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Improving the response to mental health needs in Europe

Report
Social, Health and Family Affairs Committee
Rapporteur: Mr Claude Evin, France, Socialist Group

Summary

In view of the large number of people suffering from mental disorder compared to insufficient provision of adequate care for them, the Parliamentary Assembly recommends that member states not only provide them with effective care but also promote their rights. This is in the interest of general public health.

Member states are invited to reform their legislation so as to ensure respect for the rights of people with mental disorder in compliance with Council of Europe guidelines, especially Recommendation Rec(2004)10 of the Committee of Ministers concerning the protection of the human rights and dignity of persons with mental disorder. They are also invited to draw up, adopt and implement a mental health policy backed by an appropriate budget and consistent with the principles established by the World Health Organisation (WHO) and those set out in this resolution.

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I. Draft resolution

1. The World Health Organisation (WHO) estimates that in Europe, in one out of every four families, at least one person suffers from a behavioural disorder and that more than 30 million people each year suffer severe depression. Yet only a small minority of people suffering from mental disorder receive appropriate care. Scientific research in the field of behavioural medicine has demonstrated the fundamental link between mental and physical health.

2. In view of the humanist principles to which Council of Europe member states' laws habitually refer, it is vital for them to give the political dimension of mental health legislation due prominence and to reaffirm its grounding in the sphere of humanist legislation. The Parliamentary Assembly notes, however, that national laws often fail to emphasise sufficiently the political dimension of mental health. Well-defined mental health policies are essential for the quality of life of all citizens, public health in general and society's productivity.

3. The level of budgetary appropriations earmarked for mental health is an indicator of the conception of humankind prevailing in a particular society.

4. Many countries of Central and Eastern Europe do not yet have mental health legislation consistent with human rights principles as set out in the European Convention on Human Rights or the case-law of the European Court. Where such legislation does exist, it too often remains unimplemented and unmonitored.

5. In addition to legislative reform where it is necessary, the Assembly advocates effective long-term action in the field of mental health which requires the adoption of a policy to increase the budgets committed to it by governments in order to establish new programmes and to train skilled staff. It believes that, if such a policy is to be developed, the views of users and their relatives must be taken into account as much as those of the professionals and that, in implementing such a policy, the authorities in charge of mental health must also be more open to user representation.

6. The arrangements for mental health care in the various countries must be integrated with the overall public health systems. National law-makers must be aware of the importance of the views of general practitioners, the need to involve them in drafting mental health legislation and the urgent imperative of providing general practitioners with a solid grounding in this field. If care and treatment of mental disorder are the responsibility of primary health care providers, the great majority of people should have quicker and easier access to services.

7. Care for persons suffering from mental disorder must be provided by appropriate services, so that adequate treatment is provided corresponding to these persons' individual therapeutic needs. In many countries, the past few years have seen a shift away from care of the mentally-ill in institutions to community-based provision. The Assembly supports this tendency and recalls that this process should be concomitant with a transfer of sufficient financial resources enabling patients to be cared for outside institutions. Care provided within the community often has a more favourable influence on the outcome of chronic mental disorder and on patients' quality of life.

8. The concept of "sector" used to define the organisation of mental health services should be updated to incorporate the concept of "network". The interests of users, as well as advances in clinical research, are incontrovertibly best served by close institutional links between the public psychiatric service and general medicine, other medical disciplines, all public and private healthcare systems, medical and social institutions and the vast array of other partners in the various social services, authorities and associations.

9. The Assembly believes that psychiatric treatment must be based on an individualised approach, with a treatment protocol being prepared for every patient. Treatment must span a broad range of rehabilitation and therapeutic activities. It is still not made sufficiently clear in international law instruments or in mental health legislation that the psychiatric therapy is individual and intensely personal by nature, involving an individualised plan of continuing care, based on a relationship between patient and practitioner. It is still all too often the case that the treatment given to a patient consists mainly of pharmacotherapy, either because there is a shortage of suitably skilled staff and appropriate facilities or because philosophies based on patient control and supervision still prevail. Initial and in-service trainings of different specialists should be part of national mental health policies in order to respond better to the varied and individualised needs of each patient.

10. The Assembly also stresses the importance of public educational and awareness-raising campaigns in order to remove some of the obstacles to care and treatment by explaining what mental disorders are, how they can be treated, what the chances of a cure are and what rights patients have. Campaigns of this kind would help to reduce stigmatisation and discrimination and narrow the gap between mental and physical health.

11. The Assembly has recalled on several occasions that the protection of human rights has to be an integral part of a health policy, especially in the field of mental health. Therefore, it welcomes the recent advances made by the Committee of Ministers, in particular with Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder and Recommendation No. R(1999)4 on principles concerning the legal protection of incapable adults.

12. In addition to the need to have laws guaranteeing the rights of particularly vulnerable persons, the Assembly stresses the need for states to ensure, through independent monitoring methods, that the methods practised respect the dignity of these persons, particularly where patients admitted to hospital without their consent are concerned.

13. While, as provided for in Article 20 of Committee of Ministers' Recommendation Rec(2004)10, every state may designate in its own legislation the authority responsible for determining involuntary admission to hospital ("a court or another competent body"), the Assembly considers it necessary to emphasise the advantage of the authority concerned being able to offer the best possible guarantees of its own independence and that any challenges to its decisions may be made under procedures which safeguard both the rights of the persons concerned and the proper conduct of proceedings relating to decisions on such admissions. The greatest safeguards in this respect seem to be afforded by the tendency to involve a civil court in such decisions.

14. The Assembly also stresses that appeals by persons involuntarily undergoing treatment or placement should be regularly considered by courts which offer genuine guarantees of defence for these persons, including access to legal aid.

15. The Assembly proposes that the problem raised by situations of neglect, abandonment and abuse of people with severe mental disorder, either within families or in institutional care, be tackled in the legislative context: European countries should tailor their civil law measures for the protection of adults to this state of affairs. The Assembly believes that effective criminal sanctions must be introduced for any persons in charge in institutions, or in some cases heads of families, directly responsible for these problematic situations.

