



Involuntary placement in psychiatric establishments

*Extract from the 8th General Report of the CPT,
published in 1998*

A. Preliminary remarks

25. The CPT is called upon to examine the treatment of all categories of persons deprived of their liberty by a public authority, including persons with mental health problems. Consequently, the Committee is a frequent visitor to psychiatric establishments of various types.

Establishments visited include mental hospitals accommodating, in addition to voluntary patients, persons who have been hospitalised on an involuntary basis pursuant to civil proceedings in order to receive psychiatric treatment. The CPT also visits facilities (special hospitals, distinct units in civil hospitals, etc) for persons whose admission to a psychiatric establishment has been ordered in the context of criminal proceedings. Psychiatric facilities for prisoners who develop a mental illness in the course of their imprisonment, whether located within the prison system or in civil psychiatric institutions, also receive close attention from the CPT.

26. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria also apply to involuntary placement in psychiatric establishments.

In the following paragraphs, some of the specific issues pursued by the CPT in relation to persons who are placed involuntarily in psychiatric establishments are described¹. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of such persons; the Committee would welcome comments on this section of its General Report.

B. Prevention of ill-treatment

27. In view of its mandate, the CPT's first priority when visiting a psychiatric establishment must be to ascertain whether there are any indications of the deliberate ill-treatment of patients. Such indications are seldom found. More generally, the CPT wishes to place on record the dedication to patient care observed among the overwhelming majority of staff in most psychiatric establishments visited by its delegations. This situation is on occasion all the more commendable in the light of the low staffing levels and paucity of resources at the staff's disposal.

¹ As regards psychiatric care for prisoners, reference should also be made to paragraphs 41 to 44 of the Committee's 3rd General Report.

Nevertheless, the CPT's own on-site observations and reports received from other sources indicate that the deliberate ill-treatment of patients in psychiatric establishments does occur from time to time. A number of questions will be addressed subsequently which are closely-linked to the issue of the prevention of ill-treatment (e.g. means of restraint; complaints procedures; contact with the outside world; external supervision). However, some remarks should be made at this stage as regards the choice of staff and staff supervision.

28. Working with the mentally ill and mentally handicapped will always be a difficult task for all categories of staff involved. In this connection it should be noted that health-care staff in psychiatric establishments are frequently assisted in their day-to-day work by orderlies; further, in some establishments a considerable number of personnel are assigned to security-related tasks. The information at the CPT's disposal suggests that when deliberate ill-treatment by staff in psychiatric establishments does occur, such auxiliary staff rather than medical or qualified nursing staff are often the persons at fault.

Bearing in mind the challenging nature of their work, it is of crucial importance that auxiliary staff be carefully selected and that they receive both appropriate training before taking up their duties and in-service courses. Further, during the performance of their tasks, they should be closely supervised by - and be subject to the authority of - qualified health-care staff.

29. In some countries, the CPT has encountered the practice of using certain patients, or inmates from neighbouring prison establishments, as auxiliary staff in psychiatric facilities. The Committee has serious misgivings about this approach, which should be seen as a measure of last resort. If such appointments are unavoidable, the activities of the persons concerned should be supervised on an on-going basis by qualified health-care staff.

30. It is also essential that appropriate procedures be in place in order to protect certain psychiatric patients from other patients who might cause them harm. This requires inter alia an adequate staff presence at all times, including at night and weekends. Further, specific arrangements should be made for particularly vulnerable patients; for example, mentally handicapped and/or mentally disturbed adolescents should not be accommodated together with adult patients.

31. Proper managerial control of all categories of staff can also contribute significantly to the prevention of ill-treatment. Obviously, the clear message must be given that the physical or psychological ill-treatment of patients is not acceptable and will be dealt with severely. More generally, management should ensure that the therapeutic role of staff in psychiatric establishments does not come to be considered as secondary to security considerations.

Similarly, rules and practices capable of generating a climate of tension between staff and patients should be revised accordingly. The imposition of fines on staff in the event of an escape by a patient is precisely the kind of measure which can have a negative effect on the ethos within a psychiatric establishment.

