ENSURING GOOD QUALITY TREATMENT & CARE FOR IN-PATIENTS IN MENTAL HEALTHCARE ESTABLISHMENTS IN UKRAINE:

A HUMAN RIGHTS BASED GUIDE FOR PROFESSIONAL STAFF

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INTRODUCTION

Working in the field of mental healthcare is one of the most rewarding professional roles. However, it can also be one of the most challenging.

Working in the field of mental healthcare is one of the most rewarding professional roles. However, it can also be one of the most challenging.

This booklet, written for senior clinical staff working in mental health establishments in Ukraine, is intended to provide a guide on the key standards and approaches that staff must aspire to when caring for and treating in-patients in mental health in-patient establishments; the aim being that if the suggested practices referred to in the guide are adhered to, the neglectful and ill-treatment of in-patients can be avoided and good quality mental healthcare can be provided.

Although the views expressed are solely those of the authors, they are based on European human rights standards and international clinical standards of practice combined with the authors' experience of the clinical and legal practical application of those standards. Although they have, of course, considered Ukrainian and international law and the Convention on the Rights of Persons with Disabilities (CRPD), the authors would, in particular, like to acknowledge the importance of the utilisation of key CPT[1] Standards and documentation in psychiatry (see Appendix I) which have provided a foundation for this this booklet.

Throughout the booklet, the term 'Mental healthcare establishment' is used, as the guide is applicable not just to psychiatric hospitals (civil and forensic), but also to mental health units situated within general hospitals and to social care establishments caring for residents with psychiatric disorder (although the term 'in-patient' is used throughout, rather than resident, service user or beneficiary). It should be noted that although the booklet is not intended as (and should not be used as) a guide to the treatment of mental disorders in prison or other residential settings (e.g. immigration detention), some of the principles outlined could be applicable in a such settings.

1 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

SECTION I:
BASIC PRINCIPLES

Treatment can only be effective if it is safe and of good quality.

Good Quality Care

During their stay in a mental healthcare establishment, all patients should receive the entire range of safe, good quality, individualised, multidisciplinary treatment and care that they require. This should be provided in compliance with the law, by properly qualified and trained staff and in the least restrictive environment possible, ensuring there is good clinical governance and patients' rights are protected.

Good quality care should be led by a clinical governance approach. Therefore, when a serious untoward incident (e.g. assaults, serious self-harm, suicide, unexpected death, serious errors etc.) or poor practice is detected (e.g. via a complaint), the incident/issue should be investigated and considered by a senior multidisciplinary clinical group of staff that meet frequently (e.g. monthly) so that learning can occur and changes in clinical practice and procedures made, so that there is a continuous process of clinical improvement in the quality of patient care.

Patient Safety

The safety of all in-patients must be ensured. This entails protecting vulnerable patients from harm (e.g. from self; from other persons; from exposure to illegal drugs and alcohol etc.) and/or exploitation; ensuring that evidence-based treatments are provided in a safe and appropriate material environment; and guaranteeing sufficient numbers of appropriately qualified and trained staff, who follow agreed policies and procedures. Security and safety within a mental healthcare establishment is not just based on physical/material conditions, but also upon the procedural and relational security practiced by staff. Treatment can only ever be truly effective if it is safe and of good quality.

One of the very serious risks in mental healthcare establishments is that of patient suicide. Staff members' duty of care includes making every effort to prevent patients from harming themselves; anything less would constitute therapeutic neglect. Therefore, staff need to have been trained in suicide and self-harm awareness; the material environment needs to be ligature free and as clear as possible of objects that could be used for self-harm; and when a patient is deemed to be at serious risk of self-harm, there needs to be sufficient staff to institute frequent (e.g. every 15 minutes) or continuous observation of the patient and to provide psychological support. If a patient at risk of self-harm is placed in a more protected environment, their dignity must be preserved.

The Avoidance of Ill-treatment

The ill-treatment and neglect of in-patients in mental healthcare establishments can take many forms….and can never be tolerated.

The overwhelming majority of staff, in most mental healthcare establishments, are fully dedicated to good patient care. This is often particularly remarkable when staffing levels and the resources available to them are low. However, all staff in mental healthcare establishments should still be aware that, due to a range of possible factors (individual and/or systemic), the care of in-patients can sometimes go awry, even in well-resourced and well managed mental healthcare environments. Although torture per se is extremely unlikely to occur in mental healthcare establishments, unfortunately, the ill-treatment of patients can occur, even when the vast majority of staff have the best intents for their patients. When circumstances are more challenging, such as when financial, human and material resources are lacking, in-patients may be even more vulnerable.

Whatever the cause, the ill-treatment of patients can never be tolerated. Therefore, the management of mental healthcare establishments must act in a proactive manner to prevent ill-treatment of patients by staff, exercise continuous vigilance and remind their staff, at regular and frequent intervals, that in-patients should always be treated with respect, and that any form of ill-treatment of patients, whether verbal or physical, is totally unacceptable and will be punished accordingly.

The management of the establishment must support their staff to do their job properly and must ensure there the needs of the patients in the charge are not neglected.

Forms of Ill-Treatment

The ill-treatment of in-patients by staff in mental healthcare establishments can take many forms. Examples can include:

- Verbal ill-treatment (e.g. disrespect, shouting, insulting, rudeness, verbally humiliation).
- Physical ill-treatment (e.g. pushing, slapping, hitting, punching, kicking, use of sticks).
- Psychological ill-treatment (e.g. bullying, humiliation).
- Sexual contact or exploitation.
- Inter-patient aggression and violence (e.g. bullying; overt physical or sexual abuse).
- The use of medication for non-clinical, punitive reasons.
- The use of seclusion and/or physical/mechanical restraint for non-clinical, punitive reasons.
- Severe neglect (e.g. absence of required somatic or psychiatric treatment and care resulting in major health deterioration).
- Inhuman and/or degrading material conditions.
- Lack of adequate nutrition.
- Lack of privacy and dignity.

Professional boundaries

Staff must always maintain their professional boundaries.

Although it is important for staff to take a friendly attitude towards patients in their care, they must always be mindful of the necessity not to breach professional boundaries. Given the inherent vulnerability of in-patients in mental healthcare establishments, the power dynamics involving staff, the therapeutic importance of trust and the lack of scope for any clear consent, overfamiliar personal relationships (or any sexual contact) between staff members and patients in their care is inappropriate, unacceptable and cannot be tolerated. Any such conduct on the part of staff should always be regarded as an abuse of their authority and be dealt with as such.

Staff should be aware that there can be particular situations which arise that can make them more vulnerable to being especially challenged by the attitude, approach or behaviour of patients in their care. When such challenges arise, the risk of the staff member verbally or physically ill-treating a patient can increase. If staff can maintain insight regarding such higher risk situations, the physical and verbal ill-treatment of patients is less likely to occur; increased objectivity via supervision is important in this regard. Such higher risk situations may arise when:

- A patient is directly verbally abusive and insulting to staff or other patients.
- A patient is directly verbally or physically threatening to staff or other patients.
- A patient is physically assaultive towards staff.
- A patient is very disturbed mentally or physically (including disinhibition).
- A patient has communication difficulties (including as a result of learning disability or personality disorder).
- A patient repeatedly breaks the ward rules.
- A patient repeatedly complains.
- A staff member is tired/exhausted.
- A staff member is under additional separate personal or professional stresses.
- A staff member feels a patient's behaviour is threatening their employment due to potential allegations of staff neglect (e.g. following an attempted escape).
- A staff member feels they have undue responsibilities without the requisite abilities or tools.

Such situations can be further compounded if:

- There is impunity for staff.
- There is a severe lack of properly trained and qualified staff.
- There is an absence of proper staff leadership.
- The establishment is very remote or isolated with no external oversight.
- There is a lack of legal and other safeguards.
- The material environment is poor (which can compound disrespect and lack of pride).

- Staff demonstrate an attitude that is demeaning, cynical, punitive, hostile, grudging.
- Staff have weak boundaries or are defensive, avoidant or overly casual.
- Staff have a weak understanding of the concepts of transference and counter-transference.
- There is discrimination.

Occasionally in mental healthcare establishments staff corruption can occur. This may occur when staff have conflicts of interest or may involve staff (such as medical staff) receiving financial reward from patients or their relatives in relation to the admission or discharge of a patient. Further, a patient's personal finances can be expropriated. If such behaviour is totally unacceptable and, if discovered, immediate action must be taken and the staff involved punished accordingly.

Whilst realising that mental health establishments can accommodate potentially disturbed patients and staff must of course work to maintain order therein, an approach more sophisticated than one purely based in the power dynamic between staff and patients should be deployed. Such an approach should offer, in addition to medication, a full range of therapeutic, non-punitive, approaches, such as psychosocial interventions, rewards and counselling to patients, in a co-productive spirit, to help them understand the benefits and consequences to themselves and others of compliance with treatment recommendations and of prosocial behaviour when feeling challenged (thus assisting them psychosocially to learn strategies to achieve that).

Dealing with Ill-Treatment

Any concerns regarding the ill-treatment of a patient must be properly investigated.

If an in-patient in a mental healthcare establishment complains about physical ill-treatment, they should be questioned about that by someone independent of the alleged perpetrator(s) and, if there are visible traces of violence, a thorough medical examination by a doctor should occur and the injuries should be photographed. The medical examination must be carried out in strict confidentiality. The information obtained, objective medical findings and the doctor's observations must be diligently recorded in the patient's medical file and any injuries indicated on a body chart. Any treatment/support should be provided and the relevant authorities should be informed.

Any member of staff who witnesses the ill-treatment of a patient (or hears credible allegations of ill-treatment caused by others) has a duty to intervene, so as to prevent that and to report it to their senior manager.

Senior managers who become aware of the credible ill-treatment of a patient (for example due to a patient complaint or staff report) need to urgently commence a disciplinary investigation into such allegations and ensure that the alleged staff perpetrator(s) do not have further ongoing contact with patient(s) during the investigation, if necessary by suspending the staff member in question.

All staff grades can be involved in the neglect of patients. Although doctors and nurses can be involved in the physical/verbal ill-treatment of patients, it is more often the less qualified, ward-based auxiliary staff (orderlies[2]) that act inappropriately. The work of an orderly is challenging, so it is important that

2 Sometimes referred to as 'sanitars'.

they be carefully selected and receive appropriate training on managing patients humanely and safely before commencing in post and attend related ongoing in-service training. Further, to ensure good quality care, such staff should always be closely supervised by (and be subject to the authority of) qualified health-care staff, as well as receiving counselling and support to avoid burnout.

Staff are less likely to be involved in ill-treatment if they are empathic, procedurally just, consistent (and do what they say they will do), calm, resilient, patient and good communicators.

Further, safeguards against ill-treatment, from a clinical operational perspective, can include:

- Effective Leadership & Clinical Leadership.
- Maintaining professional independence for clinical staff.
- Staff training.
- Opportunities for reflection.
- Multidisciplinary clinical team support.
- Avoidance of Discrimination.
- Facilitation of complaints.

Avoiding Inter-Patient Aggression & Violence

Inter-patient conflict is a particular problem in poorly supervised environments, with insufficient numbers of staff.

Although some disagreements, shouting and pushing between patients will inevitably occur, more serious inter-patient bullying, exploitation, aggression, fighting and violence can be a significant problem and can cause psychological damage and physical injury to patients in mental healthcare establishments. It is a particular problem in poorly supervised environments, with insufficient numbers of staff.

A mental healthcare establishment's management's obligation to care for patients includes responsibility for protecting them from other patients who might cause them harm. Therefore, staff should be alert to patients' behaviour and be both resolved and properly trained to intervene when necessary. Likewise, an adequate staff presence should be ensured at all times, including at night and weekends. Further, appropriate arrangements should be made for particularly vulnerable patients, by taking care, for example, not to accommodate them or leave them alone with other patients identified as behaving in an aggressive manner.

Avoiding Inhuman & Degrading Treatment

Inhuman and degrading treatment usually results from a constellation of adverse factors…

Whether or not patients are subjected to more direct forms of physical/verbal ill treatment, they can also experience situations in mental healthcare establishments which amount to inhuman and degrading treatment. Often (although not exclusively) conditions which amount to inhuman and or degrading treatment of the individual result from the patient being forced to experience a constellation of neglectful and adverse environmental and other factors (especially over longer time frames with a loss of hope), which have not been addressed by staff, resulting in a grave loss of their dignity. Examples of such factors may include:

- Filthy and/or very poor/dilapidated environmental hygienic conditions (including infestation).
- Filthy/Very poor personal hygiene (including infestation).
- Extreme overcrowding without privacy and personal space.
- Living in an environment with unacceptable lighting and/or ventilation and/or temperature.
- An absence of access to (or very poor) sanitary facilities.
- A severe loss of dignity.
- Isolation from other human contact.
- Confinement and restriction in very austere (sometimes small) areas (with a total lack of outdoor access).
- Absence of required somatic or psychiatric treatment and care resulting in major health deterioration.
- A major lack of individualisation (including shared clothes).
- A total lack of any furniture.
- Having no implements to eat with.

Living in certain constellations of such conditions can also be dehumanising for the patient(s) concerned.

Providing the Least Restrictive Environment

Patients should be treated in the least restrictive environment possible.

In-patients should be treated in the least restrictive environment possible. Therefore, there needs to be an available pathway of care, treatment and support across different intensities of supervision (and

security if required). Patients should be able to move along this pathway (which should offer consistency and uniformly good quality care), so that their in-patient stay offers the fullest range of treatment and rehabilitation opportunities and keeps an in-patient's stay to a minimum.

Promoting De-institutionalisation

In order to improve the quality of life of patients and reduce the potential for them to experience ill-treatment (or inhuman or degrading treatment), all efforts should be made to progress de-institutionalisation locally, regionally and nationally, so that large mental health establishments (often situated remotely) become a relic of the past. Indeed, the provision of good mental healthcare, accommodation and social support in the community for mental health patients is a priority strongly recommended by the World Health Organisation (and is required if a country is to fulfil its obligations stemming from the UN Convention on the Rights of Persons with Disabilities).

Senior staff in large institutional mental healthcare establishments, who have management and leadership responsibilities, should make all efforts to promote the development of community care for their patients, even if, ultimately, it results in the diminution (or even closure) of their establishment. The same patients will still require treatment and the staff who cared for them in in-patient environments can adapt their skills to continue providing care, albeit in a different setting.

Community accommodation, when required for mental health patients, should take the form of small living units in the community, ideally in towns, with all the relevant facilities close at hand. Transfer of a patient from a large psychiatric hospital to a large social care institution is not true de-institutionalisation or proper re-integration of a patient into the community and such trans-institutionalisation should not occur.

