The report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The special rapporteur in his report to the HRC addresses an important area in the field of torture prevention, namely its applicability to health care institutions (and probably to institutions providing institutional social care services, although they are not mentioned in the preamble). Needless to say, such analysis is needed and it plays an important role not only in the development of jurisprudence but also in facilitating discussions in the public and among specialists working in these areas. The voice of psychiatrists needs to be heard on this matter as well, no doubt about that.

I will refrain from comments on the various other topics of the report and only address the issues related to mental health care.

Allow me to start from a more general subject. The European Committee for the Prevention of Torture (CPT) – a different body from the UN Subcommittee for the Prevention of Torture and CAT that are mostly cited by the Special Rapporteur – has never during its nearly 25 years of existence used the word “torture” in its reports. Why so? There is a common understanding in the Council of Europe that torture can only be defined by the European Court of Human Rights (ECHR), and it is done on a case-by-case basis. Trying to provide a universal definition of torture is an effort unlikely to succeed and may in a long run even undermine the purpose of the global fight for the prohibition of torture.

The assessment of the applicability of the convention for the prevention of torture in health care institutions and particularly in the ones providing mental health care has successfully been carried out by the CPT – the monitoring body that for nearly 25 years has carried out country visits to all the member states of the Council of Europe. The reports have also been analysed and there are compendiums such as the CPT standards (http://www.cpt.coe.int/en/docstandards.htm) that can be used as reference to evaluate situations in case of need. On the European level there has never been a question of the health care institutions not falling under the mandate of the monitoring body.

The statement of the Special Rapporteur that involuntary treatment and other psychiatric interventions are forms of torture and ill treatment demands a clarification. Ever since the adoption of the Convention for the Protection of the Rights of Persons with Disabilities there have been voices declaring that its Article 14 paragraph 1(b) bans involuntary treatment in psychiatry. This is not true – the convention states “the existence of a disability shall in no case justify a deprivation of liberty”. One of the mistakes made in interpretation if equaling “mental disability” to “mental disorder”. The vigilant reader would notice that the convention does not define disability as automatically starting from the first symptoms of an illness, and neither is this true in mental disorders. Any attempt to proceed on this path would be arbitrary.

Another problem that stems from the report is the assumption that only the “disability” or “illness” is taken into account when providing grounds for involuntary treatment or placement in national legislations. That is not true – it is commonplace in most legal provisions that the need for commitment without consent results from a combination of dangerousness for oneself or others and a serious mental disorder. In case the mental disorder can no longer be used as a criterion, we would fall back in history to the era preceding Philippe Pinel at around 1800 – disruptive and dangerous mentally ill persons would be locked up in prisons instead of cared for in hospitals. Needless to say, the suggested model also runs against the modern evidence based on the understanding that mental disorders are treatable illnesses. It would raise ethical dilemmas among doctors.

The psychiatric community is nowadays well aware of the basic principles of human rights, as well as the mechanisms (on both national and international levels) to guarantee them. The problems relating to possible ill treatment are in most cases resulting from the lack of resources needed to provide both access to care and the necessary quality. Clear legal provisions are needed as well as public awareness on the issues of protecting the rights of the mentally ill. Yet the solutions should be found in the dialogue and not by confronting the already existing legal safeguards. I reiterate my call for a stronger involvement of the psychiatric community in these decisions, and, needless to say, we also need to speak up for ourselves.

Andres Lehmets
psychiatrist, former member and vice-president of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The Nordic Psychiatrist
Torture or Treatment

Is psychiatry torture?
An open letter to the UN special rapporteur on torture.

The Special Rapporteur
United Nations' special rapporteur on torture, Mr. Mendez, has written in his annual report for 2013 that he recommends an absolute ban on all involuntary treatments for the mentally ill.

Quotes from the report:
"The Special Rapporteur calls upon all States to: Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation."

OHCHR and WHO
The special rapporteur on torture is part of the Office of the United Nations High Commissioner for Human Rights (OHCHR). But it appears that OHCHR has not talked to another UN organization, also located in Geneva only a few hundred meters away – the World Health Organization (WHO), WHO calls for a reduction in the use of involuntary methods and an increased awareness of human rights, but it does not ask for a worldwide ban on nonconsensual methods. Due to their respective mandates, I would prefer to receive medical advice from the WHO rather than the OHCHR.