16. In the light of the foregoing, the Parliamentary Assembly calls on the governments of member states to:

i. undertake legislative reform, where necessary, in order to ensure respect for the rights of persons suffering from mental disorder in conformity with the principles of the European Convention on Human Rights, the case-law of the European Court of Human Rights and the recommendations of the Committee of Ministers, in particular Recommendation Rec(2004)10;

ii. in co-operation with the associations of professionals, users and their relatives, formulate, adopt and implement a mental health policy in accordance with the guidelines previously set out and the principles laid down by the WHO, particularly in the Mental Health Declaration and the Action Plan for Europe adopted in Helsinki in January 2005;

iii. make available the budget needed to implement such a policy by identifying the proportion of overall health expenditure earmarked for mental health, particularly for the community-based provision of care and services;

iv. pay particular attention to the conditions under which persons hospitalised for mental disorder are admitted to hospital and treated, and take action to prevent any abuse and disregard of the human rights or human dignity of such persons;

v. ensure independent monitoring and evaluation of mental health programmes in close co-operation with professionals, users and their relatives;

vi. within the framework of the Council of Europe and in co-operation with the WHO, participate in the exchange of experience and good practices relating to mental health.

II. Draft recommendation

1. The Parliamentary Assembly of the Council of Europe refers to its Resolution .... (2005) on "Improving the response to mental health needs in Europe" ;

2. It recommends that the Committee of Ministers :

i. forward this resolution to the governments of member states and ask them to take it into account when formulating and implementing their policies on mental health and respect for the rights of persons suffering from mental disorder;

ii. in co-operation with the World Health Organisation (WHO) and the European Union, assist the member states in drawing up and implementing their reform of mental health in order to ensure that restructurings of the various public mental health services are carried out without any loss of financial resources;

iii. ensure the exchange of experience and good practices between the member states.

III. Explanatory Memorandum by Mr Claude Evin[1]

The mental health situation in our societies

1. Mental health is sometimes regarded as one of society's greatest assets. No country can afford to ignore the fact that poor mental health imposes a severe burden on the bodies responsible for funding public health. The various manifestations of poor mental health represent between a third and half, at least, of overall health care costs in a number of European countries which are members of the Council of Europe. What is more, scientific observations in the sphere of behavioural medicine demonstrate the fundamental link between mental and physical health. In developed countries mental disorder, alongside cancer and cardiovascular disease, are among the major items of public health expenditure.

2. Despite its importance not only in terms of health expenditure, but above all for the general balance of a society, mental health is all too often of relatively minor importance in the overall considerations of public authorities (governments, parliaments etc). The various national laws are often principally concerned with organisational considerations and issues of individual liberties. Mental health policies should acknowledge that psychological problems are an inherent part of the human condition. When individuals are confronted with adverse events in their lives, the ensuing suffering can have a huge impact on them both psychologically and socially.

3. Today's mental health problems are linked in large part to the structure of modern societies. They are not immediately evident, however, from the national legislation of the various countries. This is true of both depression and suicide, although both are extremely worrying aspects of mental health in developed societies. Stress, like break-ups or problems in personal relations, may lead biologically vulnerable individuals into depression. In developed societies, depression has become an increasingly common disorder, whose effects are not negligible because of its consequences for the patient, his or her family and friends and society as a whole. More women than men suffer from depression, the incidence of which, according to WHO predictions, will rise over the next 20 years. Depression is left untreated, or is only poorly treated, in very large numbers of cases. It is in practice only diagnosed if the symptoms reach a certain level of severity and last for at least a fortnight.

4. The number of suicides and attempted suicides recorded in developed societies is a matter of particular concern. In all these societies, suicide is one of the main causes of death among teenagers and young adults. In numerous European countries[2], it is the second cause of death - after traffic accidents, and ahead of cancer - in the 15-34 age group. The suicide rate is higher among men than women everywhere, the overall ratio being 3.5 men to every woman. The mental problem which leads the greatest number of people to suicide is depression, but the rate is high for schizophrenia as well. And suicide is often linked to substance abuse by either the person concerned or a member of his or her family. It has recently been established that most suicides in certain countries of central and eastern Europe are connected with alcohol consumption.

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[1] The Rapporteur would like to thank Mr Jean-Louis DESCHAMPS, Deputy Director of Montfavet Hospital (Avignon, France), Senior Lecturer in the Faculty of Law and Secretary of the Association "Droit, Psychiatrie et Santé Mentale" (Law, psychiatry and mental health), for his assistance in preparing this report.

[2] Albania, Austria, Bulgaria, Croatia, Czech Republic, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Republic of Moldova, Netherlands, Norway, Portugal, Romania, Slovak Republic, Slovenia, Spain, "the former Yugoslav Republic of Macedonia" and the United Kingdom (Source: WHO world health report, 2001).

5. Alcohol and drugs substantially affect the number of suicides. In addition, binge-type drinking has increased in almost half of the countries[3]. Illicit drug use is up in almost all countries[4]. In terms of the avoidable burden of disease for the year 2000[5], alcohol ranks fifth among the ten major risk factors and these substances continue to rank very high in the projections for 2010 and 2020. Alcohol accounts for 4.0% of the burden of ill health in 2000, and illicit substances for 0.8%. The main reason for the use of psychoactive substances is that people expect them to provide a benefit, pleasure or the avoidance of pain, including when they are used socially. Yet the use of psychoactive substances is also potentially harmful in the short and long term.

6. The suicide rate varies a great deal according to age. In a country such as France it is non-existent among children and begins to appear only at the age of 15. It then rises with age, levels out among adults between the ages of 40 and 70 and reaches its highest levels in very old age.