Supporting De-stigmatisation

Mental health patients are often stigmatised in their communities as being different (and dangerous); this is unnecessarily distressing for patients and their families. To fight to address this usually requires a national strategic approach with significant political and media influence. However, professional clinical staff working in the field of mental healthcare should not forget that they too can influence society's views regarding mental ill-health and do all they can (be it at an individual level or more broadly; sometimes it can even be as simple as use of language) to reduce the stigmatisation of persons with mental disorder. After all, mental disorders are so prevalent that anyone may be affected, regardless of gender, ethnicity or age.

Avoiding Discrimination

Mental health patients are often discriminated against as a result of their mental disorder. It is important that when such patients are receiving care and treatment in mental health establishments, they do not face discrimination as a result of their gender, ethnicity or sexual orientation or as a result of their political or religious beliefs. Inclusion must be facilitated.

SECTION II:
TREATMENT & PROVISION OF A THERAPEUTIC REGIME

Avoiding the ill-treatment of in-patients residing in in-patient mental healthcare settings is more than containment and preventing their overt ill-treatment…it is ensuring that such patients are offered a full range of high-quality multidisciplinary treatments in a safe and decent environment to meet their needs.

General Principles

Treatment is more than containment and avoiding the ill-treatment of in-patients residing in in-patient mental healthcare settings. It is ensuring their right to receive proper treatment (thus avoiding their neglect) by ensuring they are offered a full range of modern, high-quality, patient-centred, multidisciplinary treatments (not just predominantly based on pharmacotherapy but including a full range of psychosocial treatments), in a safe and decent environment. The treatments should address their individual needs and tackle their full constellation of symptoms and health difficulties. A therapeutic regime is always a combination of an appropriate environment and appropriate staff.

An in-patient in a state run or sponsored mental healthcare establishment should never have to fund any aspect of their assessment or treatment (including medication or somatic care) that would otherwise be available to them for free.

Ensuring Personalisation & Individualisation

All patients should receive individualised, personalised treatment

All patients should receive individualised, personalised treatment that can be fully justified for that individual. There should no blanket treatment approaches applied without exception to all patients.

To assist patients being treated as individuals, all patients should have a named psychiatrist who is in charge of their treatment and a named qualified nurse (their 'key' or 'primary' nurse), who has a detailed knowledge of their case and to whom they can refer, as their first port of call, when they wish to discuss their daily care.

Individual patients, like all persons, need to feel that their voice is being heard by those around them in their community and that they have some control over their own destiny. Apart from being given

time to speak with the staff involved in their own care on an individual basis and having an effective complaints mechanism (see below), it can be a useful arrangement to have a daily (or at least weekly) ward community meeting to which all patients are invited and encouraged to attend, so that they can comment and question issues relating to the ward regime and facilities. This is not complicated to establish and can also benefit staff, as it provides a circumscribed space where patients can take concerns that affect the ward community, which can then be dealt with. Such community meetings can be chaired by a patient, attended by nurses and other clinical staff available and brief notes can be recorded (e.g. in a book), including undertakings made by patients or staff to resolve any particular difficulties.

Ensuring a personalised experience for all in-patients of mental healthcare establishments should help build their self-esteem. Facilitating patients' self-expression should be facilitated, including through their appearance. For example, whilst being aware of maintaining hygiene standards and reducing the risk of infestation, patients should not all be subjected to near identical (and very short) haircuts (indeed, longer stay patients should be able to access a hairdresser in the establishment and choose their style). Further, patients should not be obliged to wear pyjamas all day but encouraged to wear day clothes, their own if at all possible (or if clothes have to be provided by the establishment, they should fit properly and be retained during a stay rather than disappearing into a central pool and becoming irretrievable at every clothes wash).

Further, as long as in-patients are not threatening others or placing others at risk, they should be at liberty in mental health establishments to express their religious and political views. They should also be able to safely express themselves sexually as other adults in the community, including indulging in private masturbation should they so wish.

Initial Admission & Assessment of Patients

> *A high-quality assessment is the fundamental basis for subsequent effective and safe treatment interventions.*

The initial assessment of in-patients after admission, so as to properly plan their treatment, may occur on a dedicated admission assessment ward or on more standard treatment wards.

On admission, a patient's property should be logged and stored appropriately. Banned items should not be allowed into the ward. The patient must be informed of their rights orally and in writing. The patient should be given an induction tour of the ward. If a patient search is required this should preserve dignity and privacy and be performed by staff of the same gender who have been trained in searching.

A high-quality assessment is a fundamental basis for subsequent effective and safe treatment interventions. It should identify the key difficulties facing the patient and also provide a baseline from which to measure progress. Furthermore, a successful initial assessment of a patient should usefully initiate a trusting therapeutic engagement with them. Apart from meeting the patient, with appropriate consent/permission, staff may obtain useful information regarding the patient from relevant informants (e.g. family, friends, doctor, police etc.).

Initial psychiatric assessment should include:

- An account of the presenting complaint(s).

- A full history (i.e. family, childhood, occupations, relationships, medical, psychiatric, substances, forensic, social & financial circumstances etc.).
- A mental state examination (including risks of self-harm/suicide).
- A clinical risk assessment (risks to self and others).
- Further examinations (e.g. assessment of IQ, personality etc.).

Initial somatic assessment should include:

- Basic observations (weight, pulse, blood pressure, temperature).
- Full physical examination.
- Assessment of any physical disabilities.
- Baseline blood tests (e.g. full blood count, kidney and liver function tests, glucose, thyroid function etc.).
- An electrocardiogram (ECG).
- A risk assessment for venous thromboembolism.
- Further investigations if indicated [e.g. chest X-ray, electroencephalogram (EEG), MRI scan etc.].

The somatic assessment must occur within 24 hours of admission.

Any regular medication (psychiatric and somatic) taken by the patient should be noted and continued as indicated.

Following the initial assessment, nursing care plans and a risk management plan should be put in place.

If a newly arrived patient in the mental healthcare establishment complains about ill-treatment by those who escorted them to the establishment (e.g. police), they should be questioned about that and, if there are visible traces of violence, a thorough medical examination should occur and the injuries should be photographed. The medical examination must be carried out in strict confidentiality. The information obtained, objective medical findings and the doctor's observations must be diligently recorded in the patient's medical file and any injuries indicated on a body chart. Any treatment/support should be provided and the relevant authorities should be informed.

Diagnostic Issues

All patients should receive an ICD-10 diagnosis (or diagnoses), which should be recorded in their individual written treatment plan.

One of the foundations of providing good quality and appropriate treatment is an accurate diagnosis of the patient.

All patients should receive an ICD-10[3] diagnosis (or diagnoses), which should be recorded in their individual written treatment plan (see below).

3 International Classification of Diseases Volume 10; World Health Organisation.

Clinical Risk Assessment

When considering risk presented by an in-patient, rather than just having a system that classifies the patient as, for example, low, medium or high risk, a more sophisticated approach should be adopted that allows a more accurate formulation of risks to be made, specifically, risk of what, to who, when, where and why. This should aid more effective management of patient risks. Clinical risk assessments should be made using both clinical and actuarial approaches. Despite some static factors, risk assessment is dynamic and therefore regularly needs updating when there are situational changes.

Often when serious untoward incidents occur (e.g. assaults, serious self-harm, suicide etc.), the relevant risks were already known, but had not been effectively shared or communicated. Communication of risks between staff involved in a patient's care is vital.

Biological Treatments for Mental Disorders

Medication

Medical staff should have access to an uninterrupted supply and adequate range of newer generation antipsychotic and antidepressant medications, plus anxiolytic, hypnotic, mood stabilising and anti-epileptic medications, from which they can prescribe for their patients.

Regarding administration of medication, operational procedures should be in place that ensure that medication is reliably administered to the correct patient in accordance with prescription, with the administration recorded.

As patients treated with the medication Clozapine[4] can have, as a side-effect, a potentially lethal reduction of their white blood cells (granulocytopenia), they require regular and appropriately frequent, systematic monitoring of their white blood cell count. Further, clinical staff should be aware of the early signs of the potentially lethal side effects of Clozapine.

Regarding PRN[5] medication, it may be appropriate that a doctor prescribes this in advance to be administered by nursing staff on an as needed basis, over a limited period of time, for a selected patient. However, the generalised use of PRN medication without systematic control by medical staff is not appropriate as it distances the doctor from doing a contemporaneous assessment of the patient's needs regarding medication and places too much responsibility on nursing staff. When PRN medication is administered its use needs to be recorded and a doctor needs to be immediately notified.

Electroconvulsive Treatment (ECT)

ECT is an accepted and recognised form of treatment for psychiatric patients suffering from some particular disorders. However, great care must always be taken that such treatment is integrated into the patient's individual treatment plan and its administration must be accompanied by appropriate safeguards.

4 Also known as: Alemoxan, Azaleptine, Azaleptol, Cloment, Clonex, Clopin, Clopine, Clopsine, Cloril, Clorilex, Clozamed, Clozapex, Clozapin, Clozapina, Clozapine, Clozapinum, Clozapyl, Clozarem, Clozaril, Denzapine, Dicomex, Elcrit, Excloza, FazaClo, Froidir, Ihope, Klozapol, Lanolept, Lapenax, Leponex, Lodux, Lozapine, Lozatric, Luften, Medazepine, Mezapin, Nemea, Nirva, Ozadep, Ozapim, Refract, Refraxol, Schizonex, Sensipin, Sequax, Sicozapina, Sizoril, Syclop, Syzopin, Tanyl, Uspen, Versacloz, Xenopal, Zaclo, Zapenia, Zapine, Zaponex, Zaporil, Ziproc, Zopin.

5 Pro re nata (as required).

All mental health establishments in which ECT is administered must have the necessary staff, equipment and facilities to allow the treatments to be administered in its modified form (i.e. in the presence of an anaesthesiologist, with both an anaesthetic and muscle relaxant being used) and in an effective and dignified manner.

To ensure that ECT is only used for the proper indications and is carried out in an appropriate manner, clear, detailed and binding written rules on recourse to ECT should be available to, and known by, staff in the mental healthcare establishment where such treatment is used. The rules should include the following safeguards:

- ECT is administered only by staff who have been specifically trained to provide it.
- A fully qualified anaesthesiologist, appropriate physical monitoring (including electroencephalography and electrocardiography), and resuscitation equipment is present throughout.
- The written informed consent of the patient (or of the guardian, if the person concerned is deprived of legal capacity by a court) to the use of ECT and the associated anaesthesia, based on full and comprehensible information, is sought and kept in the patient's file and, save for exceptional circumstances clearly and strictly defined by law, the treatment is not administered until such consent has been obtained on the occasion of each treatment in the course.
- ECT is administered out of the view of other patients (preferably in a room or suite which has been set aside and equipped for this purpose).
- Recourse to ECT is recorded in detail in a specific register as well as being a part of a written individual treatment plan included in the patient's medical record.

The administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants) can no longer be considered as acceptable in modern psychiatric practice and should never occur. The use of such and out-dated method of administration of ECT entails a heightened risk of emotional distress for the patient, the unnecessary infliction of pain and a raised risk of undesirable medical complications.

Somatic Treatments

In-patients in mental healthcare establishments must also have their somatic health and treatment needs met (including regarding dental care and treatment for infectious diseases). This will require input from a combination of staff employed at the establishment and visiting external specialists. There should at least be an equivalence of somatic healthcare, in that in-patients in mental healthcare establishments should not receive somatic healthcare that is poorer in quality than they would be access were they in the community.

Medical staff should have access to an uninterrupted supply and adequate range of somatic medications, from which they can prescribe for their patients.

Preventative healthcare (e.g. cardiovascular, diabetic, breast and gynaecological screening) and conservative restorative dentistry should be available and patients should receive periodic somatic health check-ups (e.g. at least annually for long stay patients).

There should be trained staff and equipment available for resuscitation of a patient.

Infectious Diseases

In order to avoid hazardous risks to staff from infectious diseases, it can be a good principle to take precautions with all patients and their bodily fluids, as though they may be suffering from an infection.

With regards to specific infections:

- **Tuberculosis (TB)**: In areas where TB is endemic in the community (or prisons) where patients have resided, patients should be screened for TB on admission and, if TB positive, appropriately treated with medication using an approved DOTS+ programme. When patients have open TB, they will need to be segregated in dedicated wards (via transfer to another facility if required). Patients with TB should be provided with appropriately enhanced diets, additional space and access to fresh air. All efforts need to be made to protect staff working on wards with TB patients, from infection at all times.
- **HIV**: Patients with HIV infection should be provided with anti-retroviral medication as required. They should not be segregated from other patients (unless that is required by their medical condition) or otherwise stigmatised.
- **Hepatitis C**: Patients with chronic Hepatitis C infection should be provided with direct acting antiviral (DAA) oral medication as required. They should not be segregated from other patients (unless that is required by their medical condition).

Physically Disabled, Immobile & Incontinent Patients

The needs of physically disabled and/or immobile and/or incontinent patients must be met so as to ensure their treatment is equivalent to others, their independence maximised and their safety ensured. They may be even more prone to depression or anxiety, thus requiring additional input to address this.

The living environment for physically disabled in-patients needs to be adapted to meet their needs (e.g. appropriate sanitary facilities that allow them to sit; bath lifts; ramps; functioning lifts to the ground floor etc.) and they should be provided with relevant mobility aids (e.g. wheelchairs, walking frames etc.).

Bed-ridden patients should be provided with anti-decubitus mattresses and bed cot-sides (to prevent falls).

Patients prone to incontinence should be provided with incontinence pads and plastic covered mattresses and have their additional clothing and hygiene needs met.

Patients who have difficulties feeding themselves (or swallowing) should be provided with assistance from staff.

Contraception

Some patients may arrive at the mental healthcare establishment with contraceptive measures in place. These should be maintained unless there are medical contraindications, in which case, following discussion with the patient, alternatives may be required.

Patients in mental healthcare establishments should be offered appropriate education regarding safe sexual behaviour and should be able to access medical advice if they wish to discuss contraception or concerns regarding pregnancy. It would be considered good practice that condoms be freely available for patients to access in such establishments (for both contraceptive and infection control reasons).

End of Life Care

Any mental healthcare establishment that may need to offer its patients end of life care (e.g. as it accommodates long stay, elderly, or physically ill/infirm patients etc.) should have clear policies and practices in place that ensure the patient's dignity is preserved and adequate analgesia can be offered.

Psychosocial Treatments & Rehabilitation

There should be a range of possibilities for patients to be involved in clinically appropriate rehabilitative psychosocial treatment and activities, in order to prepare them for more independent living and/or return to their families. This should include psychological, occupational therapies and social rehabilitation as well as relevant recreational and sports opportunities, in addition to contact with the outside world.

Psychological Therapies

> *Psychological treatments, including a range of relevant individual and group therapies, should be available to those patients who require them.*

Apart from participating in psychological assessments (such as in relation to personality, intelligence and risk), there should be the possibility, for those patients who require it, to access psychological treatments, including psychoeducation and individual and group psychotherapies. Access to specific evidence-based therapies such as Cognitive Behavioural Therapy (CBT) for depression and Dialectical Behavioural Therapy (DBT) relating to self-harm should be available, so should therapies to address difficulties such as anxiety and, of particular relevance in forensic psychiatric hospitals, issues relating to violence and aggression and sexually deviant behaviour.

For patients who have substance misuse problems (with illegal drugs and alcohol), apart from biological therapies and keeping the environment free of such substances, relapse prevention therapy programmes should be available.

Due to the serious life-threatening risks to health from tobacco use, patients in mental healthcare establishments who smoke cigarettes should be strongly encouraged to quit smoking and, if the establishment is a non-smoking one, newly admitted patients should be supported in refraining (and withdrawing) from tobacco. To this end, such patients may require psychoeducation and psychological support (as well as being provided with nicotine replacement products[6] if indicated). Patients in mental healthcare establishments should never be offered cigarettes by staff as a reward for any task or behaviour.

Serious untoward incidents on a ward (e.g. assaults, serious self-harm, suicide etc.) can be very stressful for the patients residing there. Therefore, a debriefing session with the patient group affected, involving psychology input, should occur after such incidents. Additionally, individual patients should be offered counselling as indicated.

6 E.g. gum, patches, sprays, inhalers, lozenges.

Occupational Therapies, Social Rehabilitation & Recreational Opportunities

Patients should not be left idle day after day. A range of meaningful occupational and recreational opportunities should be available for them.

Occupational therapies and educational activities are an important part of a treatment programme, especially for longer stay patients; they encourage motivation, the development of learning and relationship skills, acquisition of specific competences and improvement of self-image. In-patients should not be left just to idly lie or sit around day after day. Therefore, a range of meaningful occupational, educational and recreational opportunities should be made available to them.

Apart from more formal occupational and creative therapeutic opportunities (e.g. art, music, drama), social rehabilitation and educational opportunities, there should also be a wide range of recreational opportunities available to in-patients in mental healthcare establishments. In-patients should be able to access board and card games, music, radio, television, printed reading material (newspapers, magazines & books, including from a library) and the internet (via phone or computer). The content viewed should of course be legal and not harmful to themselves or others. Ensuring this may be a challenge, especially regarding internet access, but engaging the patient in therapeutic discussion and agreement regarding this may be as effective as trying to impose difficult to enforce restrictions.

Sporting Opportunities

Physical exercise is proven to improve an individual's mental and physical health. Opportunities for physical education, exercise and sporting activity should be available to patients (whose medical condition permits). This should include access to exercise equipment, ideally provided in a small gym, as well as to areas (preferably indoor and outdoor) where patients can engage in sport (e.g. badminton, basketball, football etc.).

Ensuring Contact with the Outside World

To reduce the harmful effects of institutionalisation, strenuous efforts should be made to maintain patients' contact with the outside world.

In order to reduce the harmful effects of institutionalisation, strenuous efforts should be made in mental healthcare establishments to maintain all in-patients' awareness of and contact with the outside world. Even though some in-patients may not have any family ties, efforts should still be made to enhance contact with the community. This can be done via:

- Access to a telephone.
- Facilitating visits.
- Access to the local community, shops and money.

Access to a Telephone

In-patients in mental healthcare establishments should be able to access a telephone, privately, on a frequent basis, should they so wish. Allowing in-patients to retain their mobile phones would be seen as good practice (as a phone is often an integral part of an individual's daily life and identity, being used to keep contacts, personal information and manage day to day activities). If security restrictions are required regarding access to a mobile phone (such as in forensic psychiatric hospitals), such restrictions should be clearly regulated, explained to the patient, and effective alternatives provided. If a patient cannot access a mobile phone, access to a landline card/pay-phone should be possible. Patients should never have to rely upon the use of mobile phones belonging to staff. Patients who have no funds to access a phone should be provided with appropriate assistance to make calls to their family, make contact their lawyer etc.

Receiving Visits & Geographical Proximity

In-patients in mental healthcare establishments should be able to easily receive visitors on a frequent basis and the time periods for visits should not be unduly limited (especially if a relative or friend has travelled a long distance to visit and cannot visit frequently). Except in very exceptional circumstances (e.g. in a forensic psychiatric hospital, if the patient presents a serious danger or there is grave suspicion that illegal substances will be smuggled), a patient should be able to sit openly with their visitor (e.g. across a table), rather than using a 'closed' visit facility where persons speak through a screen without touch). If staff remain present to supervise a visit, they should remain at a distance and not within earshot.

While they need to be in hospital, accommodating in-patients in establishments as geographically close as possible to any family (or carers/close friends in the absence of family), will allow the maintenance of contact with family/carers/friends. Therefore, if a patient finds themselves admitted to a mental healthcare establishment distant from their home area, arrangements should be made to transfer them to their most local facility.

If a mental healthcare establishment accommodates patients without any external contacts (family or friends), consideration should be given to establishing a voluntary visitor scheme with local community groups, so that every patient might have the possibility of a visitor.

Access to the Local Community, Shops & Money

As soon as in-patients detained in mental healthcare establishments have sufficiently progressed with their treatment, part of their psychosocial rehabilitation should include visits to the local community. This will assist them in redeveloping their skills in the activities of daily living, as well as allowing staff to reassess their readiness for discharge into the community.

If an in-patient is unable to access the community and therefore local shops, their ability to purchase items (e.g. for personal consumption/use) should still be possible internally (via a shop in the establishment) or externally (via the internet or staff assistance).

In-patients should be able to access their personal finances, including any disability payments or pensions. If there are concerns regarding a patient's ability to safely manage their own finances due to their mental condition or other vulnerabilities, safeguards should be in place so that a legally appointed guardian can access to funds on their behalf. Any patients' monies held by an establishment should be transparently accounted for and open to external audit.

Spiritual Support

In-patients in mental health establishments should be able to fulfil their spiritual needs. Therefore, it is necessary to provide access to appropriate religious texts (e.g. Bible, Koran, Torah etc.) as well as space for prayer to occur; this could, for example be in the form of a multi-faith prayer room and/or specific spaces for specific faiths. Further, in-patients should be able to be visited by representatives of their religion (e.g. priest, imam, rabbi etc.).

Clinical Documentation

All patients in mental healthcare establishments should have an individual written casefile which contains documentation relating to their stay. This can be in paper or electronic form. It should contain all relevant information, including demographic details, diagnoses, admission assessment, results of psychological and somatic tests (e.g. blood results, x-rays etc.). It should also contain regular and frequent entries giving updates on the psychiatric and somatic progress of the patient.

A patient in a mental healthcare establishment should be able to consult his individual written casefile (with third-party information redacted), unless this is inadvisable from a therapeutic standpoint. A patient should have a right to read what has been written about them and their state of health and treatment and to request that the information the casefile contains be made available to their family or lawyer.

Legal documentation relating to the patient's stay should be also held in their individual written casefile; if such documentation is held in a separate legal file, the patient should also be able to access those legal papers unless prevented from doing so by law.

Individual Written Treatment Plans

All in-patients, without exception, should have an individual written treatment plan.

All in-patients, without exception, should have an individual written treatment plan, taking account of their special needs and the phase of their admission (e.g. acute; rehabilitation etc.). This plan should be filed in the individual in-patient's individual written casefile (paper and/or electronic). The plan should be regularly reviewed and, although its formulation must be led by the in-patient's treating psychiatrist in close consultation with the patient's key nurses and multidisciplinary clinical colleagues, the in-patient should also be involved in the plan's formulation and should sign the plan to indicate their awareness of it (and hopefully their agreement to the treatment approaches listed therein). The plan can then usefully be used, with the patient, to monitor implementation of the patient's treatments and therapies

Although the use of the DSM-4[7] diagnostic system is less widely used in Europe, its use of a multiaxial diagnostic model is a useful concept to bear in mind when formulating a full treatment plan as it

7 Diagnostic & Statistical Manual Volume 4, American Psychiatric Association.

places emphasis not just on a diagnosis of mental illness but also on the additional and varied needs of a patient (including relating to any substance misuse, personality issues, developmental factors including IQ, somatic conditions, situational factors and psychosocial stressors).

Elements of an in-patient's individual written treatment plan should include:

- Name & date of birth
- Diagnosis
- Risks to self & others
- Goals of treatment
- Medication (psychiatric & somatic)
- Psychological treatments being offered
- Social rehabilitation interventions
- Discharge/transfer plans
- Indicators of relapse and known triggers
- Review date

Each of the main treatments/therapies, which should in broad terms describe how these will be achieved, will require a listed named member of staff responsible for ensuring the treatment/therapy is delivered within an agreed written timescale.

Reviewing Treatment

All relevant staff should endeavour to be readily available to patients, so that patients can discuss their care, treatment and concerns with them.

In addition, an in-patient's treatment should also be reviewed more formally on a regular basis:

- At **ward level**, a **handover update** on any significant changes in a patient's behaviour, risk (including relating to self-harm) or needs should be passed over from nursing and medical staff on a departing shift to the staff on the next shift.
- At **multidisciplinary clinical team level** there should be a **regular multidisciplinary clinical meeting**, involving the team of clinicians involved on a ward, with all clinical disciplines represented and led by the doctor in charge of the patient's care, where the progress of, and treatment for, each patient on the ward is discussed, reviewed and recorded. Such clinical team meetings should ideally happen every 1-4 weeks.
- At **multidisciplinary clinical team level** there should be **regular multidisciplinary clinical case conferences** on each individual patient, led by the doctor in charge of that patient's care and involving the team of clinicians involved in that patient's care, with all clinical disciplines represented. At the meeting, the progress of, and treatment for, the patient should be reviewed in detail, diagnosis confirmed, future plans discussed and any alterations in treatment made with appropriate revision of the patient's individual written treatment plan. Such clinical case conferences should occur after the patient's initial assessment period and when any major developments occur regarding a patient. Further, for longer stay patients, such case conferences should ideally happen, every 6 months thereafter (and not further apart than 12 months).
- At **inter-team level, prior to transfer** (to another ward or establishment or the patient's discharge to the community) **a multidisciplinary handover clinical case conference** on a

patient should occur. This pre-discharge/transfer case conference should be led by the doctor currently in charge of the patient's care and include the team of clinicians who have been involved in the patient's care. At the meeting, the progress of, and treatment for, the patient should be reviewed in detail and the future plans for the patient's care and treatment after departure agreed. The meeting should be attended by at least one appropriately senior clinician (preferably the doctor) who will be involved in the patient's future care, so that all relevant clinical and risk issues can be discussed with them and handed over.

The patient should always be invited to join at least part of the discussion regarding their care at the clinical team meetings and case conferences, so that they may be given feedback and have their views and opinions heard. Treatment is not something that is done to a patent but is something that should be done with them, in a spirit of co-production. Further, with the patient's agreement, their next-of-kin/close family representative(s) may be invited to their case conferences, so that they too are aware of their loved one's progress and the plans for their future.

When reviewing a patient's care in the aforementioned meetings, their psychiatric and somatic treatment needs (biological and psychosocial) should be reviewed as well as clinical risk issues.

The Special Needs of Specific Groups of In-Patients

Female In-Patients

Female patients may present with specific mental difficulties that require particular attention and equality of access to care must be guaranteed.

Many women have histories of trauma, abuse and exploitation and exhibit post-traumatic symptomatology; certain clinical practices (restraint, seclusion, searches etc.) may reactivate traumatic symptoms. Although their level of physical aggression to others can be lower with than with men, women can present with relatively higher levels of deliberate self-harm and medically unexplained symptoms.

Access to gender-specific health screening should be available.

The management of pregnant and post-partum mothers requires particularly specialised care due to their vulnerabilities, the risks to their children from the environment, medication, specific dietary needs etc. If termination of pregnancy is being considered, legal safeguards must be followed.

Where female patients are accommodated, there should always be careful consideration of staff gender ratios and the use of chaperones, with female staff always on duty.

Child & Juvenile In-Patients

Child & juvenile in-patients should not be accommodated on the same wards as adult patients. They have their own special needs (e.g. related to conduct disorder, mood, ADHD etc.) and are vulnerable to domination and exploitation; their care needs must be met in a ward environment customised to their needs and staffed by clinical professionals with the appropriate skills. If necessary, child/juvenile patients should be transferred to an appropriate establishment offering specific care and treatment programmes and education that meet their needs. Maintaining contacts with the child/juvenile's family (and involving the family in therapy as appropriate) requires especial attention.

Every effort should be made to avoid using any form of restraint with a child/juvenile patient, (especially seclusion, mechanical and chemical restraint).

Elderly In-Patients

Elderly patients may present with specific mental and somatic difficulties that require particular attention (e.g. dementia, somatic disease, physical frailty, reduced self-care abilities etc.) and equality of access to care must be guaranteed.

Particular caution is required regarding the use of polypharmacy (the use of multiple medications) due to the resultant risks of interactions and side-effects, including delirium.

Although elderly patients may require sedative psychotropic medication, as they are more susceptible to falls and constipation, particular caution needs to be exercised when prescribing this.

Particular caution is required regarding elderly patients with neurocognitive disorders, as their ability to consent to hospitalisation and treatment may be impaired and they may be more vulnerable to exploitation.

Learning Disabled In-Patients

Patients with learning disability present with specific mental difficulties that require particular attention. Equality of access to care must be guaranteed.

Learning disabled patients should not be accommodated on the same wards as other types of patients. Individuals with learning disability have their own specific vulnerabilities and needs (including educational); these can best be met in a ward environment customised to their needs and staffed by clinical professionals with appropriate special care skills.

Patients with with learning disability can find understanding and following rules routines difficult, may struggle to communicate their physical and mental health needs and can be vulnerable to bullying, harassment and abuse.

Physically Disabled/Bedbound In-Patients

Please see above.

Foreign National In-Patients

For foreign national in-patients who have limited language abilities in Ukrainian (or other commonly spoken languages), the establishment should arrange for interpretation to be provided so that a proper assessment can occur and then treatment can be provided. Interpreters should be appropriately qualified; the use of fellow patients as interpreters should, in principle, be avoided. Further, such patients should receive written information concerning their rights in a language which they can understand.