The Norwegian Law
Norwegian Law only permits the use of coercion on people with severe mental illnesses as psychosis, and only if voluntary methods have been tried first and failed. Involuntary treatments can be used only if it is likely that the treatment will make the person better or if the patient untreated is a danger to self or others.

Disability and psychosis
Severe mental disorder is usually understood as the medical term psychosis and we mostly put emphasis on the positive symptoms as hallucinations, delusions and thought disorders. Normally psychosis will lead to a disability, but we primarily treat the symptoms and not the disability.

Voluntary and informed consent
The main principle behind all health care in Norway is that the services are voluntary and based on informed consent. Exceptions are necessary for people who are unable to understand their own best interest as a direct result of their illness. For instance, unconscious and delirious patients are given life-saving nonconsensual treatment. Likewise psychotic patients can often have an unrealistic understanding of the world and fail to see that they are ill and in need of treatment. In such circumstances it can be in the patient's best interest to receive coercive treatment. If not treated, the psychotic patient is likely to severely deteriorate. And to the best of our current knowledge, having a long-standing psychosis untreated can be toxic to the brain.

Stigmatizing
I am concerned that the special rapporteur's suggested ban will stigmatize an already vulnerable group of patients, the severely mentally ill. According to the report these people do not have any real illness, but rather merely a reduced psychosocial functioning to be treated by social workers rather than medicine. Evidence-based pharmacological treatment can, according to the report, only be given if the patient fully understands his condition and agrees with the treatment of his or her illness. And a psychotic patient will often have a distorted understanding of the real world, and hence will not be in a position to understand his or her best interest.

Modern psychiatry
I do believe that the rapporteur's view is due to a lack of understanding of how psychiatric patients are treated in today's modern psychiatry. I have no doubt that there are abuses and ill treatment of psychiatric patients in some of the world's countries. But not to treat severely ill patients most likely benefitting from treatment is hardly in accordance with human rights. As doctors, we have an ethical obligation to help patients even if they are unable to understand what will be their own best interest.

The message
The message from the special rapporteur is very clear: Calls upon all States to impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application.

It seems to me, however, that the special rapporteur fails to see that receiving proper evidence-based treatment can also be a human right. In my opinion the discussion should focus more upon whether the treatment works or not.

Action taken
How do we react after having a report that calls upon an absolute ban on all involuntary treatments for the severely mentally ill patients? I have sent an email to sr-torture@ohchr.org with this article and with anticipation, I am now awaiting a reply...

Regards,

Andreas Johan Landsnes, MD, Psychiatrist
Avdelingsoverlege, Helse Bergen HF
The European Psychiatric Association (EPA) is the largest international association of psychiatrists in Europe, with active members in as many as 75 countries, including International members. Its members include leading experts in numerous fields as well as 34 National European Psychiatric Associations with approximately 80,000 members, covering the interests of psychiatrists in academia, research, and practice. The EPA focuses on the improvement of care for the mentally ill as well as on the development of professional excellence.

Through Congresses, specialist Committees and dissemination of information thorough articles and journals, the EPA advises on and encourages progress in psychiatric clinical practice and supports the development of public health policies relevant to mental health. Through the dissemination of information about psychiatric research and practice, the EPA contributes to initiatives regarding the improvement of ethical standards within psychiatric care by encouraging professional dialogue between European Psychiatrists.

The EPA Committee on Ethical Issues is responsible for initiating, producing and disseminating position statements on ethical subjects; answering ethical questions directly addressed to EPA; taking part in consultations organised by the Council of Europe on Ethics and Human Rights; conducting information and activities generating debate concerning ethical problems and challenges faced by European Psychiatry.

With great interest but also with great concern we have read the Special Report on Torture in Psychiatry by Juan E. Méndez (United Nations Special Rapporteur on Torture). First, we greatly appreciate his engagement in this highly relevant field and agree that even in industrialized countries there is a considerable degree of unnecessary violence in psychiatric institutions.