C. Patients' living conditions and treatment

32. The CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling within the scope of the term "inhuman and degrading treatment". The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. This is of importance not only for patients but also for staff working in psychiatric establishments. Further, adequate treatment and care, both psychiatric and somatic, must be provided to patients; having regard to the principle of the equivalence of care, the medical treatment and nursing care received by persons who are placed involuntarily in a psychiatric establishment should be comparable to that enjoyed by voluntary psychiatric patients.

33. The quality of patients' living conditions and treatment inevitably depends to a considerable extent on available resources. The CPT recognises that in times of grave economic difficulties, sacrifices may have to be made, including in health establishments. However, in the light of the facts found during some visits, the Committee wishes to stress that the provision of certain basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as - in health establishments - appropriate medication.

living conditions

34. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Particular attention should be given to the decoration of both patients' rooms and recreation areas, in order to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy.

Sanitary facilities should allow patients some privacy. Further, the needs of elderly and/or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be made available; the absence of such equipment can lead to wretched conditions.

It should also be noted that the practice observed in some psychiatric establishments of continuously dressing patients in pyjamas/nightgowns is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

35. Patients' food is another aspect of their living conditions which is of particular concern to the CPT. Food must be not only adequate from the standpoints of quantity and quality, but also provided to patients under satisfactory conditions. The necessary equipment should exist enabling food to be served at the correct temperature. Further, eating arrangements should be decent; in this regard it should be stressed that enabling patients to accomplish acts of daily life - such as eating with proper utensils whilst seated at a table - represents an integral part of programmes for the psycho-social rehabilitation of patients. Similarly, food presentation is a factor which should not be overlooked.

The particular needs of disabled persons in relation to catering arrangements should also be taken into account.

36. The CPT also wishes to make clear its support for the trend observed in several countries towards the closure of large-capacity dormitories in psychiatric establishments; such facilities are scarcely compatible with the norms of modern psychiatry. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

Similarly, the CPT favours the approach increasingly being adopted of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

treatment

37. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

The CPT all too often finds that these fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consists essentially of pharmacotherapy. This situation can be the result of the absence of suitably qualified staff and appropriate facilities or of a lingering philosophy based on the custody of patients.

38. Of course, psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed. The CPT will also be on the look-out for any indications of the misuse of medication.

39. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT fits into the patient's treatment plan, and its administration must be accompanied by appropriate safeguards.

The CPT is particularly concerned when it encounters the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.

ECT must be administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose), by staff who have been specifically trained to provide this treatment. Further, recourse to ECT should be recorded in detail in a specific register. It is only in this way that any undesirable practices can be clearly identified by hospital management and discussed with staff.

40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will *inter alia* enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment. The patient should be able to consult his file, unless this is inadvisable from a therapeutic standpoint, and to request that the information it contains be made available to his family or lawyer. Further, in the event of a transfer, the file should be forwarded to the doctors in the receiving establishment; in the event of discharge, the file should be forwarded - with the patient's consent - to a treating doctor in the outside community.

41. Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Of course, consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as “sleep therapy” is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment.

D. Staff

42. Staff resources should be adequate in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), and experience and training. Deficiencies in staff resources will often seriously undermine attempts to offer activities of the kind described in paragraph 37; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

43. In some countries, the CPT has been particularly struck by the small number of qualified psychiatric nurses among the nursing staff in psychiatric establishments, and by the shortage of personnel qualified to conduct social therapy activities (in particular, occupational therapists). The development of specialised psychiatric nursing training and a greater emphasis on social therapy would have a considerable impact upon the quality of care. In particular, they would lead to the emergence of a therapeutic milieu less centred on drug-based and physical treatments.

44. A number of remarks concerning staff issues and, more particularly, auxiliary staff, have already been made in an earlier section (cf. paragraphs 28 to 31). However, the CPT also pays close attention to the attitude of doctors and nursing staff. In particular, the Committee will look for evidence of a genuine interest in establishing a therapeutic relationship with patients. It will also verify that patients who might be considered as burdensome or lacking rehabilitative potential are not being neglected.