If such patients have no family nearby, their potential isolation may be reduced by facilitating visits from any nearby friends and/or phone or videocalls with distant family (preferably by using VoIP[8] technology, so as to avoid the expense of international phone calls) and by allowing them access to written material (including electronically via the internet) in a language which they can understand.

If repatriation is required this should be arranged by liaison with the relevant authorities in Ukraine and in the patient's home country.

8 Voice over Internet Protocol.

Preparing for Discharge/Transfer

As described above, an in-patient's progress (and therefore need to remain in the establishment) should be regularly reviewed and rehabilitation and resocialisation should be actively pursued.

It is not acceptable that patients remain detained in a psychiatric hospital as a result of a lack of adequate care/accommodation in the community. An in-patient's stay should cease as soon as it is no longer required by their mental state.

Continuity of care following a patient's release from a mental healthcare establishment should be ensured with a full and carefully planned care package, including medical treatment, psychosocial support, appropriate accommodation etc.

SECTION III:
THE USE OF RESTRICTIVE INTERVENTIONS (SECLUSION & RESTRAINT)

The use of means of restraint impose extreme restrictions on a patient…. this places special responsibilities on the staff to adhere to very clear procedures, practices and safeguards.

General Principles

It is accepted that, at times, agitated patients in mental healthcare establishments who represent a danger to themselves or others, may require restrictive measures. This can include physical restraint (staff holding or immobilising a patient using manual control), mechanical restraint (immobilisation, usually using ties or belts) or seclusion (involuntary placement alone in a locked room). Such patients may also require chemical restraint (forced sedation using medication[9], usually by injection), which is often combined with mechanical restraint or seclusion.

Any restraint should be in accordance with the principles of legality, necessity, proportionality and accountability. Restraint should only ever be a last-resort intervention to necessarily and safely manage a patient's acute episode of disturbed mental state and related behaviour, within an overall therapeutic context.

Forms of restraint should not be perceived by patients within any mental healthcare establishment as being either a potential or threatened punishment for infringement of their ward's formal rules and informal codes of approved behaviour. If such beliefs exist amongst patients, staff should work therapeutically with relevant patients to dispel them. No staff member should ever threaten or apply restraint as a punitive means to try and control the behaviour of a patient in their charge or, indeed, perpetuate beliefs amongst their patients that such a staff approach exists.

Given the potential for ill-treatment and abuse inherent in restraint procedures and as the use of means of restraint impose extreme restrictions on a patient thus subjected, the staff involved in restraints have special responsibilities to adhere to very clear procedures, practices and safeguards. Key principles should be adhered to and the mental healthcare establishment should have registers of restraint, a written policy concerning its use and ensure staff have relevant training regarding restraint.

9 Such as sedatives, antipsychotics, hypnotics and tranquillisers.

Restraint should only ever be used as a last-resort intervention to manage a patient's acute episode of disturbed mental state and behaviour, within an overall therapeutic context.

Key principles that **apply to all forms of restraint** include:

- Patients are only restrained as a measure of last-resort when de-escalation techniques have failed.
- Patients are only restrained in order to prevent imminent harm to themselves or others.
- All types of restraint and the criteria for their use are regulated by law.
- If it is deemed necessary to restrain a voluntary patient and the patient disagrees, the legal status of the patient is reviewed.
- Means of restraint are never used as punishment, for convenience, because of staff shortages or to replace proper care or treatment.
- Every resort to a means of restraint is always expressly ordered by a doctor, after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking their approval. To this end, the doctor should examine the patient concerned as soon as possible. Blanket authorisation is not acceptable.
- Means of restraint must always be applied with skill and care, in order not to endanger the health of the patient and to minimise the risk of causing them any pain. Staff should be properly trained in the appropriate techniques before taking part in the application of means of restraint.
- Staff must not be assisted by other patients when applying means of restraint to a patient.
- Once a means of restraint has terminated, a debriefing between the patient and staff takes place.

Means of restraint should never be used as punishment, for convenience, because of staff shortages or to replace proper care or treatment.

Additionally, key principles with regard to **physical and mechanical restraint and seclusion** include:

- Restraints are always used for the shortest possible time (usually minutes to a few hours). When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately.
- Patients are not subjected to such restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient) as this is undignified, potentially unsafe and may be threatening to other patients; visits by other patients should only take place with the express consent of the restrained patient.
- Leaving a restrained (and probably agitated) patient alone in a room is not acceptable. Therefore, every patient subjected to such restraint must be kept under continuous, direct, personal supervision by a member of staff so they can respond to any immediate needs of the patient. In

the case of mechanical restraint, a member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide them with any assistance required. For a patient in seclusion, the staff member (outside the patient's room or in an adjacent room with a connecting window), must be able to continuously observe and hear the patient. CCTV surveillance cannot replace continuous staff presence as it is less reliable and does not allow direct personal contact.

Every patient subjected to mechanical restraint or seclusion must kept under continuous, direct, personal supervision by a member of staff

Further, key principles with regard to **chemical restraint** include:

- Only approved, well-established and short-acting medication should be used.
- Chemical restraint should never be applied without prior authorisation by a doctor.

Registers of Restraints & Monitoring

Each mental healthcare establishment that does, or may, use restraint should have ward-based registers and a specific central register recording all such means of restraints. This allows the establishment's management to monitor the frequency and greater understand and control the use of restraints. The registers should be in addition to individual entries made in the patient's personal medical file. The entries in the register should accurately record in a detailed, standardised format: name, means of restraint, the times the measure began (and for physical and mechanical restraint or seclusion, when it ended); the circumstances surrounding the event; the reasons for resorting to restraint; medication given; the name of the doctor who ordered or approved it; an account of any injuries sustained by patients or staff; and confirmation of a debrief. Patients should be entitled to attach comments to the register (and should be informed of this entitlement) and a patient should be able, at their request, to receive a copy of the full entry regarding any restraint to which they were subjected.

The frequency and duration of instances of restraint should be reported on a regular basis to a supervisory authority and/or a designated outside monitoring body. This facilitates a national overview of restraint practices, so as to assist in implementing strategies to limit the frequency and duration of means of restraint.

Policy on Restraint

Mental healthcare establishments should have a comprehensive, carefully developed, written policy on restraint. The policy should be aimed at preventing, as far as possible, the use of means of restraint and make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. The policy should also contain sections on other important issues such as: staff training; complaints policy; internal and external reporting mechanisms; and debriefing. Further, patients should be provided with relevant information on the establishment's restraint policy.

De-escalation

Effective de-escalation is crucial, it can avert the need for restrictive interventions.

Any form of restraint should only occur following all possible attempts at de-escalating the challenging situation faced with the patient. Restraint is therefore a measure of last-resort when de-escalation techniques have failed.

If staff are aware of the triggers that challenge a patient and the early warning signs that a patient is starting to become aroused (as these have been formulated and shared) before the patient fully escalates their anger and aggression, de-escalation can be instituted at an early stage.

When attempting to de-escalate a situation, staff should communicate with the patient, verbally and non-verbally, in a clear, brief, empathic, non-patronising, non-threatening but assertive manner, making it clear that they wish to help, understand the facts and to flexibly negotiate options.

The Use of Mechanical & Physical Restraint

It is accepted that the use of mechanical or physical restraint can be an important and relevant intervention when a patient is agitated and/or aggressive as a result of their mental disorder.

When deploying physical restraint, neck holds and techniques that may obstruct a patients' airways, inflict pain or hamper their ability to communicate should never be used. Further, patients under mechanical restraint should always be face up, with the arms positioned down.

The usual means of mechanical restraint is fixation by tying to a bed frame[10]. Although 'soft restraints' (bandages or strips of cloth) are frequently used, patients should be restrained using specially designed padded straps or padded magnetic belts and, ideally, a specially designed restraint bed should be used. The straps/belts should not be placed too tightly and should allow some limb movement, so as to avoid pain or discomfort and avoid any medical complications of totally static limbs (e.g. deep vein thrombosis).

Although metal handcuffs, shackles or chains are still, albeit rarely, being used to mechanically restrain patient in mental healthcare establishments, such techniques must never be used; chaining an in-patient is inhuman and degrading and can cause them physical injury.

While a patient is restrained, if they require to respond to the call of nature, this should be facilitated in as dignified a way as is possible, preferably by escorting the patient to a toilet. Alternatively, a bottle or bed pan could be used (for urination; defaecation is very difficult whilst restrained in the prone position). The solution of placing a restrained patient in an incontinence pad is unacceptable; this is degrading.

While a patient is restrained, if they require drink or food this should be facilitated; as far as possible, they should be enabled to eat and drink autonomously (e.g. a hand could be freed) or the patient should be assisted by staff to take food or drink.

10 By one or both wrists (1- or 2-point fixation), plus possibly one or both ankles (3- or 4-point fixation), plus possibly across their chest (5-point fixation).

Patients already subjected to physical or mechanical restraint should only be additionally chemically restrained in situations where they may be in danger of suffering serious health consequences if medication is not administered and if it is with a view to attempting to reduce the duration of any mechanical restraint.

Applying means of mechanical restraint for days on end endangers the patient and cannot have any medical justification, and amounts to ill-treatment.

The use of straightjackets in mental healthcare establishments are a relic of the past and they should not be used. Restraint smocks made from lighter weight material may very exceptionally not be deemed inappropriate, for example if a patient required some form of restraint but also needed to remain ambulatory (e.g. to gain access to outdoor exercise).

The placement of a patient in a net- or cage-bed[11] no longer has any place in the practice of modern psychiatry. Net or cage beds should not be used and taken out of service.

The Use of Seclusion

Seclusion rooms should be custom designed for purpose, offering safe, humane and dignified conditions.

The use of seclusion can be an important and relevant intervention when a patient is agitated and/or aggressive as a result of their mental disorder.

The seclusion room should be custom designed for purpose, offering humane and dignified conditions. It should be safe (ligature free and with reinforced windows, furniture and bedding, plus an observation window in the door or wall which allows visibility of the whole room) and, so the patient remains orientated, the room should be appropriately lit (with dimmable light appropriate to the time of day) and there should be a visible clock (e.g. on the wall outside). The room should be sufficiently spacious, adequately ventilated/heated and have en-suite toilet facilities. The environment should be calming; ideally there should be the possibility of receiving piped music in the room. If there is any suggestion that a patient may not be able to be verbally heard by staff immediately outside the room, a call bell should be available. Ideally, the seclusion room would be part of a de-escalation area or suite which offers the chance for the patient to calm in a dedicated area, hopefully avoiding actually then having to be placed in an adjacent seclusion room.

Any withholding of basic implements (e.g. spoon for feeding; toothbrush) should only occur for the shortest possible time, be justified on a proper risk assessment and reinstituted as soon as possible, with additional staff supervision as indicated.

Patients placed in seclusion should only be additionally chemically restrained in situations where they may be in danger of suffering serious health consequences if such medication is not administered and if it is with a view to attempting to reduce the duration of the seclusion.

Long-Term Segregation

Very exceptionally, such as in forensic psychiatric settings, even after a period of some days in seclusion, a patient may still not sufficiently improve. In such circumstances and in order to manage highly

11 A bed with a frame on top, the entire frame covered in netting or wire, locked in place.

treatment resistant, long-term, immediate and very serious risks to others in their vicinity, a patient may be deemed to require long-term preventative individual segregation (longer-term placement in a room alone). Such an intervention must only be initiated for clinically sound reasons, based on clear risk-based criteria, rigorously monitored and reviewed and have in place special arrangements to compensate for the detrimental long-term isolating effects on patients undergoing such a measure.

Key principles that apply to the use of long-term segregation include that:

- The reasons for initiating and continuing the long-term segregation of the patient are medically authorised and justified, involve multi-disciplinary clinical input, are risk-based and are fully recorded in the patient's personal file as part of the patient's individual treatment plan, which should also include, in addition to medication, the psychosocial therapies that they will be offered.
- There will be a clearly described planned pathway, formulated in consultation with the patient, which defines how attempts will be rigorously made to re-integrate the patient back into full association with others in a less restrictive environment, as soon as possible.
- The patient will have regular, meaningful, daily, face-to-face human contact, opportunities to participate in meaningful activities, (including recreational, with access to reading material and radio or TV) and possibilities to maintain contact with the outside world via visits or telephone.
- The patient will be able to attract staff attention from within the room without delay, such as via a call bell.
- The patient will be offered daily outdoor exercise (unless there are clear medical contraindications).
- Staff will monitor and record the patient's state on a daily basis and continuation of the long-term segregation is reviewed and justified by a multi-disciplinary team and recorded on at least a weekly basis.
- Should the period of preventative individual segregation still be occurring after some months, there is a formal independent, external clinical review of the patient's case to consider possible alternative approaches.
- The patient concerned has the possibility to appeal against the imposition/prolongation of the measure to an independent authority.
- A separate register is established to record all instances of such long-term preventative individual segregation. The entries in the register should include the time at which the measure began and ended; the reasons for resorting to the measure; daily entries by the staff on the clinical review of the patient's state, time out of the room, activities offered and taken; and weekly entries on the review by a multi-disciplinary team.

Any mental healthcare establishment which uses long-term preventative individual segregation should have a comprehensive, carefully developed, written policy regarding its use (which also includes the above key principles).

Chemical Restraint

The use of chemical restraint can be an important and relevant intervention when a patient is agitated and/or aggressive as a result of their mental disorder. The medication used may also have direct palliative effect (e.g. antipsychotic) on the patient's mental illness.

The choice of medication to be used must be carefully chosen, bearing in mind such factors as the age and size of the patient, their diagnosis, their presenting symptoms/signs and their previous responses to medication. The side-effects that such medication may have on a particular patient needs to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion. As part of the close supervision of a chemically restrained patient, their physical observations (e.g. pulse, blood pressure, respiration rate) will need to be regularly monitored.

Only in exceptional situations, when a patient's agitation cannot be controlled by nursing staff and the presence of a psychiatrist is not possible within minutes, may the administration by nursing staff of chemical restraint (i.e. rapid tranquillisers), under a conditional PRN prescription, be justified. In such a situation, a medical doctor must be contacted (e.g. by phone) and must confirm the prescription prior to its administration having learnt of the prevailing circumstances. Furthermore, a medical doctor must arrive without delay to monitor the patient's response and deal with any complications. The use of a PRN prescription for chemical restraint must be accompanied by specific safeguards: as a minimum, any such PRN prescription should have been drawn up by an experienced doctor after having thoroughly assessed the patient's physical status, should only be valid for a limited time (i.e. days or weeks rather than months) and should be re-assessed each time it is used or where there is any change in the patient's status or other medication.

Restraint at a Patient's Own Request

It is not unknown that a patient may occasionally ask to be subjected to a means of restraint. Before complying, staff need to be clear that such a request is not because the patients' needs are being insufficiently met via other therapeutic measures which should first be explored. However, if a patient is nevertheless subjected to any form of restraint at their own request, the restraint measure should be terminated as soon as the patient asks to be released and the situation re-evaluated.

Post Restraint Debriefing

> *Once an episode of restraint has terminated, a debriefing between the patient and staff should always take place.*

Once an episode of restraint has terminated, a debriefing between the patient and staff should always take place, so that staff can properly explain to the patient why they were subjected to restraint. It should also offer the patient an opportunity to explain their emotions prior to the restraint. Such debriefing can reduce any psychologically traumatic aspects of the restraint, improve the patient's and staff's understanding of the incident and the issues that arose, as well as helping to rebuild any damage done to the relationship between staff and patient.

The debriefing discussion (and other subsequent discussions) should also assist the staff and the patient to find alternative means for the patient to maintain control over themselves, thus hopefully preventing any further need for staff to resort to means of restraint.

Staff Training Regarding Restraint

Due to the fact that the restraint of a patient can place the patient and staff in situations where they can be at risk of harm and as means of restraint impose such extreme restrictions on patients, staff must be appropriately trained in restraint techniques. Apart from training in the use of safe and approved physical/manual holding/restraint techniques and the use of mechanical restraint equipment that minimise the risk of injury, as well as training regarding placement in a seclusion rooms, staff should also be trained in de-escalation techniques (with the aim of averting the need for restraint) and in effective post-restraint debriefing.

SECTION IV:
REQUIRED MATERIAL CONDITIONS

The clinical environment must allow patients to be treated with privacy and dignity and have an easily detectable therapeutic atmosphere.

General Principles

In order to provide safe and good quality care and treatment to patients residing in in-patient mental healthcare settings, their environment must be:

- Conducive to their treatment and welfare.
- In a good (non-dilapidated) state of repair.
- Clean and hygienic.
- Properly ventilated (and not damp).
- Warm.
- Adequately lit.

Patients should always have access to:

- Adequate clothing.
- Adequate food.
- Sanitary facilities.
- Personal hygiene products.
- A bedroom or dormitory.
- An outdoor area.
- A dayroom.

Such environments must allow in-patients:

- To be treated with privacy and dignity.
- To be treated safely (including an absence of ligature points, possibility to jump from a height and with regards to fire safety/effective fire escape).

Mental healthcare establishments will often have a number of different wards which may be stratified based upon patient need (e.g. admission assessment; intensive care; treatment; rehabilitation, younger persons; older persons; addictions; somato-psychiatric etc.). Such stratification can be useful as it can allow patients' treatment to be more targeted within a particular ward environment.

The Ward Environment

The general ward milieu should have a positive therapeutic atmosphere that can be detected by in-patients, staff and visitors alike. This means getting a balance between a highly clinical environment and something a little homelier and more welcoming. Décor should not be austere and bare and have overly clinical furniture, (although there will be hygiene and safety considerations), it should be bright and cheerful and there should be visual stimulation, including pictures or murals and patients should be allowed some personal items.

In order to avoid big, cavernous, impersonal, institutionalising, counter-therapeutic environments, wards in mental healthcare establishments should not be unduly large, ideally holding no more than ~25 patients. Therefore, any old-style large-capacity wards holding high numbers of patients (e.g. 50 -100) should be phased out and replaced with smaller living units. Similarly, any large-capacity dormitories should be phased out or architecturally redesigned into smaller units, so that dormitories hold preferably no more than a maximum of 4-5 patients. Such measures should not only facilitate the allocation of patients to relevant categories for therapeutic purposes but also help preserve their safety, privacy and dignity and should assist with their psychological and social rehabilitation.

In order to ensure staff (and patient) safety, there should be an appropriate alarm system which staff can activate in the event of a serious incident requiring immediate additional staff assistance.

If CCTV is installed on a ward, in order to ensure privacy it should not cover normal bedrooms nor sanitary facilities.

Patients' Rooms

Patients' rooms must not be overcrowded, allowing sufficient space to maintain privacy and dignity. It should never be the case that beds are touching or that patients have to share beds. There should be sufficient clean bedding at all times for patients (with additional blankets if required); every bed must have at least one pillow and the state of the beds must be adequate, with any broken-down beds replaced.

Under normal circumstances bedrooms or dormitories should not be locked by staff as a matter of course. If a patient is locked alone in a room, then all the safeguards of such a seclusion must be adhered to (see above). If a group of patients are locked together in a dormitory (as is sometimes found in forensic psychiatric environments), this should be clinically justifiable for each individual patient thus restricted, should be for a clearly delineated time period and properly supervised and should not place the safety of any of the patients at risk.

All in-patients in mental healthcare environments should have access to their own personal lockable space. Ideally, all patients would have single bedrooms to which they hold a key (which staff can override if required) as this provides the ultimate 'personal lockable space' within which to maintain their privacy and dignity and to secure their possessions. Patients who reside in shared ward dormitories should have lockable bedside lockers, cabinets or wardrobes in which to keep their possessions. Failing this, there should be a series of lockers for patients, with individual patients able to freely access their own locker. Patients should be able to access their own locker using their own key or by obtaining the key from staff without delay.

The preferred approach is that patients, who so wish, can access their bedroom during the day, rather than being obliged to always remain together with others in communal areas. However, it is understood that there may sometimes be therapeutic reasons to withhold totally free access to a bedroom for a patient (e.g. to increase social and therapeutic engagement).

Of course, in the unusual situation that two patients on the same ward are in a stable and consenting close relationship, staff may make arrangements for them to be accommodated together in a double room.

Dayrooms

Dayrooms should provide access to TV with a reasonable choice of channels. There should be sufficient comfortable seating for the number of patients who may want to use the day room, sit and watch TV etc.

Outdoor Areas

All patients should have unrestricted daily access to an outdoor area.

Unless there are clear medical contraindications or treatment activities which require a patient to remain inside, all patients should be able to have unrestricted daily access to an outdoor area. The area must have sufficient fresh air space to allow patients to safely walk and genuinely exert themselves physically, should they so wish. The outdoor areas should also be accessible to physically disabled patients (e.g. via ramps, lifts etc.). Under no circumstances should a patient have their possibility for outdoor exercise prohibited as an informal sanction.

The outdoor area should provide seating, as well as some shelter from inclement weather and direct sunlight. In particular due to psychotropic medication induced photosensitivity, patients should ideally be able to access sunscreen.

So that all patients can access fresh air daily, regardless of the weather, they must all have access to sufficiently warm and waterproof clothing and footwear.

Although patients would ideally be able to exercise in the grounds of the hospital (which would ideally be landscaped and pleasant) or go farther afield into the local area, so that all patients, including those that present a security or escape risk, can access fresh air daily, some exercise areas may need to be circumscribed, secure and supervised.

Sanitary Access & Toilet Access

Ensuring good standards of personal hygiene for in-patients is an essential component of humane care.

Ensuring good standards of personal hygiene for in-patients is an essential component of a humane care. Water should be warm. Basic personal hygiene products (e.g. soap, toothpaste, toothbrush, toilet paper, sanitary materials for women), should be provided to patients if they cannot independently obtain them.

Ideally, all patients should have unrestricted access to a warm shower at all times. If access to a shower is restricted, access should certainly be possible much more than once per week.

All patients should have guaranteed access to proper toilet facilities, without delay, on a 24 hour/day basis. This requires patients to have separate (or fully screened) sanitary facilities in their bedroom, which they can access at all times, or unhindered access (not visits at set times) to ward sanitary facilities (which must therefore be unlocked). If sanitary facilities on a ward are required to be kept locked for safety reasons, there must be sufficient staff to always allow patients unhindered access. If a patient is subject to continuous monitoring/supervision by staff, their dignity should be ensured when using the toilet (for example, the supervising staff can remain in the near vicinity but should not be in sight of the patient, except in very exceptional high-risk situations). Whether accommodated alone or with others, patients should never have to urinate/defaecate in a bucket in their room. This is undignified, unhygienic, unhealthy and could be adjudged as degrading.

All patients should have guaranteed access to proper toilet facilities, without delay.

Gender Segregation

Wards in mental healthcare establishments are often segregated. This can assist in optimising patients' privacy and dignity. However, sometimes it is deemed appropriate to keep patients in mixed-gender wards in order to assist socialisation and normalisation but the benefits of a mixed-gender ward should not be to the detriment of patients' privacy and dignity. Therefore, in such circumstances, in order to preserve patients' privacy and dignity, wards should be stratified so that the bedroom areas for male and female patients are in separate zones of the ward, staff should ensure that patients of each gender strictly respect those zones and do not enter a zone that is not theirs and ensure that, in addition to communal areas, there are additional, separate, dayroom areas for both male and female in-patients. Further, such wards need to have gender segregated sanitary facilities.

Interview Rooms

Any room where a patient is interviewed should be maintained in a hygienic condition. Its layout should be safe with clear exits (to reduce the chance of nay hostage/barricade incident) and free of items that could be potential weapons. A patient in a mental health establishment should never be interviewed through bars.

Smoking Areas

If smoking is legally permitted within the wards of a mental healthcare establishment, there should be separate, clearly delineated smoking areas (e.g. a smoking room) which are properly ventilated. Due to the serious health risks involved, non-smokers should never be unwillingly exposed to the effects of passive smoking via exposure to the cigarette smoke of others.

Fire Safety

To avoid the risks of intentional or accidental fires that can endanger patients' lives, staff should have procedures in place which control patients' access to matches and lighters.

Further, ward fixtures and fittings should be fire retardant. Further, there should be fire extinguishers, a functioning and tested smoke and fire alarm system and there should be effective and tested fire evacuation procedures (all of which staff should be trained and practiced in). There should be clear access to any special equipment required to facilitate the evacuation of disturbed patients who may be restrained or of physically disabled or bedbound patients.

Infestation

There is a risk that in-patient accommodation may become infested with vermin (e.g. bed bugs, lice, cockroaches, mice, rats). It is therefore incumbent upon the management of the healthcare establishment to ensure that measures are taken to reduce the risk of such infestation and also perform thorough de-infestation treatments on a regular basis.

Staff Rooms

Staff offices should be maintained in a hygienic and safe condition which shows respect for those using them.

Non-standard issue objects capable of being used for inflicting ill-treatment (e.g. wooden sticks or batons, baseball bats, etc.) should never be kept in staff offices.

Clinical Room

Each ward should have access to a clinical room where patients can be physically examined if required. The room should have a high level of hygiene, have an examination couch, a range of basic medical examination equipment (e.g. thermometer, sphygmomanometer, urine test dipsticks, masks, gloves, syringes etc).

The clinical room should also provide safe storage for the medication required for patients on the ward. This should be in the form of a lockable cupboard (or lockable trolley that can be fixed), with access limited to medical and qualified nursing staff only. Any controlled drugs should be stored especially securely and separately registered. For medicines that need to be stored at lower temperatures, there should be a fridge, reliably functioning at the correct temperature.

Staff on each ward of a mental healthcare establishment should have speedy access to a defibrillator. If there is not one stored in each ward's clinical room, its placement in the establishment should be in a centrally placed clinical room.

Occupational Therapy Areas

Mental health establishment should provide occupational therapy areas for patients. Although these may be on a ward, an economy of scale often dictates that they be situated separately but still easily accessible to patients.

The areas should include appropriate equipment (e.g. for art, music, drama, handicrafts etc.) and should also allow for the assessment of activities of daily living.

Visits Room(s)/Area

An appropriate room(s) or designated area should be available for patients to greet their visitor(s) and sit openly with them (e.g. across a table), in a relaxed environment.

In a forensic psychiatric hospital, if the patient presents a serious danger or there is grave suspicion that illegal substances will be smuggled, it may be appropriate that a 'closed' visit facility (where persons speak through a screen without touch) be provided.

Kitchen & Food

> *Patients need to be provided with sufficient quantities of a varied range of appetising and healthy food of good equality which is attractively presented and hot.*

In-patients in mental healthcare establishments need to be provided with sufficient quantities of a varied range of appetising and healthy food of good equality (including red and white meat, fish, vegetables, grains & bread, dairy products, fruit, sweets). There should be an accessible menu which demonstrates dietary planning for patients and takes into consideration required calorific values/grams of the food provided.

The establishment's kitchens need to be maintained to a high standard of hygiene and equipped with effective and functioning equipment, including fridges for meat and dairy products etc.

At the point of serving, arrangements need to be in place to ensure that hot food is not served cold. Therefore, any transportation of food from kitchen to ward servery need to ensure appropriate insulation. Food should be attractively presented as possible and eaten seated at a table with proper utensils.

There should be special diets available for those patients who require them for medical (e.g. diabetes, TB etc.) or religious reasons.

Pharmacy

In larger mental health establishments where medication is not just stored at ward level, there should be a central pharmacy offering a safe and secure storage facility for medication. Controlled drugs should be stored especially securely and separately registered. For medicines that need to be stored at lower temperatures, fridges should be available, reliably functioning at the correct temperature.

Laundry

Ideally patients should be able to wash their own clothes (e.g. in a washing machine/dryer on their ward), as part of maintaining good self-care. If this is not possible, the mental health establishment should have a laundry of appropriate capacity or have arrangements for clothes to be sent out of the establishment for laundering.

Any laundry needs to be maintained to a high standard of hygiene and equipped with effective and functioning equipment.

Transportation

The transport of patients to and from a mental healthcare establishment, should be under the responsibility and supervision of suitably trained clinical staff (e.g. from the establishment or the ambulance service) who understand mental disorder, although it is accepted that sometimes the police may transport a patient to the establishment.

A mental healthcare establishment should have access to an appropriately safe and equipped vehicle.

Overcoming Potential Difficulties with Material Issues

Sometimes in-patient mental healthcare has to be provided in physical environments that were not originally designed for such a purpose. Whenever possible, additional capital should be obtained from national authorities (or international bodies) so as to build new purpose-built mental health facilities or substantially upgrade and refurbish existing ones so that all the relevant material issues can be provided. When refurbishing facilities, expenditure should first prioritise safety (structural and environmental) and basic needs. Developing an action plan (with clear timescales), within an overall strategic plan, using basic project management skills (e.g. Prince2 methodology) can be an effective approach.

Due to the importance of ensuring a high standard of hygiene in mental health establishments, the importance of employing sufficient cleaning staff should not be underestimated; staff receiving higher salaries with greater clinical skills should not be wasted performing this basic, albeit crucial, function.

Apart from providing appropriate outdoor exercise areas, the management of the establishment must also arrange for there to be sufficient staff to ensure that patients can exercise their rights in this regard.

SECTION V:
STAFFING ISSUES

The foundation of high-quality mental healthcare is multidisciplinary clinical teamwork.

General Principles

Staffing costs will be the greatest expenditure made in a mental healthcare establishment and staff are the most valuable resource for any such establishment.

As described in Section II, offering care and treatment to in-patients with mental disorder is complicated and multifaceted; it cannot be satisfactorily provided by any one individual alone. The foundation of high-quality mental healthcare is multidisciplinary clinical teamwork.

Further, staff (and managers) must maintain their professional standards. They should be conscientious, honest and act with integrity, take responsibility and be accountable for their actions, complying with the law and the establishment's policies and procedures. Additionally, staff should be courteous, reasonable and fair in their dealings with all patients, colleagues and visitors, treating people with decency and respect. Managers must ensure that standards are maintained.

All in-patient mental healthcare establishments require sufficient numbers of carefully selected, properly trained, multidisciplinary staff to provide good quality, safe care to all patients in their care.

Of course, all in-patient mental healthcare establishments require sufficient numbers of carefully selected, properly trained, multidisciplinary staff to care for patients. Insufficient staff numbers can seriously undermine attempts to offer rehabilitative and therapeutic activities to patients and could lead to high-risk situations, notwithstanding the good intentions and genuine efforts of the staff present. Any system of individual staff occupying more than one full-time post may be detrimental to satisfactory patient care, if it extends beyond short-term situations of staff shortages.

Regarding widely applicable guidelines on the precise numbers of staff (whole-time equivalents), of different clinical disciplines, that are required in mental healthcare establishments, these are very difficult to formulate. The number of staff required to safely manage a group of patients on a particular ward will depend upon not just on the number of patients residing therein but on a range of other factors, such as shift patterns, the actual physical size and layout of the ward (affecting safe observation etc.) as well as the patients' level of disturbance, their diagnostic profile, their psychological and physical dependency needs etc. (all of which can vary). Further, to safely staff any ward and provide varied

good quality treatments, there will need to mix of staff with different skills at different times of the day (with staffing levels lower at night when most patients will sleep). Therefore, the guiding principle for staffing levels should be that there are sufficient numbers of adequately trained staff to ensure that the rights of all patients in their care, including their right to treatment, are met, so that good quality, safe and effective treatment is always provided to all. The situation that is sometimes found in mental healthcare establishments where 3-4 ward-based staff are attempting to care for 30-60 patients is clearly totally unacceptable.

> *An in-patient in a mental healthcare establishment should never be placed in any position of authority over another patient.*

Whilst accepting that in-patients may wish to assist each other, in-patients in mental healthcare establishments should never be placed in any position of authority over another patient(s). Therefore, a patient should never be employed to perform some or all of the duties of an auxiliary member of staff (with or without material recompense) on a regular or ad hoc basis. Thus, for example, an in-patient should never be involved in assisting in the restraint of another or responsible for the maintenance of another's personal bodily hygiene. In-patients should never hold the keys to clinical areas nor be given the role of guarding the door of a ward, gate of the establishment etc. If staff, such as occupational therapy staff, decide for rehabilitative reasons that it would be beneficial for a patient to be involved in simple tasks such as cleaning or carrying, this should be agreed with the multidisciplinary clinical team, included in the patient's individual treatment plan and, usually, some small recompense should be offered. The fulfilment of such tasks should never depend upon a patient's assistance.

Medical Staff

Psychiatrists[12] are at the core of treatment in a mental healthcare establishment, not just because it is they that diagnose the patients and prescribe their medication but because the multidisciplinary clinical team should be medically led and the doctor should be responsible that the necessary full range of multidisciplinary clinical care is provided.

Psychiatrists should have formal higher training in psychiatry in addition to their basic medical training. They should be compliant with continuing professional development and ongoing training requirements and be registered with their professional body with a licence to practice.

A mental healthcare establishment will also require medical staff who can provide high quality somatic healthcare to patients. This must include a resident or frequently visiting general practitioner, as well as other visiting specialists (e.g. internist, pulmonologist, cardiologist, gynaecologist, dentist etc.). Patients should also be able to access medical specialists that do not visit their establishment by travelling to visit them, with staff assistance as required.

A mental healthcare establishment must always have access to 24-hour medical cover and emergency medical attendance in case of acute illness, serious injuries from self-harm etc. (e.g. ambulance availability with transfer to an emergency department).

12 Including neuropsychiatrists.

Paramedical Staff

Paramedical staff (e.g. laboratory clinician, radiologist, physiotherapists) may be required to provide for patient needs.

Nursing Staff

Mental healthcare nurses need to provide the day to day safe mental health and somatic care required by in-patients. They should be compassionate, have a genuine interest in engaging and establishing a therapeutic relationship with patients and be good listeners who are able to offer them counselling and psychological support, whilst using legitimate authority.

Regarding working patterns, nursing shifts should ideally be in 8-hour or 12-hour periods (i.e. 2-3 shifts/day). Although, sadly relatively frequently still occurring, staff should not be expected to work shifts that are 24-hours long; apart from being detrimental to the staff's own health, it does not allow staff to safely nor optimally perform their duties vis-à-vis patients and will inevitably have a negative effect on professional and clinical standards, as no-one can perform in a satisfactory manner the difficult tasks expected of a nurse for such a length of time.

Qualified Nursing Staff

Mental healthcare nursing is a profession. Nursing staff in mental healthcare establishments should be trained not just in the required basic somatic healthcare but also have a dedicated, approved and certified training in mental healthcare. Further, they should be compliant with continuing professional development and ongoing training requirements and be registered with their professional body with a licence to practice.

Each patient (whether or not they are considered as burdensome or lacking rehabilitative potential) should have written nursing care plans, prepared by a qualified nurse (preferably their 'key' nurse), which covers the patient's various identified needs as well as their relapse 'signature' and a crisis intervention plan. Nursing care plans should be complied with to ensure that the patient is not neglected. Establishing a system of nursing care plans is not complicated.

Auxiliary Nursing Staff

In order to manage patients on wards in mental healthcare establishments, qualified nurses on wards usually need to be assisted by auxiliary nursing staff. Although such staff do not usually have any formal care certification, their role carries great care responsibility.

During a shift, auxiliary nursing staff should always work under the supervision of a qualified nurse. They should not be responsible for dispensing medication.

Multidisciplinary Clinical Staff

Clinical specialists (psychologists and other allied health professionals including occupational/creative therapists; social workers etc.) are required to provide the psychosocial treatments and rehabilitation activities needed by patients.

Clinical Psychologists

Clinical psychologists should be available in sufficient numbers to be able to offer, within a reasonable timescale, psychological assessments and psychological therapies to all those patients who require them. The psychologist's input should facilitate the clinical team in understanding the patient's psychological functioning and what is required to address difficulties in this domain.

Clinical psychologists should have a basic degree in psychologist plus a higher training in clinical psychology. Further, they should be compliant with continuing professional development and ongoing training requirements and be registered with their professional body.

Psychologists are likely to have particular skills providing and advising on the treatment of patients with personality disorder, who can provide particular challenges to staff as a result of their emotional difficulties and behaviour (sometimes based in abusive past histories).

Social Workers

Social workers should be available in sufficient numbers to be able to offer, within a reasonable timescale, social support, advice, guidance and rehabilitation to all those patients (and their families/carers) who require them. This may be regarding financial, pension or accommodation issues but may also be of a more overtly therapeutic nature, including psychological support and counselling. The social worker's input should facilitate the clinical team in understanding the patient's social issues (and those relating to family/carers) and accommodation needs and what is required to address/fulfil them.

Social workers should have a formal qualification in social work and be registered with their professional body.

Occupational & Creative Therapists

Occupational therapists should be available in sufficient numbers to be able to lead, within a reasonable timescale to all those patients who require them, occupational therapy assessments and therapies, in order to build patients' skills and self-esteem. Such assessments and therapies should facilitate the clinical team in understanding the patients daily living skills, self-care and occupational potential and what is required to address/fulfil them.

Occupational therapists should have had formal training in their area of expertise, ideally a formal qualification.

Occupational therapists are often assisted by technical instructors, creative therapists etc. (e.g. art therapists, music therapists). Such staff should work under the supervision of an occupational therapists.

Pharmacists

A mental healthcare establishment should have a pharmacist who is responsible for the managing the supply and storage of required medication.

Non-Clinical Staff

Managerial Staff

The senior management team and its leader are responsible for the safe and effective management of the establishment.

A mental healthcare establishment would usually be managed and led by an identified Director (e.g. senior manager or doctor), supported by a small multidisciplinary team comprised of senior clinicians (e.g. medical director, head nurse, chief psychologist etc.) and administrators (e.g. head of finance, operations manager, legal advisor etc). Such a senior management team and its leader are responsible for the safe and effective management of the establishment. A clear management structure in an establishment clarifies roles and responsibilities.

Ancillary and Administrative Staff

Any mental healthcare establishment will have a range of ancillary and administrative staff such as those working in finance and human resources, plus secretaries, drivers, caretakers etc. Such staff must understand issues of confidentiality and understand that their role is to support clinical staff in caring for patients.

Guards

In forensic psychiatric settings caring for potentially dangerous psychiatric patients, adequate security must, of course, be maintained. Although it may be that guards (from national or private companies) are employed to provide such security, the guards' presence will be known to patients (whether or not the guards are fully uniformed and/or visibly carrying truncheons or other special means). As such, guards in clinical areas are unnecessarily intimidating to patients and not conducive to the establishment of a therapeutic environment.

The core security in clinical areas of a health-care facility should be provided by clinical staff (utilising appropriate environmental and dynamic security means), therefore, any guards should normally remain on the perimeter of the establishment and never be routinely present in clinical areas.

In exceptional circumstances (such as a serious untoward incident involving violence), if clinical staff need to call upon guards for assistance, the guards should only intervene in the presence of, and in consultation with, qualified clinical staff. Guards should never be present (within hearing) during the interview of a patient by a clinician, unless, in some highly exceptional situation, the clinician were to request this.

As it is possible that such guards may have access to (or even carry) special means (e.g. handcuffs, truncheons, sprays, firearms etc.). The drawing or use of any such special means should be outlined in a clear policy and should only occur in the most exceptional of circumstances (which must be described in detail in written reports after any such deployment).

Staff Recruitment & Training

All staff should be sufficiently qualified to perform their role; they should receive initial and ongoing in-service training on managing patients humanely and safely.

All staff employed in mental healthcare establishments should be carefully selected and be sufficiently professionally qualified for their role (and registered with professional bodies as appropriate). Before commencing in post, all staff should receive appropriate induction and training on managing patients humanely and safely and attend related mandatory ongoing in-service training, including on resuscitation, fire safety and personal safety (including breakaway and safe restraint techniques), as well as the establishment's policies and procedures. It is also highly desirable for staff to be offered further training possibilities outside their own establishment, including secondment opportunities.

Ensuring Staff Supervision, Support & Safety

All staff should be properly supervised and adequately supported.

In order for staff to best care for patients and remain resilient, they need to have role clarity, feel safe, confident in their abilities and not stressed that they are imminently about to be criticised or investigated. Therefore, apart from providing them with all the practical means they need to do their job properly, staff need to feel supported by their immediate management and believe that if they make a genuine mistake but were doing their best to care for their patients (within any existing constraints), they will be treated fairly and supported as required and appropriate.

To ensure good quality care, all clinical staff should receive regular (e.g. monthly) supervision from a more senior clinician where they can reflect upon their practice and improve their self-awareness; such supervision should be placed in a written record, to provide evidence that it has occurred. Such supervision is mutually beneficial and is not resource intensive.

Apart from more formal supervision, reflective practice groups involving staff who share similar experiences, can offer mutual support (and even humour), advice, insight and comfort and can provide very useful therapeutic feedback for frontline staff. Establishing such groups is not complicated

Serious untoward incidents (e.g. assaults on staff, serious self-harm, suicide etc.) can be very stressful for staff. Therefore, a debriefing session with the staff group affected should occur after such incidents and relevant staff offered counselling as indicated.

Apart from offering and providing training, in order to avoid staff burnout (which can reduce the quality of care), staff should be able to access an identified counselling and support service. Further, the presence in of independent persons (e.g. students, researchers etc.) can re-energise staff. Staff should also be supported in engaging in an active and fulfilling life outside of their work.

In order to keep staff safe, they should be trained in de-escalation and physical breakaway techniques and be provided with access to an appropriate alarm system.

Overcoming Potential Difficulties with Staffing Issues

Recruitment

Providing sufficient numbers of staff of all clinical disciplines can be costly. The staff budget of a mental healthcare establishment should be reviewed regularly (e.g. every 3-5 years), as agreed staffing complements are often set up many years previously and then become no longer adequate to provide good quality, modern mental healthcare. Funding for necessary increases in staff numbers and/or to expand multidisciplinary clinical input can then be bid for.

Although there may be resistance from funding authorities to provide increased funds for staffing, apart from the duty to provide modern, effective treatment to patients, a case can be made that by investing in this way, patient length of stay can be considerably reduced (as patients are discharged or transferred more rapidly to become the funding responsibility of others) and therefore the cost per patient can actually be reduced.

It is often difficult to ensure that there are sufficient numbers of properly trained, multidisciplinary staff of appropriate quality, to care for patients and provide the necessary full range of modern psychiatric therapies. This is particularly so in remoter areas or areas where there are low levels of unemployment with varied employment choices. Therefore, to aid recruitment, it may be necessary to review and improve the terms and conditions being offered, including salaries, which may require negotiation with regional or national authorities as required. Additionally, offering part-time posts or flexible working patterns can be attractive to some staff (e.g. those with family commitments) and can make it easier to retain staff. Further, it may be necessary to consider novel approaches to increase the accommodation options for staff (e.g. hostel or subsidised accommodation) and improve transport options (e.g. subsidised transport or provision of a specific bus etc.).

Investing in employing good quality medical staff is important as it is such staff that lead the multidisciplinary medical teams and therefore have significant influence over the quality and effectiveness of treatment and the use of resources.

Caution should be exercised when recruiting auxiliary nursing staff. Their role is challenging but their background education is likely to be of lower quality than other staff and they may have very little prior experience of work in a caring profession. As previously stated, auxilliary require a proper induction and relevant training, as well as close supervision and support from qualified nursing staff.

Maintaining Staff Presence

Rates of staff sickness or unexplained staff absences should be monitored. If they are raised on particular wards, that can suggest that there may be difficulties there (e.g. a disturbed environment, lack of leadership etc.) which is causing staff burnout. Following appropriate investigation, the situation can then be addressed to improve the staffing situation.

In order to cover unexpected nursing absences and maintain sufficiently safe numbers of ward-based staff on a ward, arranging, in advance, a bank of staff who are willing and available to cover such eventualities within an establishment (and paying additional rates when their work is overtime) can prevent a short-term staffing crisis happening on a ward.

Ensuring Good Quality Staff Care

In mental healthcare establishments that employ ward-based staff (i.e. qualified and auxiliary nurses) on 24-hour shifts, it can be a challenge to change such practices and institute more appropriate working patterns, especially as some staff prefer such long shifts as it allows them subsequent time off (which some use to perform other employment). However, as stated, such practice does not allow staff to safely and satisfactorily perform their clinical duties vis-a vis patients, placing patients (and potentially themselves) at risk, so assertive action must be taken.

Due to the importance of staff training, it is useful to ringfence a staff training budget and develop ongoing staff training programmes.

In forensic psychiatric hospitals where guards are employed, they are usually under the authority of a ministry other than the Ministry of Health. Therefore, when ensuring appropriate practice vis-à-vis guards' contact with patients, inter-ministry liaison is likely to be required and would need to be requested.

Ensuring that there are dedicated high quality training programmes in mental health for nurses is a national responsibility and beyond the competence of individual mental health establishments. However, senior leaders of such establishments can lobby for this. Further, ensuring that staff of other disciplines, in particular psychologists, social workers and occupational therapists, are fully trained and therefore competent to perform the requisite clinical therapies, is likely to require a similar approach. Just 're-allocating' other staff (e.g. nurses) to the role of 'social worker' or 'occupational therapist', whilst attempting to offer broader therapies, cannot be justified as a long-term approach.

When, following an appropriate investigation, staff are found to have behaved inappropriately and require disciplinary sanctions or punishment, appropriate action should be pursued, even when that is difficult. Such staff should be held accountable. It is not appropriate just to accept a staff member's resignation without any further action, especially if the behaviour may be of a criminal nature (e.g. assault). Further, systems should be in place to prevent the member of staff in question just moving to other related employment where similarly inappropriate behaviour may occur and put others at risk. Such systems usually need to be based on some form of national registers.

SECTION VI:
LEGAL SAFEGUARDS

Legal safeguards to protect the rights of persons with mental disorders are a necessity, not just extra paperwork.

The Necessity of Legal Safeguards

Legal safeguards for persons with mental disorder are necessitated by their particular vulnerability. From a medical standpoint, some of the additional procedures may appear superfluous. However, such safeguards are meant to ensure that patients' human rights are always protected. Consequently, both medical and administrative staff must understand the need for the required paperwork and remain constantly vigilant as regards persons who might wish to take undue advantage of the patient's mental disorder, as well as to be alert to any situations that might potentially threaten the human rights of persons suffering from mental disorder.

All relevant issues must be covered by a specialised legislative act on mental healthcare which should be compliant with human rights, as recognised by the legal system of the state concerned, in particular, in its Constitution, as well as with its obligations under international law. As regards the latter, they comprise, *inter alia*, the 1950 European Convention on Human Rights, the 1966 International Covenant on Civil and Political Rights, the 1997 Convention on Human Rights and Biomedicine ('the Oviedo Convention') as well as the 2006 UN Convention on the Rights of Persons with Disabilities. In Ukraine, the relevant legislative act is the Law of Ukraine No. 1489-III *'On Mental Healthcare'* of 22 February 2000 (hereinafter referred to as 'the 2000 Mental Healthcare Act').

Information for Patients and Their Families

Patients and their families should receive precise and clear information on their rights and the ways to protect them, as well as on the establishment's house rules.

Patients of mental healthcare institutions should receive complete, clear and reliable information, in particular concerning their right to consent to placement or to refuse to give such consent and also on the possibility to revoke such consent subsequently. Such information should exist as a part of a information brochure written in a simple and straightforward language, including matters such as the rights of patients and the mental health establishment's house rules. This information should also be included in the informed consent form which the patient should be offered to sign. Persons incapable of understanding the contents of such information on their own should be provided with appropriate assistance. The above-mentioned information should also be provided to the patient's next-of-kin.

Voluntary Placement in a Mental Healthcare Establishment

Consent to placement must not be viewed as a mere formality.

In many cases, persons are placed in mental healthcare institutions on the basis of a decision made by a psychiatrist, based on the patients' request or their informed consent given in writing.

To ensure respect for patients' rights and the lawful functioning of a mental healthcare establishment, it is imperative that whenever a patient refuses to give their consent to placement, the procedure for involuntary placement is followed. Further, consent to treatment should not be seen as a mere formality. Therefore, care should be taken to ascertain that the person consenting to placement fully understands the meaning of his/her consent. This is why, whenever a patient's mental condition, due to the influence of alcohol or drugs, makes it impossible to give valid consent, a decision on voluntary or involuntary placement may be postponed within the 24-hour limit provided by law.

It goes without saying that only the patient themselves and not their relatives on their behalf, can give consent to their placement to a mental healthcare establishment. Under Ukrainian law the only exception is made for minors (i.e. juveniles below the age of 14) who can be placed in a hospital when their parents request so or give their consent to placement.

Ukraine's legislation (Section 13 of the 2000 Mental Healthcare Act, sentence 6) contains a rule to the effect that a person, who, under a lawful procedure has been declared incompetent and who, due to the state of his/her health, is incapable of requesting or giving informed written consent, may be placed into a mental healthcare institution based on the decision or consent of the relevant guardianship body, given within 24 hours following the request made by the person's legal representative (i.e. guardian); such placement decisions may be appealed against as provided by law, including to the court. In 2018, this rule was declared unconstitutional by the Constitutional Court of Ukraine (which happened for the second time as the previous version of the same rule was declared unconstitutional in 2016). This means that it is the court who should authorise involuntary placement of a person previously declared incompetent under a judicial procedure. Such decisions of Ukraine's Constitutional Court are fully based on the international obligations of Ukraine as well as on the best international practices.

"De Facto Involuntary Placement"

"De facto involuntary placement" is a dangerous practice which denies patients their rights and legal safeguards.

One of the biggest legal issues regarding the functioning of mental healthcare establishments in Ukraine (and many other European countries) is the great number of so-called "de facto involuntary patients", i.e. patients who are considered to have been placed in the respective establishments voluntarily but in fact they have either not consented to their placement (the respective forms having not

been signed at all or signed by someone other than the patient) or their consent has not been voluntary and/or informed. This category of patients also comprises persons who have voluntarily agreed to be placed in a mental healthcare establishment but who would like to revoke their consent, with the establishment simply choosing to ignore their change of opinion rather than initiating (if necessary) the procedure for involuntary placement.

As far as the rights and lawful interests of such patients are concerned, the situation of 'de facto involuntary placement' is the worst due to the fact that the person concerned is viewed as a voluntary patient who does not then require the application of any legal safeguards.

Involuntary Placement in Mental Healthcare Establishments (Civil Procedure)

Procedure & Grounds for Involuntary Placement

Involuntary placement must be based on an objective assessment of the patient's state of health.

According to Section 14 of the 2000 Mental Healthcare Act, persons suffering from mental disorder may be placed into a mental healthcare institution without their informed written consent (or, in case of minors, without the consent of their legal representatives) if their assessment or treatment are only possible in an inpatient facility and provided that a medical doctor has established that the persons concerned suffer from a serious mental disorder causing them:

- to commit, or display real intentions to commit, actions constituting a direct danger to self or others; or
- to be incapable of meeting their basic needs at a level sustaining their life.

Ukraine's law provides that the respective procedures are carried out on the basis of a court decision, preceded by the opinion of a commission of psychiatrists on the necessity to commit the person to a hospital and an application made by the manager of the mental healthcare institution, addressed to the local court, within 24 hours after the placement.

An important element for involuntary placement should be the objective assessment by an unbiased psychiatrist, independent of the institution requesting the placement. However, so far, the Ukrainian legislation has regrettably failed to provide for such an automatic requirement. That being said, every patient is legally entitled to an alternative psychiatric assessment, if he or she wishes to undergo one. Patients are also entitled to have any other psychiatrist (should he/she agree) join the commission and participate in its activities. Accordingly, the management of the mental healthcare institution should facilitate the implementation of these rights.

Legal Aid, Time Limits & Participation of Patients

In cases of involuntary placement, the patient concerned should be provided with legal aid.

Whenever the court hears the case for involuntary placement, the patient concerned should receive legal aid. Ukraine's legislation on free legal aid does envisage this, however these provisions should be implemented in practice. This should be facilitated to the fullest possible extent by the management of the mental healthcare establishment concerned. A necessary precondition for such legal aid is having all the conditions for confidential meetings between the patient and their lawyer.

Ukraine's Code of Civil Procedure stipulates that the court must hear the application on the involuntary placement of a patient to a mental healthcare facility within 24 hours, counting from the day of its receipt by the court. Pending the court's ruling, mental healthcare may be provided based on a decision by a psychiatrist or a commission of psychiatrists.

The law requires the compulsory participation in the hearing of the person in respect of whom the involuntary provision of psychiatric healthcare applies, as well as the compulsory participation of a state attorney (prosecutor), psychiatrist, a representative of the mental healthcare establishment applying for involuntary placement and a legal representative of the person concerned. The law also provides for the possibility that the person in respect of whom the issue of involuntary provision of mental healthcare is considered, may participate in the hearing via videoconference should his/her state of health require that.

Termination of Involuntary Placement/Discharge of Patients

Involuntary placement must not last longer than is required by the patient's state of health.

Under Ukrainian law, any involuntary patient should be re-assessed by a commission of psychiatrists at least once a month, so as to identify grounds for the continuation or termination of the patient's placement. To prolong involuntary placement, a representative of the mental healthcare establishment should apply to the court with a written application to extend the placement. Such an application should contain reasons for involuntary hospitalisation and be accompanied by an opinion of the commission of psychiatrists, which sets out detailed reasoning for the extension of the involuntary placement. Every subsequent prolongation of placement should follow the same procedure and never exceed six months.

Requests to terminate involuntary placement may be filed by the patients themselves or their legal representatives after every three months following the court's decision authorising or continuing involuntary placement.

Placement in a Forensic Mental Healthcare Facility (Compulsory Medical Measure; Criminal Procedure)

Regular review is the key element of the application of compulsory medical measures

Similar to other European countries, the Criminal Code of Ukraine envisages compulsory medical measures for persons who have committed socially dangerous acts (i.e. crimes) while being fully or partially criminally irresponsible, as well as for persons who committed crimes while being criminally responsible but whom have subsequently developed a mental illness prior to having been convicted or while serving their sentence. According to Chapter XIV of the Criminal Code's General Part, the court may decide to provide outpatient compulsory treatment or to pace the person in a forensic psychiatric facility with standard, reinforced or high security.

Forensic mental health patients should be assessed by a commission of psychiatrists at least once every six months to determine the possible existence of grounds to request the court to terminate or modify the compulsory measures. Their conclusion, following such an assessment, is then sent to the court, which is requested to terminate or, on the contrary, to prolong the compulsory measure. No extension can exceed six months. Importantly, following the 2017 amendments to the Code of Criminal Procedure of Ukraine, the person concerned, as well as his/her legal representative and lawyer, should always participate in the court hearing on compulsory medical measures. Hence, the procedure stipulated by Ukrainian law generally complies with contemporary European standards.

Legal Safeguards for Psychiatric Patients

Consent to placement and consent to treatment should be dealt with separately.

Psychiatric care should always follow the principle of least restriction which is recognised both in Ukraine's legislation and European standards.

The psychiatrist should explain, to the person who requires psychiatric care, the situation regarding the state of their mental health, the medical prognosis regarding the development of their disorder, the application of diagnostic methods and of available treatment, possible risks and side effects, conditions and duration of the required psychiatric care, the patients' rights and the possible lawful limitations of those rights in psychiatric care. Such explanations should be provided in an understandable manner and with consideration of the mental status of the person concerned. The person receiving psychiatric care, or their legal representative, should have the right to consult the medical file of the patient and other relevant documents and also to receive any decisions concerning the provision of their psychiatric care in writing. Any restrictions on the provision of such information to the patient (but never to their legal representative) must be carefully based on medical necessity and documented.

Legal safeguards for persons with mental disorders are based on a distinction between the issue of consent to placement and consent to treatment. In other words, patients' consent to placement does not automatically mean they have consented to the treatment prescribed by psychiatrist.

Every patient suffering from a mental disorder should be in a position to provide his/her free informed consent to treatment. Every patient, irrespective of the reasons for placement, should have an opportunity to reject treatment or any other medical intervention.

Appealing Against Decisions on Psychiatric Care

The existence of a functioning appeal procedure ensures both patients' rights and a good functioning of the mental healthcare establishment

The law provides for an opportunity to appeal against any decisions, acts or omissions that are detrimental to the rights, freedoms and lawful interests of psychiatric patients, their social protection and so on:

- to the owner of the mental healthcare institution, or the establishment for social protection of persons suffering from mental disorders;
- to their superiors and public officials; or
- directly to the court.

Correct functioning of a mental healthcare establishment critically depends on the existence of a real, not just formal, possibility to lodge complaints and appeals. Consequently, measures should be taken to inform patients of all legal avenues for lodging complaints and appeals and to ensure that they have trust in such mechanisms. Those complaining/appealing should also be provided with legal aid as required.

Basic principles on handling complaints are as follows:

- Availability of complaints mechanisms which include a real possibility for the patient and their representatives to reach them;
- Accessibility to information about such mechanisms (in brochures on patients' rights, posters, announcements etc.), appropriate standard simple complaints forms for use by patients, access to the complaints bodies not being contingent on legal competence, necessary support to the patient by the staff to lodge a complaint;
- Confidentiality & safety regarding complaints, with the strictest prohibition of any reprisals against complainants;
- Effectiveness of the available mechanisms, provided, inter alia, through their promptness, expeditiousness and thoroughness in dealing with complaints;
- Traceability of the sent complaints, in particular their registration for further use by the establishment's management and possible inspections.

Legal Incompetency of Persons Suffering from Mental Disorder

Legal procedures on establishing legal incompetency of persons suffering from mental disorder must be fully complied with.

Ukraine's legislation providing for the existence of a chronic and stable psychiatric disorder resulting in the person's failure to understand the meaning of her/his acts and/or to control them, is one of the reasons why a person could be declared legally incompetent. Consequently, the management and staff of mental healthcare establishments have to regularly deal with persons declared by the court as legally incompetent and also with those in respect of whom this issue arises.