On the other hand, we are concerned about Mendez' general claim, that every compulsory treatment of patients with mental disorders, except in life threatening situations, is torture.

First, Mendez' report has redefined the term “torture” so that compulsory medical treatments performed with the aim of helping patients can be subsumed under this term. For that, Mendez has reduced the definition of torture as defined in the “Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment”, whereby he embraces an “on-going paradigm shift”. The canonical definition of torture contains four elements, namely an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence. Mendez' new definition of torture leaves out the elements purpose and intent. With the help of this reduced new definition, he can ascribe the term “torture” also to treatments of patients whose purpose is to help patients, not to humiliate or punish them, but where this nevertheless is the result (from some patients’ views). We share the worry of the World Medical Association that that Mendez' report with its reduced definition of torture might critically dilute the concept of torture, as defined by the Convention against Torture.

We are particularly concerned because the report focuses only on “psychiatric treatment” and “psychiatric disorders” – thus suggesting that similar compulsory treatments of e.g. neurological disorders in neurology, intensive care
Torture or Treatment

United Nations

General Assembly

A/59/871

Human Rights Council

Economic and social

Prevention of torture

Promotion and protection of all human rights, civil,

political, economic, social and cultural rights,

including the right to development

Report of the Special Rapporteur on torture and

other cruel, inhuman or degrading treatment or

punishment,

Juan E. Méndez

ity.

The present report focuses on certain trends of abuse in healthcare settings that may amount to a violation of the right to the highest attainable standard of physical and mental health. It describes the policies and practices that have been employed to address these issues.

1. Introduction

The Special Rapporteur examines a number of the above practices currently applied in healthcare settings and describes how they are used to infringe on the right to the highest attainable standard of physical and mental health. The focus is on torture and other cruel, inhuman or degrading treatment or punishment that is inflicted upon patients in healthcare settings.

2. Compulsory treatment

Compulsory treatment is the use of medication or other interventions to control behavior that is perceived as threatening to oneself or others. It is often used in the management of individuals with severe mental illness. However, there is growing concern that compulsory treatment may be used disproportionately to manage behavior that is perceived as threatening to oneself or others, and that it may be used to control those who are deemed to be at risk of harm to themselves or others.

3. Harm to others

Harm to others includes physical harm, emotional harm, and economic harm. It is often used in the management of individuals with severe mental illness. However, there is growing concern that harm to others may be used disproportionately to manage behavior that is perceived as threatening to oneself or others, and that it may be used to control those who are deemed to be at risk of harm to themselves or others.

4. Harm to oneself

Harm to oneself includes physical harm, emotional harm, and financial harm. It is often used in the management of individuals with severe mental illness. However, there is growing concern that harm to oneself may be used disproportionately to manage behavior that is perceived as threatening to oneself or others, and that it may be used to control those who are deemed to be at risk of harm to themselves or others.

5. Conclusions

The Special Rapporteur concludes that the use of compulsory treatment and other interventions to control behavior is often used disproportionately to manage behavior that is perceived as threatening to oneself or others, and that it may be used to control those who are deemed to be at risk of harm to themselves or others.

By Danuta Wasserman, Andreas Heinz, and Sabine Müller

Towards, senior citizen homes, or closed homes for chronic patients would be ethically unproblematic. From our clinical experience, we know that ethically problematic issues of compulsory treatment do not occur exclusively in psychiatry, nor do they concern only "psychiatric disorders".

A few real clinical examples may suffice to illustrate our arguments:

A Parkinson patient developed a psychotic state due to voluntarily taking dopaminergic medication; in this state, he tried to burn down his bed and nearly set the whole ward on fire. Application of a neuroleptic medication directly counteracts the hyperdopaminergic state induced by anti-Parkinson drugs via blockade of dopamine D2 receptors. Therefore, we regard involuntary neuroleptic medication in such a case not as a "personality-altering drug" but as a "personality-restoring" drug. Furthermore, we are convinced that the patient should not be treated as a legally responsible person who committed malicious arson, but as a person who is temporarily incapable and has the right to be delivered from the drug-induced psychotic state even against his acute drug-influenced will to restore his "free will", in order to prevent severe harm both from him and others.