7. In terms of change, a study conducted in 2004[6] demonstrated that the suicide rate had increased among boys in 21 out of 30 European countries and among teenage girls in 18 out of 30 countries. In the other age groups the overall trend is downwards and, while suicide sometimes increases, it does so less than among young people. This specific rise among young people is apparently due to changes in society, the absence of new values and the problems posed by unemployment. According to a WHO survey of industrialised countries, there are almost four times more suicides among boys than among girls[7].

8. The suicide rate thus varies according to sex at all ages and this ratio is increasing. Almost everywhere, the suicide rate is higher among men than among women, with an overall ratio of 3.5 to 1. Conversely, attempted suicide is more common among women. While dependence on alcohol or drugs accounts for 31% of neuropsychiatric disabilities among men, it accounts for only 7% among women. Alcohol and drug consumption seem to be definitely linked to the suicide rate - whence the higher suicide rate among men.

9. Women more frequently suffer from depression. Poverty, domestic isolation, powerlessness and patriarchal oppression are all linked to a higher prevalence of psychological illness among women. In France there is a gap of more than five points between women and men in the 30-34 and 40-44 age groups in terms of episodes of depression. Women's health is of undeniable importance because it has positive repercussions on all members of society. This makes it necessary to promote policies geared to sex equality which encourage wide-ranging investment in women's health – from education to financial responsibility, by means of legal and political mechanisms for improving the status of women. It seems essential to improve and upgrade social welfare and mental health benefits and the skills of professionals. Specific personal development programmes (eg further education, return-to-work support) should be provided for women.

10. To cope with this serious public health problem, considerable efforts in the area of suicide prevention have already been made in many countries[8]. In Finland the National Suicide Prevention Strategy was implemented throughout the country from 1986 to 1996, with special measures at local, regional and national level. In Scotland the 2002 national strategy and action plan to prevent suicide aims to reduce the suicide rate by 20% by 2013. The same may be said of Estonia, Germany and Denmark.

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3 *Press backgrounder EURO/04/01*, WHO, Copenhagen and Stockholm, 20 February 2001: Ireland, Denmark, Poland, Norway, Malta, Slovenia, Czech Republic, Iceland, Estonia, Croatia, Slovak Republic, Portugal, Finland, Sweden, Hungary, Lithuania.

4 *Press backgrounder EURO/04/01*, WHO, Copenhagen and Stockholm, 20 February 2001.

5 *Neuroscience of Psychoactive Substance Use and Dependence*, WHO, 2004.

6 DUVAL (A.). *Faits et chiffres – Le suicide en Europe*, Arte, 02/02/2005.

7 DUVAL (A.). *Faits et chiffres – Le suicide en Europe*, Arte, 02/02/2005.

8 WHO European Ministerial Conference on Mental Health, *Facing the Challenges, Building Solutions*, Helsinki, 12-15 January 2005.

11. The 2001 WHO world health report, which focused on mental health, observed that the level of morbidity linked to mental illness was on the increase. The WHO estimated that at least one person in four suffers from a behavioural disorder, and that more than thirty million people each year suffer severe depression in Europe. Mental and neurological illnesses accounted for some 12% of the disability adjusted life years (DALYs) lost to all illnesses and injuries, and it is projected that the burden of these disorder will have increased to 15% by 2020. Yet only a small minority of the people currently affected qualify for care.

12. In the light of the actual mental health situation in our societies, public educational and awareness-raising campaigns should be run so as to remove some of the obstacles to care and treatment, explaining what mental disorder are, how they can be treated, what the chances of a cure are and what rights patients have. Campaigns of this kind would help to reduce stigmatisation and discrimination and narrow the gap between mental and physical health.

Not enough account is taken of the political dimension of mental health

13. The national laws in place throughout the West, and in the countries of central and eastern Europe, take the form of technical legal mechanisms which often fail to emphasise sufficiently the political dimension of mental health. The legislation as such gives no indication of the role of mental health policies in improving the quality of life of all citizens, public health in general and society's productivity.

14. This failure to assert the political dimension of mental health in legislation is damaging to society. It is significant that most of the member States of the Council of Europe have cut mental health budgets substantially and closed down the major hospitals without transferring the corresponding funds to the out-patient services which were supposed to replace them. The WHO, Council of Europe and European Union must co-operate to ensure that the restructuring of public mental health services is achieved without loss of funding.

15. The financial problems facing mental health provision have frequently reflected a society's dominant political culture, or that imposed upon it. Two competing approaches, rooted in different political cultures, have guided the decisions taken about how to deal with mental health in modern societies: one legal and based on humanism, the other based on economic considerations and eugenics. The laws based on economic considerations and eugenics, adopted before World War II, took the toughest line towards the mentally ill; these had frequently been enacted in the wake of drastic cuts in mental health budgets. The level of budget funds earmarked for mental health is an indicator of the view of humankind prevailing in a particular society.

16. It is vital that the member States of the Council of Europe highlight the political dimension of mental health legislation and reaffirm its place within the sphere of humanist legislation, in view of the humanist principles to which their laws habitually refer. The countries concerned must be mindful of the fact that the economic considerations and eugenics-based approach always wins more support when there is a downturn in the economy. The resurgence of these theories invariably occurs at times when access to mental health care is becoming more difficult for the population as a whole, and when mental illness and mental handicap are stigmatised.

17. According to the concept of a "public mental health service" which is dear to associations championing the rights of the mentally ill, particularly in France, the persons who benefit from public mental health services are service "users". A "public mental health service", according to the Council of Europe's philosophy, is a system based on humanist principles and designed to serve the population. This differs from the system in the United States, the country which saw the emergence of the economic considerations and eugenics-based approach, where a model of economic liberalism prevails. There, market forces dominate, and the users of mental health services are regarded first and foremost as "consumers".

18. On 22 September 2004, the Committee of Ministers of the Council of Europe adopted Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder. This recommendation makes it possible, relying on the principles already referred to in the fundamental Council of Europe texts, to ensure that these are specifically applied to provision for persons suffering from mental disorder. It will oblige a number of member States to adapt their legislation to bring it into line with these principles, but it would not be enough to add these rules to national legislation unless they were accompanied by a new determination where the arrangements for mental health provision are concerned. As well as legislative reform where it is necessary, effective long-term mental health action requires the adoption of a policy under which there are programmes enabling states' mental health budgets to be increased and skilled staff to be trained.

The benefits of taking into account the views of users and their relatives

19. It is very difficult to achieve a consensus among mental health professionals on technical concepts, owing to the wide diversity of schools of thought and clinical practices. "User" involvement in drawing up national legislation, in such circumstances, might be regarded as an additional complication. When the writers of mental health legislation invite users to help to define technical concepts, however, experience has shown that the users, through associations recognised by the authorities as partners in dialogue, contribute to the development of the legislation and to refining the technical solutions devised.

20. Authorities in charge of mental health must open up more to the representation of both users and their relatives, and parliamentary committees should take care to give users' associations a hearing whenever a technical text relating to mental health is in preparation. The same should apply to the work of the Council of Europe. The organisations representing mental health service users, for instance, expressed concern about the lack of transparency, and the inadequacy of their participation, in the recent process culminating in the adoption of Committee of Ministers Recommendation Rec(2004)10. However, prior to the finalisation of the recommendation itself, CDBI has organised a public consultation on the principles to be included in the future recommendation (The White Paper 2000).

21. However, prior to the finalisation of the recommendation itself, CDBI has organised a public consultation on the principles to be included in the future recommendation (The White Paper 2000). Canvassing the views of associations of psychiatric patients past and present is also necessary when other public health instruments are being drafted. This approach allows the user's point of view to be taken into account from the earliest drafts of public health legislation. Thought needs to be given to financial compensation for the user representatives who are in employment and who are asked to participate in the activities of consultative bodies in the mental health sphere.

22. National legislators must bear in mind that the views of users are just as important as those of the profession, and, moreover, offer the best protection against attempts to reintroduce provisions inspired by economic considerations and eugenics-based theories. The temptation to introduce provisions of this kind arises when legal reforms are planned in relation to family law, issues of consent to health-related decisions, therapeutic research and donor samples, sexuality, maternity, voluntary termination of pregnancy, sterilisation, comfort medicine, the demand for greater well-being and psychological needs.

The institutional organisation of mental health provision

23. Whatever organisational arrangements are made for mental health services, it is necessary first to affirm that care for persons suffering from mental disorder must be provided by appropriate services, so that adequate treatment corresponding to these persons' therapeutic needs is given. In a number of countries, particularly in central and eastern Europe, shortcomings in provision may lead to situations similar to "inhuman and degrading treatment", with institutions parallel to the health system and affording no guarantees of quality of care taking in persons suffering from mental disorder, in discriminatory and deplorable living conditions.

24. In many countries, the past few years have seen a shift away from care of the mentally ill in institutions. Where there is a tendency of this kind, there must also be resources enabling patients to be cared for outside the institutions. Nor should such a tendency lead to a failure to take account of the need of some persons with serious mental disorder for suitable institutions, as well as for local services providing psychological and material support, with a round-the-clock capacity to respond to calls from such persons, even at weekends. It is also vital to consider support for families caring for a relative who is unwell.

Organisation on a sectoral basis

25. The public psychiatric service continues to be viewed by all legislators in the West as a medical field with an institutional basis. In the past its institutional nature was based on the legal principle of providing specialised psychiatric institutions. Today it rests on a different legal concept: that of a sector. This legal concept was defined by Council of Europe Committee of Ministers Resolution (76)40 on the organisation of preventive services in mental illness. This resolution should be updated to incorporate the "network" concept. The interests of users, as well as progress in clinical research, are best served by close institutional links between the public psychiatric service and general medicine, both public and private, other medical disciplines, the private health care system as a whole, medical and social institutions, and the vast array of other players from the various social services, authorities and associations. At all events, care provided within the community often has a more favourable influence on the outcome of chronic mental disorder and on patients' quality of life.

26. If the psychiatric service is to be organised on a sectoral basis, there is no reason for sectors to be exclusively psychiatric. Hence the "health areas" which are the basic structure in the Spanish healthcare system are wide-ranging sectors which include the facilities of the public mental health service. Health areas, as defined by Spanish law, must include psychiatric facilities. Each must therefore incorporate a mental health centre staffed by a multidisciplinary team, in addition to a psychiatric unit within the general hospital. This psychiatric unit must have a consultation service. In Italy, the health unit (USL) coordinates all the health care facilities in a particular geographical sector. Each USL is required to set up a psychiatric department.

The inclusion of mental health care in public health systems as a whole

27. Whatever the cultural, constitutional and administrative arrangements which explain their structure, the mechanisms for mental health care in the West must form part of the overall arrangements for public health systems. Their inclusion means that public authorities must include mental health in their overall approach to health policy.

28. However, different choices have been made. Some west European countries have decided to move psychiatric and mental health services completely or partially back into general hospitals, others to keep them within specialised establishments designed to act as the focal point for public mental health structures (including those located in general hospitals).

29. The move back into general hospitals in France is merely an element of ministerial doctrine, whereas in several western European countries it is anchored in legislation, such as the United Kingdom's Mental Health Act of 1959 and Italy's Law No. 180 of 13 May 1978.

30. Italian Law No. 180 has since been amended and supplemented by the law of 23 December 1994. The Italian legislation, which relates exclusively to the public psychiatric sector, did away with the legal concept of psychiatric hospitals: as a result, no new patients can be admitted to psychiatric hospitals, and the construction of new psychiatric hospitals is prohibited.

31. The move back into general hospitals has also formed the cornerstone of Spanish legislation on public psychiatric and mental health services since the adoption of the *Ley General de Sanidad* on 25 April 1986. Article 20 of the Spanish law designates general hospitals as the centres for the treatment of

psychiatric admissions, stating that patients whose illness so requires are to be admitted into the psychiatric departments of general hospitals. This amounts to a prohibition on new admissions to psychiatric hospitals, as in the Italian legislation.

32. The move back into general hospitals is a subject of debate within the profession, both because specialised action which falls outside the other medical disciplines is required to deal with mental illness, and because of the diminution in psychiatry's profile in society and in its effectiveness which might well result.

The importance of general practitioners' role

33. National law-makers must also be aware of the importance of the views of general practitioners, the need to involve them in drafting mental health legislation, and the vital need to provide general practitioners with a solid grounding in this field. Given that, in the developed countries, one person in five will experience a period of depression in his or her lifetime, mental health services should also draw on general medicine. Indeed, one third of the patients visiting general practitioners have psychological problems. If care and treatment for mental disorder are the responsibility of primary health providers, greater numbers of people should find access to services both easier and quicker.

National legislation relating to mental health must guarantee both the rights of persons suffering from mental disorder and proper health care

34. Committee of Ministers Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder sets out a number of rules which now need to be included in national legislation guaranteeing the rights of persons suffering from mental disorder and the good quality of their care.

35. Many countries of central and eastern Europe have not yet adopted mental health legislation. Where such legislation does exist, it is incompatible with the principles of the European Convention on Human Rights or the case-law of the Court. In some of these countries, for instance:

- there are no specific provisions on the right to the services of a lawyer in civil proceedings relating to guardianship or supervision;

- there are no clear procedures for judicial monitoring of guardianship or supervision or relating to restrictions on capacity;

- checks of the situation of persons placed in institutions or under guardianship or supervision are few and far between;

- placements are made de facto, at the initiative of the guardianship department or social services for which the local administrative authorities are responsible, without any court proceedings.

36. Even in some of these countries where the legislation is compatible with the European Convention, judicial checks are all too frequently still a mere formality, without the effective assistance of a lawyer and without funds. Not only is it necessary to have laws guaranteeing the rights of particularly vulnerable persons, but it is for the public authorities in each state to ensure, through independent monitoring methods, that the methods practised respect the dignity of these persons, particularly where patients admitted to hospital without their consent are concerned. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment regularly refers in its reports to failures to respect the dignity of patients compulsorily placed in psychiatric establishments.

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[11] Steering Committee on Bioethics, *"White Paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment,* 10 February 2000.

37. Those societies with more up-to-date legislation are seeing more and more cases of neglect and abandonment of persons with severe mental disorder. The WHO has observed marked differences in the care of persons with mental disorder in Europe. There is excessive recourse to hospitalisation in some east European countries, where 60% of patients are cared for in large establishments with 500 beds or more. In some of these hospitals, unacceptable standards of care together with deficiencies in the areas of human rights and human integrity result in high death rates of up to 60%. On the other hand, in several west European countries, people with serious mental disorder are abandoned with unacceptable indifference; in some capitals, up to 50% of homeless people suffer from psychotic disorder.

38. The CDBI experts consider that the member states should take the necessary steps to eliminate all forms of discrimination on grounds of mental disorder, including those occurring in health-care services. The White Paper of 10 February 2000 on the protection of the human rights and dignity of persons with mental disorder, especially those placed as involuntary patients in psychiatric establishments, which preceded Recommendation Rec(2004)10, also recommends that the member states encourage the conduct of public awareness campaigns on discrimination against people with mental disorder. It also stresses the importance of Article 14 of the European Convention on Human Rights in this connection. The experts highlighted a number of examples including the media's improper and derogatory use of terms such as schizophrenia, discriminatory insurance practices and the provision of fewer funds and less equipment to psychiatric establishments and departments of general hospitals accommodating people with mental disorder[11].

39. Associations, national and international organisations, national governments and local authorities have at last become aware of the need to change attitudes to mental illness and bring home to the public the idea that the causes of mental illness are no different from those of other illnesses, and that diagnosis and treatment are available and effective. Campaigns such as "Changing Minds", launched by the Royal College of Psychiatrists in the United Kingdom[12], are intended to inform the public and dispel the myths and stereotypes surrounding people with mental disorder. Since 1991 the Slovak Republic[13] has made considerable efforts to reform its mental health care system to cope more effectively with problems such as stigmatising.

40. Those societies with the most up-to-date legislation are seeing more and more cases of neglect and abandonment of persons with severe mental disorder; meanwhile, in countries where the legislation is the least developed, excessive recourse to detention continues. The problem of neglect and abandonment of people with severe mental disorder should be tackled in the legislative context. European countries need to tailor their civil-law measures for the protection of adults to deal with this situation, which adds a new dimension to the question of individual protection. They must also introduce effective criminal penalties for any persons in institutions, or in specific cases any family members, directly responsible for the neglect or abandonment of persons with severe mental disorder.

Decisions on compulsory placement or treatment

41. Mental health care, in some cases, necessitates the compulsory placement or treatment of patients, either because their mental disorder prevent them from giving their consent to care, or because they represent a danger to others. Such a placement against the patient's will must be accompanied by every possible guarantee that the patient's rights will be protected.

42. The legislative reforms of the period 1983-1994 in several European states reflected a real obsessive fear of arbitrary detention. Parliamentary debates revealed how shocked those responsible for legislating were by the use made of psychiatry by the communist regimes in eastern Europe. Clearly, law-makers were anxious to prevent abuses of that kind, although the likelihood of their occurring would seem to have been quite small, given the vigilance of the European Court of Human Rights.

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12 *Mental Health – A Call for Action by World Health Ministers,* WHO, Geneva, 2001

13 Idem.

43. Those reforms were influenced by the observations made by the European Court in examining applications from nationals of several of the countries concerned. What was at issue in these cases was the conformity of domestic legislation with the provisions of Article 5 of the European Convention on Human Rights. Paragraph 4 of that article states that "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful".

44. In a series of decisions, the European Court of Human Rights reiterated the applicability of Article 5 to psychiatric legislation. The cases showed that some laws, such as those in England and Wales, although apparently highly appropriately providing for the jurisdiction of a court, were nevertheless not in strict conformity with Article 5 of the Convention. The subsequent amendments to the Mental Health Act arose in part out of the Court's ruling against the United Kingdom on 5 November 1981.

45. While, according to Recommendation 1235 (1994) of the Parliamentary Assembly of the Council of Europe on psychiatry and human rights, "in the event of compulsory admission, the decision regarding placement in a psychiatric institution must be taken by a judge", Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder adopted less precise wording, stating that "The decision to subject a person to involuntary placement (or treatment) should be taken by a court or another competent body". This change is viewed by some non-governmental organisations, such as the Mental Disability Advocacy Centre (MDAC), in Budapest, as entailing risks of a lowering of the standards required to justify a compulsory placement.

46. Several European countries have already introduced a procedure for court jurisdiction in cases of compulsory admission to hospital. This court jurisdiction principle has long been a feature of British and German positive law. Germany, for example, uses a judicial procedure for compulsory admission to hospital based on principles laid down in a federal law of 1990, although the procedure in fact has its origins in the German Civil Code of 18 August 1896.

47. It nevertheless has to be said, as pointed out by the European Court of Human Rights in a judgment of 2003 (case of Rakevich v Russia, No. 58973/00), that the existence according to the letter of the law of the principle of court jurisdiction does not necessarily guarantee the effective application of that principle. In this case, the Court, after considering the conformity of Russia's Psychiatric Treatment Law with Article 5 (1) of the European Convention on Human Rights, showed that the safeguard for which this text provided was not effective. While the law provided that a judge must grant or refuse a detention order within five days of the hospital's application for it, the court to which an application had indeed been made had taken 39 days to issue its ruling.

48. In a few countries of central and eastern Europe, such as Estonia, prosecutors are empowered to order detention in a psychiatric establishment. It cannot be concluded from this fact that this procedure really corresponds to "court jurisdiction ". It has to be said, inter alia, that the prosecutors in the countries concerned have power to take such a decision without any medical opinion or certificate. Bulgaria was forced to acknowledge, when the European Court of Human Rights issued a judgment in 2000 (case of Varbanov v Bulgaria, No. 31365/96), that its legislation needed amending in this respect.

49. Although some law-makers in countries of central and eastern Europe regard French legislation relating to psychiatry and mental health as a reference in certain areas, the same legislation is criticised by certain theorists who regard some aspects of it as incompatible with the Council of Europe's ideal. The move into line with European legislation effected by Law No. 90-527 of 27 June 1990 was effectively a minimum alignment. The writers of the 1990 French law retained the specific historical features of French legislation on compulsory admission to hospital, including the allocation to the authorities, rather than to the courts, of responsibility for placement decisions.

50. There is no contradiction between the concepts of court jurisdiction and administrative procedure. Administrative efficiency is compatible with systematic monitoring of freedoms by a judge. The compatibility of the two concepts is proven by Italian law, under which the municipal court bailiff must

inform the guardianship judge within 48 hours of a provisional decision by the mayor on administrative procedure. The judge must then examine the case within 48 hours before taking a final decision, of which he must inform the mayor. The mayor, and any interested party, may then appeal. If compulsory treatment in hospital extends beyond seven days, the case goes before the judge again for a further decision.

51. In 1983, Spain reformed its legislation concerning compulsory admission to hospital. The arrangements instituted by Law 13/1983 involve the jurisdiction of the courts. The procedure is that the judge first holds a meeting with the person concerned, then has a medical report prepared, appoints a defence lawyer and forwards the file to the prosecuting authorities. The judge issues a provisional confinement order after hearing both parties and subsequently reviews the confinement order regularly (every six months). Implementing Act No. 6/1984, which introduced the principle of *habeas corpus* into Spanish law, allows detained persons, whatever the nature of the establishment, or wherever they are being held, to have the legality of their detention examined by a court, which may lift the confinement order if it is found to be unlawful.

52. The Dutch law of 1984, the Belgian law of 26 June 1990 and the German law of 1990 provide for mechanisms very similar to those in the Spanish legislation with regard to the existence of a prior judicial decision, but also as regards disputes concerning compulsory admissions, which are a separate legal issue.

53. While, in accordance with Article 20 of Council of Europe Committee of Ministers Recommendation Rec(2004)10, every state may designate in its own legislation the authority responsible for deciding on involuntary admission to hospital ("a court or another competent body"), it does seem necessary to emphasise that it is beneficial if the authority concerned can offer the best possible guarantees of its own independence, and if any challenges to its decisions may be made under procedures which safeguard both the rights of the persons concerned and the proper conduct of proceedings relating to decisions on such admissions. The greatest safeguards in this respect seem to exist where a civil court is involved in such decisions.

The grounds for compulsory placement or treatment

54. Parliamentary Assembly Recommendation 1235 (1994) set out limited criteria for the justification of compulsory placement, which was to remain exceptional: there had to be "a serious danger to the patient or to other persons", and another possible criterion was "if the absence of placement could lead to a deterioration or prevent the patient from receiving appropriate treatment". Committee of Ministers Recommendation Rec(2004)10 is far more explicit. Article 17 thereof on involuntary placement and Article 18 on involuntary treatment provide for these measures to be applicable only to a person who has a mental disorder, when the person's condition represents a significant risk of serious harm to his or her health or to other persons. There must be no less restrictive or less intrusive means available of providing appropriate care, and the opinion of the person concerned must have been taken into consideration. Where involuntary placement is concerned, Article 17 says that such placements must, inter alia, have a therapeutic purpose. The requirement for the opinion of the person concerned to be taken into consideration appears to some extend to be in conflict with the compulsory nature of the placement or treatment decision. Nevertheless the criterion set out in this Committee of Ministers Recommendation should offer better safeguards to the persons concerned.

