# Outline of the relevant CPT standards concerning involuntary detention and involuntary treatment

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Many thanks to the organisers for holding this event dedicated to the rights of vulnerable people – those who find themselves in need of inpatient psychiatric care or who are, for other reasons, confined in psychiatric hospitals.

My contribution today will be twofold: first, to bring to this exchange the serious aspect of article 3 of the European Convention on Human Rights, namely the prohibition of ill-treatment; and second, to say something about the CPT's thinking on involuntary measures in psychiatric care.

## I. Message on ill-treatment

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) pays systematically attention to situation of people deprived of their liberty in the context of psychiatric care and, year after year, it comes across instances of ill-treatment in all possible forms:

- poor living conditions including regime during hospitalisation,
- abuse of means of restraint [use of force], for example to compensate for a lack of therapeutic staff,
- failure to keep patients safe and protect them from self-harm or harm caused by others
- and, in the most disturbing cases, also as ill-treatment of patients by members of the staff,
- failure to provide adequate treatment, which – in extreme cases – leads to so called „therapeutic abandonment" and pure containment [especially as regards forensic patients, whose admission to a psychiatric establishment has been ordered in the context of criminal proceedings]
- and also by enforced medical interventions.

There remains a substantial risk of ill-treatment of patients in psychiatric hospitals. Moreover, there are health-care systems in Europe where breaches of art. 3 seem not to represent isolated events but a systemic issue. In other words, cases in which the European Court of Human Rights finds violations under Articles 3, 5 and 8 of the Convention don't represent exceptional cases but rather the tip of the iceberg.

## II. Standard on consent to treatment

Today, a lot has been said about safeguards against arbitrariness. The CPT views them also as safeguards against ill-treatment. Let me tell more on the CPT's standards related to the safeguards and show you what ensures their effectiveness in practice. (They come from the CPT's quite old standard text: Involuntary placement in psychiatric establishments, CPT/Inf(98)12-part, extract from the 8th General Report of the CPT, published in 1998.)

**Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment.**

- Findings – consent is not sometimes sought: For example, the admission of a person to a psychiatric establishment on an involuntary basis is seen as authorisation for any treatment, without the patient's consent. Or, giving consent to hospitalisation is understood as implicit agreement to all treatment prescribed, which makes further communication unnecessary.
- Recommendation: To provide information about intended treatment to all patients, including those under a court measure or assisted by a legal guardian. To provide patients with support to understand the therapeutic offer, to express their needs and fears, to make a decision. To make repeated attempts to get the patient for treatment, allowing time unless emergency. Obtaining consent may be the result of a process in which also the patient may express concerns and needs.

**Every competent patient, whether voluntary or involuntary, should be given an opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and be allowed only under clearly and strictly defined exceptional circumstances.**

- Findings – only consent is taken seriously, refusal is ignored (at best). Medical indication is seen as necessity and active resistance is perceived as a threat and a reason for coercion. In some countries, visit after visit the CPT sees that mental health law is silent or is so unclear that it doesn't provide any meaningful guidance to medical professionals.
- Recommendation: Appropriate rules for establishing patient's decision-making capacity including their informed consent to treatment should be put in place and implemented by psychiatric hospitals; competent decisions should be respected. The law should set out the conditions for treatment against patient's wishes.

**Exceptions should be accompanied by safeguards against abuse.**

- It may be that the law requires a second psychiatric opinion in any case where a patient does not agree with the treatment proposed by the treating doctors and yet the treatment is considered necessary to prevent danger to the patient or to others.
- There should be ways how to challenge guardian's consents to the treatment.
- Patients should be able to challenge a compulsory treatment decision before an independent outside authority and must be informed of this right in a comprehensible written format.

## III. Standard on consent to placement

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

- Legal framework for legal safeguards connected to involuntary admission usually exists but CPT still must often reiterate its recommendation so as the legal protection is made

really available. In many countries, a considerable number of patients are prevented from leaving the hospital and are restricted from contact with the outside world without benefiting from protection from a court. They are formally voluntary, but the CPT calls them *de facto involuntary*. Even if they are not directly prevented from addressing the courts, they may lack information and support for effectively doing so.

- Second challenge is to prevent procedural safeguards from remaining a dead letter. Findings show that there may be court proceedings, but the patient has no real access to legal aid and expert opinion is reserved for later stages which the proceedings in his or her case may never reach. The courts in their decisions sometimes limit themselves only to mirror the treating doctor's opinion and say nothing about their perception of necessity of the placement and lack of less coercive alternatives.

**Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state.**

- The CPT has found, in a number of countries, that patients whose mental state no longer requires them to be detained in a psychiatric establishment nevertheless remain in such establishments, due to a lack of adequate care/accommodation in the outside community.
- Or, the treatment required is not provided due to a lack of professional capacities and, therefore, a limited offer of therapeutic programmes. The ECtHR could qualify it as confinement in inappropriate place since this deprivation of liberty doesn't meet its therapeutic purposes.
- Vis-à-vis these situations the court proceedings look like a mere formality – which is probably felt by all involved parties.

## IV. Conclusion

Prevailing risk of ill-treatment in psychiatric – but also social care – institutions calls for a systemic response. Robust prevention of ill-treatment including through procedural safeguards, in the language of the CPT recommendations. General measures, in the language of implementation of the ECtHR's judgements.

The CPT's experience shows that making the legal safeguards effective in practice is quite challenging and deserves high attention, going beyond efforts of individual hospitals.

Thank you for your attention.