Since persons with schizophrenia also develop acute psychotic states due to hyper-dopaminergic neurotransmission, we see strong parallels to the case described above. For example, such a patient saw "devils" entering human bodies and, in order to defend himself from the devils, severely injured one young doctor so that she was permanently disabled and quit her job. After cessation of the psychotic state, the patient was deeply concerned about the harm he had caused due to the temporary misconception of reality. We think that even in such acute situations, open hospital settings, sufficient personnel to talk with the patient and a person-centred, psychotherapeutic as well as psychosocial approach can limit compulsory treatment to an absolute minimum. Nevertheless, we consider it inhumane to leave a person in a psychotic state, in which they can harm themselves and others significantly and to treat them like persons who have freely decided for acting violently and to make them legally responsible.

Harm includes direct physical harm (e.g. by self-injuring or because of the denial of medically necessary therapies such as drugs against encephalitis), social harm (e.g. loss of child custody), and financial harm (e.g. because of compulsive gambling or manic spending of money). Recently, a psychotic man jumped naked into a well in the centre of Berlin, injured himself with a knife, threatened a policeman and was finally killed by this policeman in presumed self-defence.

These examples illustrate the ambivalence of exclusively emphasising autonomy. Such ethical dilemmas cannot simply be solved by prohibiting involuntary treatment in psychiatry without exception.
Compulsory care in Sweden:
the United Nations, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the WHO in Europe on mental health, mental disability and mental disorders.

UN Convention on Mental Disability
The United Nations’ Convention on the Rights of Persons with Disabilities went into force 3 May 2008. The European Union ratified it in December 2010. The Convention states that Countries must protect the physical and mental integrity of persons with disabilities, just as for everyone else, guarantee freedom from torture and from cruel, inhuman or degrading treatment or punishment and prohibit medical or scientific experiments without the consent of the person concerned.

Conceptualizing abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. Essential elements reflected in the definition of torture are: an act inflicting severe pain or suffering, whether physical or mental; the element of intent, the specific purpose; and the involvement of a State official, or a State official being aware of. Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment (ill-treatment).

In the context of medical treatment, serious violations and discriminations against persons with disabilities may be defined as “well intended” on the part of health-care professionals. The administration of non-consensual medication is often claimed as being necessary for the so-called best interest of the person concerned. Treatments through coercion cannot be legitimate or justified under the medical necessity doctrine. Forced psychiatric interventions, when committed against persons with psychosocial disabilities satisfy the definition of ill-treatment.

In many countries where mental health policies and laws do exist, they focus on confinement of people with mental disabilities in psychiatric institutions, but fail to effectively safeguard their human rights. Involuntary commitment to psychiatric institutions has been well documented.

The Convention radically departs from this by forbidding deprivation of liberty based on the existence of any mental or intellectual disability:
- Legislation authorizing the institutionalization of persons with disabilities on the ground of their disability without their free and informed consent must be abolished.
- This applies also to preventive detention of persons with disabilities on grounds such as likelihood of their posing danger to themselves or others.
- It also applies to all cases where such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.

Under the European Convention on Human Rights:
- A mental disorder must be of certain severity in order to justify detention.
- The State must also show that the detention is necessary to protect safety for the person or others.
- The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application. Scarce financial resources cannot justify postponement of its implementation.
- A detention in a psychiatric institution, forced medication, ECT, the use of restraints and seclusion, the segregation from family and community could fall in the scope of the Convention against Torture.

Compulsory care in Sweden
All patients have the right to be treated according to the Health Care Act, which states that the care should:
- be of good quality and satisfy the patient's need of safety,
- be easily accessible,
- be based on respect for the patient's autonomy and integrity, promote a good relation between the patient and staff, and
• as far as possible be planned and carried out in consultation with the patient.

The Compulsory Psychiatric Care Act and the Forensic Psychiatric Care have since 1 January 1992 been the legal basis for the compulsory admission and involuntary treatment of mentally ill patients. This legislation, revised version 2000 and 2008, aims to:
• strengthen the legal safeguards for the patients,
• restrict the use of compulsory care and coercive measures,
• enhance the collaboration with the next-of-kin and the community,
• ensure that all compulsory admitted and involuntary treated patients have a documented treatment plan with regards to medical and psychosocial aspects, and
• improve the safeguard for the next-of-kin and the community.

The term "serious mental disorder" has been introduced and defined and manifests that the mental disorder has to be of a certain severity and that mental health problems have biological as well as social and psychological dimensions. There are three conditions which have to be met simultaneously in order for compulsory psychiatric care to be permissible. The patient must:
• suffer from a serious mental disorder,
• must have an absolute need for full-time psychiatric care owing to the mental disorder, and
• object to the care which is needed or, on account of the mental state, be incapable of expressing a considered decision.

When assessing the patient's need for care, it must also be considered whether, as a result of the mental disorder, the patient is a threat to the health or safety of any other person.

The laws of compulsory care do not allow compulsory care based solely on the ground of mental disability. The purpose of care according to the laws of compulsory admission and involuntary treatment is to get the patient into a condition making it possible for the patient to accept needed care.

CPT
The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment went into force in Sweden 1 February 1989. The Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has visited Sweden on 5 occasions, last visit 2009. CPT visits police establishments, prisons, Migration Board establishments, psychiatric establishments and juvenile establishments. The CPT established that no changes had been made in the legislative framework of compulsory psychiatric care in Sweden.

Various recommendations comments and requests have been formulated by the CPT. After a visit to a country, the CPT requests information about the full account for the actions taken to implement CPT’s recommendations. Examples of recommendations to visited psychiatric establishments and Swedish authorities as follows:
• Enable all patients to have at least one hour of outdoor exercise every day.
• Equip the courtyard for outdoor exercise with protection against inclement weather.
• Replace hospital beds with normal beds unless medical reason dictate otherwise.
• Urgent steps to ensure that the individual treatment plans include a psychosocial rehabilitation component.
• Recruit qualified staff (psychologists and occupational therapists) in order to meet the request of a complete individual treatment plan.
• Introduce a register for recording of all cases of resort to means of restraint and seclusion.
• Inform the CPT of the existing legal possibilities for an external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment’s doctors.
• All staff should receive accurate and detailed information about patients’ rights, with a view to be in a position to help patients understand their rights.
• Swedish authorities are invited to set up a mechanism for visits to psychiatric establishments by an outside body.

WHO European Mental Health Action Plan
In a resolution of 19 September 2013 the WHO Regional Committee for Europe welcomes the involvement of Member States, users and family representatives, professional organizations and expert in developing the Action Plan of 10 July 2013. The Action Plan proposes effective and integrated actions to strengthen mental health and well-being of the entire population in Europe and reduce the burden of mental disorders:
• Ensure actions for promotion, prevention and intervention on the determinant of mental health.
• Combine universal and targeted measures with special focus on vulnerable groups.
• Respect the rights of people with mental health problems.
• Promote their social inclusion and offer equitable opportunities to attain the highest quality of life.
• Counteract stigma and discrimination and isolation.
• Strengthen access to and appropriate use of safe, competent affordable, effective and community-based mental health services.
• All steps should be taken to promote voluntary admission and treatment, and avoid coercion, while guaranteeing protection in accordance with international and national human rights instrument.
• Strong safeguards need to be in place if involuntary admission and treatment are deemed necessary including independent reviews, inspections of the conditions under which people are detained and access to complaint procedures, independent legal advice, and relevant support.

Conclusion
The current Swedish legislation on compulsory care fulfills the demands of the UN, the CPT and the Action Plan. There is, however, room for improvement when it comes to the continuous process of implementation. It is of the greatest importance to respect the spirit of the statements put forward by these supranational organization, which Swedish state has pledged to follow, when applying existing laws as well as when making new.

Karl-Otto Svärd
Medicinhöfd Inspektionsn för vår och omsorg

Your opinion of our journal would be greatly appreciated.

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and the Editorial Committee of THE NORDIC PSYCHIATRIST

Can Science save psychiatry?