55. Grounds for compulsory placement have been laid down in various countries' legislation. In French law, for instance, a "serious threat to public order" continues to be a ground for compulsory admission to hospital, but this is not the case in other countries' legislation. The Mental Health Act of 1983 (England and Wales) explicitly states that a person cannot be deemed to be mentally ill by reason only of immoral conduct, sexual deviance or dependence on alcohol or drugs. The French legislation is less clear. While it aims to remove from the psychiatric sphere the medical treatment of alcoholics and drug addicts, the category of "morally marginalised persons" appears to be much more prominent in the French legislation on public psychiatric and mental health services than in the UK legislation.

56. In most countries, public psychiatric and mental health legislation has been rebuilt on a pattern comprising a single method of admission to hospital. Where procedures for admission against a patient's will under French law are concerned, however, admission to hospital at the request of a third party remains alongside compulsory admission. This was the second great act of resistance against alignment with legislation elsewhere in Europe, following France's rejection of subjection to court jurisdiction. Most modern European legislation provides for a single set of arrangements for admission to hospital encompassing two procedures: an emergency and an ordinary procedure.

The handling of disputes relating to mental health

57. Article 13.I.ii of Recommendation 818, adopted by the Council of Europe's Parliamentary Assembly in 1977, advocates the setting up of "*independent special mental welfare tribunals or commissions, with a duty to exercise protective functions by investigating complaints, or by intervening on their own initiative in any case, with power to discharge patients where they find that confinement is no longer necessary*".

58. United Kingdom law comes closest to realising this aim of having a highly specialised mental health court. The UK does have a Mental Health Review Tribunal, which investigates thoroughly the approach taken to treatment and the experts' conclusions. Each hearing is conducted by a two-person panel, one person with a legal and the other with a medical background. The fact that one of the members has a medical background prevents perceptions of over-simplification. The panels, moreover, are able to find solutions other than simply upholding or lifting confinement orders. Hence, as observed by Thomaïs DOURAKI, the Tribunal may specify in its decision the date on which the patient is to be discharged, thus effectively lifting the order, but with delayed effect (*La Convention Européenne des Droits de l'Homme et le droit à la liberté de certains malades mentaux et marginaux*, p. 287, LGDJ, Paris, 1986).

59. The United Kingdom legislation allows the chair of the panel to defer the lifting of the order, while giving the applicant the assurance that he or she will be discharged on a given date. This allows carers to help the patient to prepare for discharge. The Tribunal may also, if it feels unable to set a precise date, defer the lifting of the order until such time as the applicant has been found somewhere to live, and everything has been done to help him or her to return to life in the outside world.

60. The most unusual type of specialist tribunal, made up exclusively of doctors, is found in Greece.

61. Recommendation Rec(2004)10 of the Council of Europe Committee of Ministers does not pursue the line that it is a good idea to set up specialised mental health courts. Article 25 of the Recommendation calls for appeals by persons compulsorily undergoing treatment or placement to be regularly considered by courts which offer a genuine guarantee of these persons' defence, including legal aid. The associations which represent patients attach particular value to these safeguards.

Professional code of practice and ethical issues relating to the treatment of persons suffering from mental disorder

62. The ethical issues are fairly comprehensively dealt with in British and German legislation and in international law. One of the main reference texts in international law is Resolution 46-119, passed by the UN General Assembly on 1 December 1991. This very detailed text sets out twenty-five Principles relating to ethical issues. Council of Europe Committee of Ministers Recommendation 1235 (1994) is also highly specific, referring to "treatment such as lobotomies and electroconvulsive therapy", and stipulating that such acts "may not be performed unless informed written consent has been given by the patient or a person, counsellor or guardian, chosen by the patient as his or her representative and unless the decision has been confirmed by a select committee not composed exclusively of psychiatric experts".

63. The legal approach to ethical issues used in international law draws its inspiration from the approach of British and German legislators as reflected, for instance, in the United Kingdom's Code of Practice under the Mental Health Act of 1959, revised in 1983. This Code is a fairly concentrated text setting out the conditions governing compulsory admission, but also including detailed provisions on ethical issues.

64. The law adopted by the German *Land* of Berlin on 20 March 1985 relating to the large-scale prescription of psychotropic drugs, electroconvulsive therapy, surgical operations and a host of other subjects, meanwhile, offers a veritable practical guide to ethical issues in the mental health field.

65. The legislation on public psychiatric and mental health services which shows the greatest willingness to embrace ethical issues tends to be drafted by legislatures which are generally respectful of regional cultures. The law applied in England and Wales, for instance, differs from Scottish law and from that in Northern Ireland. The law of the *Land* of Berlin is also a regional mechanism distinct from legislation in Germany's other *Länder*. Hence it is clear that the legal arrangements governing public psychiatric and mental health services carry the imprint of the cultural, constitutional and administrative context in the country concerned.

66. In the countries with a unitary structure, national psychiatric legislation has from the outset concentrated on two core issues to the exclusion of virtually all other matters: the organisation of public mental health services and compulsory admission to hospital. In countries with a federal structure, the principle of the need for legislation on public psychiatric and mental health services is asserted, and is sometimes acted upon at federal level, but what makes the legislation in these countries different is the fact that their federated states are responsible for the detailed legislation. These laws deal very comprehensively with issues which are regarded elsewhere as a matter for professional guidelines, local ethics committees or the conscience of the individual practitioner.

67. French law deals with neither "restraint" (physical restraint of patients) nor "seclusion". These are two issues regarded as exclusively medical in France, and are therefore a matter for professional recommendations or practitioners' conscience. In contrast, such practices are covered by positive law in most western democracies (United States, United Kingdom, Germany, Canada, Belgium, Netherlands). Russia also has a legislative text covering restraint and seclusion.

68. Under most of the relevant legislation in western democracies, agitation or violence does not necessarily require the use of mechanical means of restraint. Among the texts dealing specifically with agitation and violence is the German law of 20 March 1985 on "the restraint of patients". This text refers to the concept of "special safety measures". Under German law, such measures may be taken only where a considerable risk exists which cannot be prevented in any other way. Provision is made for three possible cases: the patient may be at risk of seriously injuring him or herself, may become violent, or may discharge him or herself from the care establishment without permission.