45. As in other health-care services, it is important that the different categories of staff working in a psychiatric unit meet regularly and form a team under the authority of a senior doctor. This will allow day-to-day problems to be identified and discussed, and guidance to be given. The lack of such a possibility could well engender frustration and resentment among staff members.

46. External stimulation and support are also necessary to ensure that the staff of psychiatric establishments do not become too isolated. In this connection, it is highly desirable for such staff to be offered training possibilities outside their establishment as well as secondment opportunities. Similarly, the presence in psychiatric establishments of independent persons (e.g. students and researchers) and external bodies (cf paragraph 55) should be encouraged.

E. Means of restraint

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, strait-jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.

The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

49. Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise “unmanageable” patients, a procedure which has a long history in psychiatry.

There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.

Seclusion should never be used as a punishment.

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence.

F. Safeguards in the context of involuntary placement

51. On account of their vulnerability, the mentally ill and mentally handicapped warrant much attention in order to prevent any form of conduct - or avoid any omission - contrary to their well-being. It follows that involuntary placement in a psychiatric establishment should always be surrounded by appropriate safeguards. One of the most important of those safeguards - free and informed consent to treatment - has already been highlighted (cf. paragraph 41).

the initial placement decision

52. The procedure by which involuntary placement is decided should offer guarantees of independence and impartiality as well as of objective medical expertise.

As regards, more particularly, involuntary placement of a civil nature, in many countries the decision regarding placement must be taken by a judicial authority (or confirmed by such an authority within a short time-limit), in the light of psychiatric opinions. However, the automatic involvement of a judicial authority in the initial decision on placement is not foreseen in all countries. Committee of Ministers Recommendation N° R (83) 2 on the legal protection of persons suffering from mental disorder placed as involuntary patients allows for both approaches (albeit setting out special safeguards in the event of the placement decision being entrusted to a non-judicial authority). The Parliamentary Assembly has nevertheless reopened the debate on this subject via its Recommendation 1235 (1994) on psychiatry and human rights, calling for decisions regarding involuntary placement to be taken by a judge.

In any event, a person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court.

safeguards during placement

53. An introductory brochure setting out the establishment's routine and patients' rights should be issued to each patient on admission, as well as to their families. Any patients unable to understand this brochure should receive appropriate assistance.

Further, as in any place of deprivation of liberty, an effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. Specific arrangements should exist enabling patients to lodge formal complaints with a clearly-designated body, and to communicate on a confidential basis with an appropriate authority outside the establishment.

54. The maintenance of contact with the outside world is essential, not only for the prevention of ill-treatment but also from a therapeutic standpoint.

Patients should be able to send and receive correspondence, to have access to the telephone, and to receive visits from their family and friends. Confidential access to a lawyer should also be guaranteed.

55. The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (eg. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.

discharge

56. Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such a placement should be reviewed at regular intervals.

When involuntary placement is for a specified period, renewable in the light of psychiatric evidence, such a review will flow from the very terms of the placement. However, involuntary placement might be for an unspecified period, especially in the case of persons who have been compulsorily admitted to a psychiatric establishment pursuant to criminal proceedings and who are considered to be dangerous. If the period of involuntary placement is unspecified, there should be an automatic review at regular intervals of the need to continue the placement.

In addition, the patient himself should be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority.

57. Although no longer requiring involuntary placement, a patient may nevertheless still need treatment and/or a protected environment in the outside community. In this connection, the CPT has found, in a number of countries, that patients whose mental state no longer required them to be detained in a psychiatric establishment nevertheless remained in such establishments, due to a lack of adequate care/accommodation in the outside community. For persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs.

G. Final remarks

58. The organisational structure of health-care services for persons with psychiatric disorders varies from country to country, and is certainly a matter for each State to determine. Nevertheless, the CPT wishes to draw attention to the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units. The Committee considers this is a very favourable development, on condition that such units provide a satisfactory quality of care.

It is now widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. Care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres.