Presidency of the Council of Ministers

TREATMENT OF PSYCHIATRIC PATIENTS:BIOETHICAL PROBLEMS

24 September 1999

The National Bioethics Committee's Statement concerning the Council of Europe White Paper on the treatment of psychiatric patients.

In response to Recommendation N° 1235 (1994) of the European Parliamentary Assembly, the Steering Committee for Bioethics of the Council of Europe (CDBI) dedicated a special work session to the involuntary treatment of psychiatric patients. The mandate of the work group (CDBI-PH) was to "provide guidelines to be included in a new legal instrument of the Council of Europe. These guidelines should aim to ensure the protection of human rights and dignity of people suffering from mental disorders especially those placed as involuntary patients, including their right to appropriate treatment". On this basis, the work group drew up a "White Paper", a detailed document dedicated to the "protection of human rights and dignity of people suffering from mental disorders especially those placed as involuntary patients in a psychiatric establishment". The White Paper was then sent for approval to all the European National Ethical Committees, with an invitation to answer specific questions on the fundamental issues discussed in the document.
In response to the invitation, the Italian National Committee for Bioethics produced a short critical statement. The following text sets forth the answers provided by the National Committee for Bioethics together with the questions asked and relevant extracts from the White Paper.

1) The scope of application of the new legal instrument

The White Paper proposes that:

a) "It should deal with both involuntary placement and involuntary treatment, whether or not the latter takes place in the context of the involuntary placement
b) involuntary placement should only take place for therapeutic reasons
c) the new legal instrument should also apply to involuntary placement and treatment decided upon in criminal justice system".

Question: Are these proposals acceptable and appropriate?

Answer: The National Committee for Bioethics considers these proposals both acceptable and appropriate.

2) The Categories included in the concept of mental disorder

The White Paper suggests that:

a) "involuntary placement or treatment should only be appropriate with regard to certain types of mental disorder, eg. some people suffering from psychoses, certain types of severe personality disorder and in severe mental handicap.
b) Involuntary placement should under no circumstances be used for political ends.(In this respect, reference could in particular be made to Recommendation No R (83) -quoted- which states that "Difficulty in adapting to moral, social, political or other values, in itself, should not be considered a mental disorder")".

Question: Are there categories which should be included in or excluded from the concept of "mental disorder" for the purpose of mental health legislation?

Answer: The classification of mental disorders for legislative purposes into mental illness stricto sensu, psychiatric handicaps and personality disorders is approved as such classification corresponds to the D.S.M. abandoning the old distinction between psychosis and neurosis which, for example, included anxiety among 'mental illnesses'. As far as the medical and legal concept of 'mental inability' is concerned, presumed to be an equivalent to 'incapability', such concept obviously plays a fundamental role in legislation both for observance of informed consent and decision of Involuntary treatment.

3) Criteria for involuntary placement in a psychiatric establishment and for involuntary treatment.

The White Paper considers that:

"A distinction had to be made between the legal ground as a result of involuntary placement or administration of an involuntary treatment should always be accompanied by procedures to protect the rights of the person concerned".

Question: Is a distinction between involuntary placement and treatment valid and meaningful?

Answer: Distinction between involuntary placement and involuntary treatment is useful in abstract terms, even though it seems rather utopian to assume that an involuntarily placed patient will be able to choose his cure.
Furthermore, in cases of CHT, it is extremely difficult to distinguish between involuntary placement and involuntary treatment as the patient's decision-making ability can often assume a dynamic and evolutionary character, i.e. escape static alternatives of ability and inability by assuming elements of temporariness and development.

Furthermore the European document observes that:

"It appeared appropriate to retain the view that if the patient was admitted involuntarily, the presumption of competence to decide about his\her own treatment prevails, unless inability to decide on his\her own treatment was one of the legal criteria behind placement.

A number of criteria should be met before involuntary placement or treatment occurs:

a) The existence of a mental disorder must be recognised or assessment required to determine whether a mental disorder in present".

Question: Should the grounds for detection for assessment in the absence of definite signs of a mental disorder be defined? If so, how?

Answer: The reasons for placement must be specified in a scientific manner.
Although placement should always be imposed with the maximum circumspection, taking

care to avoid abuse, in certain cases it is necessary in order to provide a rigorous diagnosis in the absence of visible signs of mental disorder.

The White Paper continues:

b) "This mental disorder must represent:
i.) a serious danger to the person concerned (including to his/her health) and/or
ii.) a serious danger to other persons (provided that the placement should be beneficial to the person concerned)"

Question: Should proposal for the determination and definition of the required level of dangerousness be included in legislation? Is the concept of "risk" preferable to that of "danger"?

Answer: The concept of risk is certainly wider-reaching than that of danger, however the concept of danger (for the patient and others) does not have any truly valid alternatives on the condition that social stigma is not included in the concept and the concept is not used in all category of psychiatric nosography. As matter of fact, only certain patients are dangerous to themselves and others (through the adoption of self- and hetero-aggressive behaviour), -e.g. those suffering from major depressive disorders, paranoid schizophrenia, paranoid personality disorders, borderline personality disorders, antisocial personality disorders etc.* patients which constitute a distinct minority in comparison with the total number of people suffering from mental disorders. In any case, the need for a balance between the principle of benefit and the principle of autonomy with regard to the criteria of protection of individual rights and liberties should always be kept in mind.

Question: Given the serious nature of this legislation, should legislation specify certain alternatives which should always be available? If so, which?

Answer: The law should provide for the use of alternative therapies where considered appropriate to the patient's clinical situation (e.g. day hospital treatment, home treatment etc.).

Question: Should deprivation of liberty in the criminal field be based on different/more criteria as the criteria described under a.to d. above?

Answer: Even in prison, should a pathological condition be diagnosed, therapeutic objectives must prevail. Therefore there is no ethical justification for regulations which differ from those regarding people suffering from mental disorders in general, although danger and suitable control measures should nevertheless be considered.

4) Procedures for taking a decision of involuntary placement and of involuntary treatment

The CDBI work group express the opinion that it is necessary that:

a) "The patient be examined by a psychiatrist or a doctor having the requisite experience and competence, in particular as regards risk assessment, in order for a decision on

involuntary placement or extension of involuntary placement or for a decision on involuntary treatment or its extension to be taken.

b) The decision confirming involuntary placement or treatment should be taken by a relevant independent authority, which should base its decision on valid and reliable standards of medical expertise".

Question: What should be the characteristics of the "relevant independent body"? Who might reasonably fulfil this role and who not?

Answer: The competent independent body should be a judicial authority and must be supported by the (not constraining) opinion of a competent psychiatrist. The opinion of members of the family or other persons close to the patient should be acquired but the independent body must confirm that such opinions are provided by persons with an adequate cognitive ability, balanced emotional tolerance and ethical guaranties. In any case such opinion cannot be constraining.

5) Procedures for involuntary placement and treatment in cases of emergency

The White Paper observes that:

"It would seem neither reasonable nor advisable, inter alia because of the immediate danger to the person concerned and/or others in an emergency situation, to always await the placement or treatment decision of the relevant independent authority. The work group has thus considered that, in an emergency situation, the involuntary placement and treatment can take place without the relevant independent authority having taken the decision but on the basis of a valid and reliable medical opinion following medical examination of the patient with a view to the placement and treatment. The work group nevertheless underlined that the emergency procedures should not be used with the aim to avoid applying normal procedures".

Question: Are there other necessary safeguards relating to emergency situations?

Answer: In cases of emergency, it is ethically correct to proceed with placement and treatment on the advice of more than one doctor without having to wait for the competent authority to decide. However, the competent authority must validate the decision.

6) Special treatment

The White Paper observes that:

"The effectiveness of psychosurgery has not been established by appropriate controlled research. Thus, where States continue to sanction the use of it, the consent of the patient should be an absolute prerequisite for its use. Furthermore, the decision to use psychosurgery composed of psychiatric experts. The Working Party considered that in each member State the legislators should establish special protocols for the administration of psychosurgery".

Question: What further safeguards are necessary for the administration of psychosurgery ?

Answer: As far as the psychiatric use of psychosurgery is concerned, the risk-benefit parameter clearly advises against its use. In fact, while reducing the symptomology of agitation, psychosurgery can lead to serious alterations in the personality of a strong apathetic and demented nature and a real destructuring of cognitive ability and mood.

7) Involuntary treatment and criminal justice

The CDBI Working Party considers that:

"When the police had to deal with people, for example on the public highway, whose behaviour led them to suspect such persons were suffering from serious mental disorders, they should be able to obtain a medical examination".

Question: Are there particular considerations that the Working Party should make with regard to the way in which courts and prisons deal with mental disorders?

Answer: While protection of the personal dignity of defendants with mental disorders should be guaranteed, with therapeutic aspects taking precedence over penal and custodial procedures, the problem of the protection of the community following the end of involuntary treatment should also be carefully assessed.

8) Human rights of people suffering from mental disorder, in particular those placed as involuntary patients

The CDBI Working Party considers that:
"Every person suffering from mental disorder should have the right, to the extent possible, to live and work in the community. In particular, the person concerned should not automatically be deprived of the right to vote or to make a will, and he or she, whenever possible, should be enabled to enter into legally effective transactions of an everyday nature".
Question: Are there other considerations that should be made as regards the civil and political rights of people suffering from mental disorder?

Answer: In order to ensure continuity between clinics and rehabilitation, the recovery of personal and social skills should be considered a primary objective, encouraging patient to progressively increase and/or mature his ability to recognize and exercise his civil and political rights.

Following an examination of the question of physical restraint, the CDBI Working Party considers that:

"The use of a short periods of physical restraint should be due in proportion to the patient's degree of agitation and the risks entailed, and that thorough training in these techniques should be provided to staff. In this context, it was underlined that the response to violent behaviour by the patient should be graduated, ie that staff should initially attempt to

respond verbally; thereafter, only in so far required, by means of manual restraint; and only in a last resort by mechanical restraint.
It is furthermore felt that isolation and mechanical or other means of restraint for prolonged periods should be restored to only in exceptional cases and where there is no other means of remedying the situation; furthermore, such measures should be used only on the express order of a doctor or immediately brought to the knowledge of a doctor for approval: the reasons and duration of these measures should be mentioned in a proper dossier".

Question: What safeguards should be provided to govern restraint to patients?

Answer: The use of restraint and isolation must be drastically reduced and only practised in exceptional cases when there are no alternatives or in states of emergency. Furthermore, such measures should only be used for limited periods of time. There is convergence of ethical rule protecting personal dignity and clinical and therapeutic criteria. In fact, nosodromic studies of pathologies deriving from hospitalization have highlighted that long periods of placement encourage chronicization.

The Working Party also examined the question of permanent infringement of individual's capacities to procreate and considered that:

"Should this issue be mentioned in the new legal instrument being prepared, it would be appropriate that the recommendation provide that expect in most exceptional cases, there must be no permanent infringement of an individuals capacities to procreate without the individuals consent. Furthermore, the permanent infringement of an individuals capacities to procreate should always take place in the best interest of the person concerned; in other words, the clinical aim of such an infringement should always be the protection of the person concerned. It should then certainly be appropriate to specify that the mere fact that a person suffers from a mental disorder does not constitute a sufficient reason for causing permanent infringement to that person's capacities to procreate".

Question: Are there any exceptional circumstances permitting permanent infringement of procreation capacities of people suffering from mental disorder? If so, what are these circumstances? Should the exceptional circumstances where permanent infringement of procreation is deemed permissible be specified?

Answer: As far as procreation is concerned, it should be kept in mind that genetic research with regard to mental illness is still at the research stage. However several publications indicate a certain frequency in a same relationship both of schizophrenia and depression cases which should lead to extreme caution. Anyway infringement of procreation capacities is legal only in case of spontaneous recovery.

The CDBI Working Party observes that:

"In certain cases and in compliance with the relevant provisions of the house rules of the psychiatric establishment concerned, it might prove necessary to restrict these rights where failure to do so could be harmful to the patient's health future prospects or to the rights and freedoms of other people"

Question: What circumstances would justify restriction of the rights to communicate? What safeguard should exist to protect this right?

Answer: The right to communicate can only be restricted in exceptional and highly motivated situations, considering the importance that communication and its disorders have in schizophrenia. Generalized restriction could have pathogenic effects.

Finally, the NCB would like to underline that the White Paper lacks any mention of the need to give support and help to the families of psychiatric patients. As many years' experience in Italy have shown, voluntary treatment is only effective if there is strong support from the community, in the living environment of the person concerned, and to his family.

9) Discrimination against people suffering from mental disorder

The White Paper observes that:

"When considering this problem, the experts felt that member States should take measures to eliminate discrimination against people suffering from mental disorder. Here the importance of Article 14 of the European Convention on Human Rights (prohibition of discrimination) and of the case-low of the European Court of Human Rights where stressed. Certain examples have been highlighted by the experts, in particular incorrect and stigmatising use of terms such as schizophrenia in the media, discriminatory practices concerning employment of patients or former patients, discriminatory practices concerning assurance, less financial and technical means in favour of psychiatric establishment, etc".

Question: What measures should member States take to reduce discrimination?

Answer: Social stigma and discrimination could be eliminated and counteracted through the promotion in schools and other training and educational centres of information and health-education programs, although excessively radical solutions should not be expected in the short term.