69. The law in the United Kingdom covers "seclusion", which is an ethical issue very similar to that of "the restraint of patients". Provision for seclusion as a means of medical treament is made in the Mental Health Act 1983. The seclusion for which the Act provides is "the supervised confinement of a patient in a room, which may be locked to protect others from significant harm".

70. Under the UK law, "seclusion" must be used as a last resort, and for the shortest possible time. The use of seclusion rooms must be in accordance with the relevant provisions of the Code of Practice published by the Department of Health. The use made of these rooms and the files of the patients whose care has necessitated the use of such measures are monitored at least once a year by the Mental Health Act Commission, an independent body responsible for ensuring that patients' rights, welfare and safety are protected.

71. It is worth drawing attention to the provisions of Section 118-1 of Quebec's Mental Health and Services Act, which came into force on 1 June 1998. This law is one of the most noteworthy pieces of reference legislation, stating that "Force, isolation, mechanical means or chemicals may not be used to

place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must be appropriate having regard to the person's physical and mental state". The Act states that, in respect of records, "Any measure referred to in the first paragraph applied in respect of a person must be noted in detail in the person's record. In particular, a description of the means used, the time during which they were used and a description of the behaviour which gave rise to the application or continued application of the measure must be recorded". It further specifies that "Every institution must adopt a procedure for the application of such measures that is consistent with ministerial orientations, make the procedure known to the users of the institution and evaluate the application of such measures annually".

72. Psychiatric treatment must take an individualised approach, with a treatment protocol being prepared for every patient. The Rapporteur welcomes the provision in the explanatory memorandum to the Recommendation Rec(2004)10 which highlights the importance of individualised treatment plans (paras. 90-93). Treatment must span a broad range of rehabilitation and therapeutic activities. It is still not made sufficiently clear in international law or in mental health legislation that the nature of psychiatric therapy is individual and intensely personal, involving an individualised plan of continuing care, based on a relationship between patient and practitioner. It is still all too often the case that the treatment given to a patient consists mainly of pharmacotherapy, either because there is a shortage of suitably skilled staff and appropriate facilities, or because philosophies based on patient control and supervision are still pursued.

Civil-law measures to protect adults suffering from mental disorder

73. The protection of mental patients' rights and freedoms and the protection of adults fall into two distinct spheres of legislation, although there are close links between them. European law-makers have been aware of this problem for a long time, with the French law of 30 June 1838 and the Belgian laws of 18 June 1850 and 23 December 1873 dealing with both compulsory admission to hospital and the protection of property. These two issues are now dealt with in separate legislative instruments. The protection of rights and freedoms comes under European countries' Public Health Codes, whereas the protection of property, also extended to include protection of the person, is dealt with in the Civil Codes.

74. Provisions still exist in the constitutions or legislation of certain countries of central and eastern Europe prohibiting any adult without legal capacity from taking part in elections and dealing with their own private affairs. Priority must be given in these countries to reform of the civil measures for the protection of adults. And in some of these countries, whose Civil Codes remain virtually unchanged since the Soviet era, there are persons detained in psychiatric establishments for the purpose of an evaluation of their mental capacity with a view to implementation of a civil measure for the protection of an adult. States' political responsibility for resolving the problem of this inadmissible practice is clear.

75. Hungarian law differs from the law of other countries of central and eastern Europe, and is comparable to that of Quebec and Germany. It lays down the principle of a regular review of the status of any person declared incapable. Under the law of Quebec and that of Germany, any protective measure has to be reviewed after a maximum of five years. This review is based on a medical or psychological/social assessment of the protected adult.

76. Guardianship and supervision, involving authority conferred by a court, exist in several European countries, including France and Spain, as well as Germany, where a law promulgated in April 1990 replaced the prohibition which had previously existed by a system based on the principle of modulated protection. Like French law, German law now makes a distinction between guardianship and supervision. Guardianship is used where the adult requiring protection is recognised to be completely incapable, whereas supervision is a system of protection which recognises partial incapacity, under which the supervisor assists, advises and supervises the protected adult.

77. It has to be pointed out that, while several laws now come very close to French law, and have even overtaken it where regular review of protection measures is concerned, the *sauvegarde de justice* system (for protecting adults whose faculties are not diminished to the extent of requiring a guardian or supervisor) remains a particularly relevant feature unique to French law. It has no equivalent in comparative law.

78. The Committee of Ministers of the Council of Europe, in Recommendation No. R(1999)4 to member states on principles concerning the legal protection of incapable adults, laid down useful principles for the implementation of legislation effectively guaranteeing the protection of such adults.

Conclusion

79. Prevention of abuse and safeguard of human rights and dignity of people suffering from a mental disorder remain a priority for governments to tackle.

80. In view of the current process of mental health reforms across Europe, it is essential for member states to follow the guidelines that have been set up by the World Health Organisation (WHO)[14] and the Council of Europe[15] . Such reforms of mental health policies should aim to achieve social inclusion and equity, by taking a comprehensive view of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems.

81. A positive shift away from large institutional care to a wide range of community-based services should be accompanied with adequate financial resources. Care provided within the community most often has a more favourable influence on the outcome of chronic mental disorder and on patient's quality of life.

82. Finally, the Rapporteur would like to stress the importance of involving a wide range of professionals, users and their families in different stages of mental health reform process, its implementation and monitoring – as a key to the success of the reform.

83. Well-defined mental health services with adequate budgets are essential for the quality of life of all citizens, public health in general and society's productivity.

[14] "World health report 2001"; Helsinki declaration (WHO European Ministerial conference on Mental Health, January 2005)

[15] Committee of Ministers Recommendation R (2004)10 concerning the protection of the human rights and the dignity of persons with mental disorder; European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; European Social Charter

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