with reference to the relevant articles.

2.1. Equality

Article 3 states that all forms of discrimination on grounds of mental disorder should be prohibited. This article has perhaps the widest potential of all the recommendations to be used as an instrument by individuals or groups in a legal challenge. The explanatory report accompanying the guidelines advises proportionality (that actions taken should be in proportion to the requirements of the situation), recognising that measures taken to safeguard others should not automatically be seen as unfair discrimination. For example, the issuing of a firearms license to an individual with a severe recurrent men-

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tal illness such as mania, should not be considered discriminatory, although the detention of someone purely for the protection of others on the basis of diagnosis rather than individual assessment would be. Persons with mental illness should be entitled to exercise all their civil and political rights. Any restrictions to exercise these rights should be within the provisions of the Convention for the Protection of Human Rights. Articles 8 (respect for family and private life) and 12 (right to marry and found a family) are given further weight in the recommendations in which the right to procreate, and the exclusion of mental disorder in itself being a justifiable reason for termination of a pregnancy are specifically stated (Articles 30 and 31). Equitable access to services is also specified. Article 10 states that persons with mental disorder should be provided with equal access to physical health care services, and Article 35 states that persons with a mental disorder who are in prison should receive equivalent care as those outside of prison.

2.2. Principle of least restriction

This principle is established that a person should be treated in the least restrictive environment, and with the least restrictive or intrusive treatment available, taking into account their health needs and the safety of others. This principle is central to the recommendations. It is explicitly stated in Article 8 but reverberates throughout the document.

The key recommendations deal with the involuntary treatment and/or placement in a psychiatric facility of people with mental disorders. The criteria for involuntary placement are defined. A person may only be detained involuntarily if all the following conditions are met: The person has a mental disorder, their condition represents a significant risk of serious harm to their health or other persons, the placement includes a therapeutic process, no less restrictive means of providing care are available, and the opinion of the person concerned is taken into account. The decision to subject an individual to involuntary placement should be made by a doctor with requisite expertise, or by a court or other recognised body. Close relatives should be consulted if possible, and information should be given to the detainee regarding their treatment, their rights and way of appeal. During involuntary placement, the individual should be allowed to communicate with their advocates or representatives, and be allowed to receive visits. Involuntary placement or treatment should be terminated if any of the criteria for detention are no longer met Member states should aim to minimise the duration of involuntary placement by the provision of aftercare services. Provisions for independent review and appeal are also specified.

The use of seclusion and restraint, and use of specific reversible or irreversible physical treatments are dealt with in chapter 5. Again, the least intrusive option should be used taking into account the opinion of the person concerned. Particularly intrusive or irreversible physical treatments should in addition be subject to the scrutiny of an ethical committee.

2.3. Objectivity

Recommendations are made to ensure that definitions of mental illness, diagnostic categories and treatments are in line with international standards. The definitions and criteria contained within ICD-10 are used as an example of internationally accepted medical standards. With this in mind, persons with personality disorders are included, but an individual who fails to conform to social, moral or political values is not to be considered as having a mental disorder.

"Staff involved in mental health services should have appropriate training and qualifications. Clear documentation, including written treatment plans should be kept when persons receive involuntary treatment or placement, and treatment must be reviewed regularly. The whole process of involuntary detention or treatment must be transparent and subject to external scrutiny. If a patient does not appeal against involuntary detention, then a court should, at intervals review to ensure that the detention remains legal."

Member states should have in place systems to monitor compliance with the standards set out in the recommendations. These should be independent from the bodies being monitored. In addition statistical information on the application of mental health law should be collected and made available to the public. It is also recommended that an independent body should monitor the treatment and care of people in penal institutions who have a mental disorder.

2.4. Separation of custody and therapy

As stated above, one of the criteria for involuntary detention is that it includes a therapeutic purpose. This statement is further strengthened in the explanatory notes which state that "if the purpose of the placement is solely custodianship, this should not take place in a psychiatric facility". Consent to treatment and placement are deemed to be separate processes. Although someone may require involuntary placement, this does not automatically mean that they require involuntary treatment. They may consent to treatment in these circumstances and, in any case, this distinct decision needs to be given appropriate consideration. It may also be the case that somebody is deemed to require compulsory treatment but not placement, e.g. admission to hospital. As services have become more community based with mobile teams available to provide intensive support, the development of compulsory treatment in the community has become a reality in many countries and occurs by use of leave provisions in many others. The recommendation is designed to regulate this by ensuring that procedures used are at least as rigorous as those for involuntary placement and that full access to appeals processes are available. The criteria for placement and treatment is the same—that the person or others are at significant risk of serious harm—and likewise when the person no longer meets those criteria the involuntary measure must be terminated. It does not therefore sanction continuing prophylactic use of medication when these criteria are not met. The wishes