The procedure for declaring a person incompetent can be initiated by his/her relatives and family members, irrespective of whether they live together, by the state guardianship authority or by the mental healthcare establishment. The court verifies the information on the person's mental disorders and orders a forensic psychiatric assessment of the person concerned.

Cases of legal incompetency are heard by the court in the presence of the person who initiated the hearing, the person concerned, and a representative of the state guardianship authority. The person concerned may participate in the hearing by videoconference from a mental healthcare establishment, should his/her state of health require that.

The person concerned should be fully provided with necessary support and (free) legal aid and also given an opportunity to communicate with his/her lawyer confidentially.

Appointment of a Guardian for an Incompetent Person

Conflict of interest must be avoided when appointing the guardian.

Ukraine's Civil Code provides that a person declared legally incompetent must have a guardian. According to well-established European standards, to avoid a conflict of interest and to exclude any possibilities for abuse, as well as to prevent any suspicion or accusations of corruption-related offences, the guardian should never be appointed from among the staff of the establishment providing psychiatric care for the patient.

UN Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities requires a paradigm shift in dealing with persons with mental disorders

The UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted in 2006. As of 1 October 2019, it has 180 states parties, including Ukraine. Therefore, CRPD is a part of Ukraine's domestic legal order and its provisions supersede any contradicting provisions of the national legislation.

The Convention is one of the nine main United Nations multilateral human rights treaties. CRPD contains a classic catalogue of the human rights of persons with disabilities in a modern just society.

CRPD's provisions are applicable to any persons with disabilities, which are defined as long-term physical, *mental, intellectual* or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (*highlighted by the authors*).

One should pay special attention to the provisions of CRPD which are of direct relevance to the functioning of mental healthcare establishments:

- Persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life – Article 12(2);
- Persons with disabilities should have access to the support they may require in exercising their legal capacity – Article 12(3);
- All measures that relate to the exercise of legal capacity should provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law; such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body – Article 12(4);
- The existence of a disability (including due to a mental disorder) shall in no case justify a deprivation of liberty – Article 14(1);
- Persons with disabilities should have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement – Article 19.

The issue of practical implementation of the above-mentioned provisions in the care of patients of mental healthcare establishments remains open. It is obvious, however, that CRPD's provisions necessitate:

- Changing the concept of declaring a person legally incompetent from the traditional concept (common to Ukraine and the majority of other countries) of the *complete replacement* of legally incompetent persons by their guardians as far as taking any decisions is concerned to the concept of *assisted decision-making* where the guardian helps the person concerned to take decisions;

- Assistance with the implementation of person's rights (legal capacity) should be free from any conflict of interest and be subject to external administrative and/or judicial supervision;
- The placement of persons within mental healthcare institutions should be as short as minimally necessary.

CRPD has also raised serious issues concerning the very possibility of civil involuntary placement and civil involuntary treatment of persons. Currently, the practice of European states and judgments of the European Court of Human Rights allow for – and occasionally require – involuntary placement and involuntary treatment but exclusively while strictly observing the entire range of various legal safeguards for persons with mental disorders.

SECTION VII:
OTHER SAFEGUARDS

Apart from legal safeguards, a range of other safeguards should also be available to patients (and their relatives/guardians as applicable).

In-patients should be able to safely access a complaints system that is formalised, simple, user-friendly, reliable, trusted, confidential and effective.

Complaints Mechanisms

Effective complaints procedures are one of the basic safeguards against ill-treatment in a mental healthcare establishment.

It can be hoped that in-patients would be able to resolve any complaints they have by speaking with the staff in charge of their treatment. However, if the responses they receive are unsatisfactory to them, all in-patients (as well as their family members or legal representatives) should be entitled to address their complaints, on a confidential basis, directly to the establishment's management or other external independent bodies (who have the power to investigate complaints). This will ensure that in-patients are thus able to express their concerns and always have their voice heard. Patients should never perceive they are being punished for complaining; indeed, although some staff may feel uncomfortable with patients' rights to complain, patients should be actively encouraged to complain when they express discontent with their treatment; such an approach can often diffuse tensions and subsequent investigations should find in favour of staff if they have not behaved neglectfully or inappropriately.

To facilitate their right to complain, in-patients should be able to safely access a complaints system that is formalised, simple, user-friendly (particularly regarding the language used), reliable, trusted, confidential and effective. At its most basic level, this should include locked complaints boxes within all in-patient areas, with guaranteed access to paper and pens[13] for patients to write complaints; such boxes being emptied on a regular basis by a named senior member of the hospital's management.

All complaints submitted within the establishment should be logged in a central register and considered by a small multidisciplinary clinical group of senior staff (including senior managers).

All complaints should be objectively and properly investigated and responded to, in writing, within an agreed reasonable period of time[14]. The outcome of the complaint and actions taken should be recorded in the register and the small multidisciplinary clinical group of senior staff should have systems, using clinical governance principles, that demonstrate multi-disciplinary learning from complaints and investigations, so as to then improve the quality of patient care.

13 If there are concerns about a patient using keeping a pen as a weapon, the pen can be a short version and only used under staff supervision (whilst ensuring confidentiality of what the patient writes).

14 E.g. 21 days for non-urgent complaints.

Patients should be entitled to seek legal advice about complaints and to benefit from free legal assistance when the interests of justice so require.

Providing Information Brochures

> *On admission, each patient should be provided with a comprehensive introductory information brochure, which contains information on a full range of key issues regarding their stay.*

Each patient (and their families/guardians), on admission to a mental healthcare establishment, should be provided with a comprehensive introductory information brochure, which contains information regarding:

- The establishment's routine.
- Patients' rights (including information on avenues of complaint).
- Legal assistance.
- Review of placement (and the patient's right to challenge this).
- Consent to treatment.
- Complaints procedures.

Such brochures may be printed booklets or can even consist just of printed sheets. They should supplement oral explanations given by staff. Although information on house rules, patients' rights etc. should also be displayed on a noticeboard in clinical areas, a small brochure passed to a patient on admission is much more personalised and individual and is likely to be appreciated as such by the patient at an important moment at the beginning of their stay. Any patients unable to understand this brochure should receive appropriate assistance and it would be appropriate to have it available in a range of languages if foreign national patients are commonly admitted.

Supporting External Inspections

Encouraging and supporting constructively critical, independent, external assessment of one's mental healthcare establishment can demonstrate an openness to reflect on one's practice in the establishment, avoiding complacency. Therefore, visits by NGO's, representatives of the NPM, representatives of the Ombudsperson or international organisations (such as the CPT or SPT) should be embraced and their recommendations seriously considered and complied with where required. Indeed, apart from objectively assisting clinical practice improvement, using such recommendations to enhance negotiations when managerially attempting to obtain increased resources can be a helpful adjunct.

Deaths of In-Patients

The unexpected death (where a clear diagnosis of a fatal disease has not been established prior to death by a doctor) of an in-patient in a mental healthcare establishment is a serious incident. It may, for example, result from deliberate self-harm, as a direct or indirect result of a violent interaction with another, as a result of an undiagnosed illness or be otherwise related to neglect or ill-treatment.

In all cases of the unexpected death of a patient in a mental healthcare establishment (or after transfer to a hospital), the death should be promptly certified by a medical doctor on the basis of a physical examination and a subsequent autopsy should be carried out.

Further, there should be a thorough and independent inquiry into every such death of an in-patient, with a view to ascertaining whether there are lessons to be learned as regards care quality, operational procedures and any neglect. If a patient dies under suspicious circumstances or following an injury, relevant investigative authorities should always be informed.

A register of the clinical causes of patients' deaths should be kept at the establishment.

Operational Policies

A mental healthcare establishment should have a full range of detailed operational policies and procedures that should be used to inform and guide staff in their practice.

Participation in Research

It may be appropriate on occasion that in-patients in mental healthcare establishments participate in research programmes, such as to assist in developing and/or improving novel evidence-based treatments. Any such participation must be subject to the patient having mental capacity and having given their fully informed consent (i.e. a full understanding of the risks and benefits of participation). The patient's consent form will therefore need to be sufficiently detailed to evidence this.

Further any research performed should have been considered by an independent research and ethics committee.

FINAL COMMENTS

All patients in mental healthcare establishments require and deserve properly governed, high quality, effective, individualised treatments, provided by sufficient numbers of properly trained multidisciplinary clinical staff, surrounded by efficient legal safeguards, in safe, decent, dignified environments, which offer privacy, have the fewest possible restrictions and sit within a progressive pathway of care.

To overcome the many difficulties and challenges faced by the management and staff in mental healthcare establishments in Ukraine, so that all of the issues in this guide can be satisfactorily complied with, will require great effort and coordination within the establishments, as well as regionally and nationally. Some, but not all, the issues will require funding, a particular challenge during times of economic difficulty.

Improving entrenched systems of clinical practice can be extremely challenging, especially in large institutional environments when staff morale is low, resources scarce and there are concerns that anything that alters current practice may increase risks or vulnerability to criticism. Meaningful change and improvement in care quality can only be made when strong and effective clinical leadership is in place.

In national systems of mental healthcare, it is often the case that the quality of clinical practice and living conditions vary considerably within and between establishments, with examples of good, acceptable and poor practice being co-existent. Regional and national leaders in the mental healthcare field should be strongly encouraged to celebrate and disseminate good practice and examples of effective improvements in clinical care across the whole system to improve the consistent provision of high-quality mental healthcare.

All patients in mental healthcare establishments require and deserve properly governed, high quality, effective, individualised treatments, provided by sufficient numbers of properly trained multidisciplinary clinical staff, surrounded by efficient legal safeguards, in safe, decent, dignified environments, which offer privacy, have the fewest possible restrictions and sit within a progressive pathway of care. This aspiration can be worked towards and, in time, achieved.

All staff in mental healthcare establishments should be vigilant; if there seems to be an abuse of human rights, then consider; enquire; explore; try to understand; and then, if needed, work tirelessly to rectify the failings. If it feels wrong, it probably is. You will feel that. The patient will feel that that.

All staff in mental healthcare establishments should be vigilant; if there seems to be an abuse of human rights, then consider; enquire; explore; try to understand; and then, if needed, work tirelessly to rectify the failings. If it feels wrong, it probably is.

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They also acknowledge the contribution to their knowledge made by the participation in CPT visits and other human rights based activities, in addition to their clinical (CM) and legal (MG) work and the many discussions that they have had over the years with many professional colleagues (clinical and legal).

However, it is notable that the key source of information for the authors, when considering the issues discussed in this guide, has been the patients in mental health establishments themselves. The multitude of generous and trusting accounts of patients' own treatment experiences in mental health establishments have been invaluable to us.

APPENDIX I.
KEY COUNCIL OF EUROPE CPT REFERENCE DOCUMENTATION

A wide range of CPT documents are accessible via HUDOC-CPT on the CPT Website (https://www.coe.int/en/web/cpt/database). This includes visit reports to countries (with implicit standards & evolving jurisprudence), Public Statements, Annual reports, Standards and checklists.

- Involuntary Placement in Psychiatric Hospital – Extract from the CPT's 8th Annual Report (1998): https://rm.coe.int/16806cd43e
- Checklist for the Evaluation of a Psychiatric Hospital (October 2009): https://rm.coe.int/16806fc231
- Checklist for Visits to Social Care Institutions Where Persons May be Deprived of Their Liberty (May 2015): https://rm.coe.int/16806fc22b
- Means of Restraint in Psychiatric Establishments for Adults – Revised CPT Standards (March 2017): https://rm.coe.int/16807001c3

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Professor Mykola Gnatovskyy is an international lawyer and Associate Professor of International Law at the Institute of international relations, Taras Shevchenko National University of Kyiv; First Vice-President of the Ukrainian Association of International Law, he has been a member of the European Committee for the Prevention of Torture or Inhuman or Degrading Treatment since 2009 and its president since 2015. As a member of the CPT, as a participant and head of Committee delegations, he has been actively involved in the planning and implementation of numerous international monitoring visits, as well as in writing reports on their results and maintaining dialogues with governments on the implementation of the CPT's recommendations. He is the author of numerous publications on international and European human rights law and a member of editorial boards of scientific journals on human rights and international law.

This guidebook, written for senior clinical staff working in mental health establishments in Ukraine, is intended to provide a guide on the key standards and approaches that staff must aspire to when caring for and treating in-patients in mental health in-patient establishments; the aim being that if the suggested practices referred to in the guide are adhered to, the neglectful and ill-treatment of in-patients can be avoided and good quality mental healthcare can be provided.

Although the views expressed are solely those of the authors, they are based on European human rights standards and international clinical standards of practice combined with the authors' experience of the clinical and legal practical application of those standards. Although they have, of course, considered Ukrainian and international law and the Convention on the Rights of Persons with Disabilities (CRPD), the authors would, in particular, like to acknowledge the importance of the utilisation of key CPT Standards and documentation in psychiatry which have provided a foundation for this this guidebook.

The guide is applicable not just to psychiatric hospitals, but also to mental health units situated within general hospitals and to social care establishments caring for residents with psychiatric disorder. It should be noted that although the guidebook should not be used as a guide to the treatment of mental disorders in prison or other residential settings (e.g. immigration detention), some of the principles outlined could be applicable in such settings.

Dr Clive Meux OBE MB BS FRCPsych has worked as a doctor in mental healthcare for 35 years. He has been a Consultant Forensic Psychiatrist at Oxford Health NHS Foundation Trust in the United Kingdom, since 1999 and is an Honorary Senior Clinical Lecturer in Forensic Psychiatry at the University of Oxford. His health Trust employs over 6,200 staff and provides mental and physical healthcare across a wide geographical area. He was formerly the Clinical Director of the Trust's forensic mental health services (2006-11) and then the Trust's Medical Director & Director of Strategy (2011-16). Previously he was a Senior Clinical Lecturer in Forensic Psychiatry at the Institute of Psychiatry, University of London and a Consultant Forensic Psychiatrist at Broadmoor High Security Hospital's Personality Disorder Unit (1992-99). He has also worked for over 20 years with the Council of Europe (CoE), especially in Eastern Europe and countries of the Former Soviet Union, training staff in prisons and psychiatric hospitals on human rights issues and has also worked as an Expert on over 30 missions inspecting mental health and other detention facilities (including in Ukraine) with the CoE's Committee for the Prevention of Torture & Inhuman & Degrading Treatment or Punishment (CPT). He was awarded the UK Royal College of Psychiatrist's President's Medal in 2014 and received the OBE from the Queen in 2017 for services to people with mental ill-health.

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