

Assignment Module 6: Mrs. A.'s Case

Discuss the case of Mrs. A in relation with UN standards on human rights (especially the CRPD) and of the 2008 Interim Report of the special Rapporteur on Torture

The case of Mrs. A brings attention to three essential mental health issues: involuntary admission, involuntary treatment and the use of seclusion and restraint. In the first part of this assignment, the use of these coercive measures is evaluated in the light of international legal standards and the provisions laid out by the 2008 Interim Report on Torture. The case is then analyzed on the grounds of the German legal framework, to eventually identify legal and administrative implications for the improvement of the protection of mentally ill people from torture or ill-treatment within the mental health system.

Involuntary admission: While the circumstances leading to the involuntary admission of Mrs. A are not laid out in detail, the report arouses doubts on the justification of the admission by stating that the decision is made “considering that she refuses medication and voluntary admission”. According to international legal standards, the involuntary admission of mentally disabled people into a psychiatric facility must not be solely based on the person’s refusal of treatment. Article 14 of the CRPD ensures the right to liberty and freedom of disabled persons and states that “the existence of a disability shall in no case justify a deprivation of liberty”. The MI Principles provide further implications on the criteria for involuntary admission and treatment in principle 16: both may only be applied in the case of “serious likelihood of immediate or imminent harm to that person or to other persons” and/or if there is risk of “a serious deterioration in his or her condition” and if “appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.”. However, especially the second criterion of deterioration has lead to controversy as many stakeholders, particularly among mental health users, consider it too vague and therefore not sufficient as a safeguard against the arbitrary deprivation of liberty. Meanwhile, the Special Rapporteur on Torture takes a clear position on the issue of involuntary admission:

“The acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities” (p. 10, sec. 44)

As there is no mentioning of Mrs. A posing a danger to herself or others and it does not become obvious to what extent her condition would have deteriorated if left untreated, the legitimacy of her involuntary admission remains uncertain.

Involuntary treatment: Mrs. A also faces involuntary treatment as soon as she is admitted to the psychiatric ward. No details are offered on which legal grounds the forced medication was legitimated, but it can be assumed that the legislature is using a combined approach and therefore allows involuntary treatment as soon as involuntary admission is approved. After five days, there is strong evidence that the treatment with antipsychotic medication is not only inefficient but has also worsened her condition.

Article 12 of the ICESR and Article 25 of the CRPD promote the fundamental right to the highest attainable standard of physical and mental health based on free and informed consent. The forced medication with psychiatric drugs is addressed in the Interim Report on Torture as a significant threat for the human rights of mentally ill persons. The Special Rapporteur regards the right to refuse medical treatment as part of the right to equal recognition before the law (Article 12, CRPD). He underlines that “non-consensual administration of psychiatric drugs (...) needs to be closely scrutinized” and that “depending on the circumstances of the case, the suffering inflicted and the effects upon the individual’s health may constitute a form of torture or ill-treatment¹”. By monitoring the efficiency of the non-consensual medication can be evaluated. In Mrs. A’s case, the lack of improvement of her condition despite the medical treatment should have lead to a new assessment and the consideration of other treatment options. The fact that she was forced to continue with the treatment under the additional use of restraints can be regarded ill-treatment as it clearly leads to personal suffering and does not comply with the provisions of health care as laid out in the CRPD and ICESCR.

Use of restraints: The most evident violation of human rights in this case is the arbitrary use of physical restraints which ultimately leads to Mrs. A’s death. While the

¹ 2008 Interim Report on Torture, p.16, sec. 63.

staff claims the measure was taken in order to “‘protect her’ from possible falls and from aggressions from other patients”, one could also consider that the restraints were applied for the convenience of staff who had to deal with Mrs. A’s agitated behavior. Either way, the use of restraints is unjustified and poses a violation of Mrs. A’s fundamental rights, as it does not solely serve treatment purposes.

The 2008 Interim Report on Torture addresses the higher risk of (mentally) disabled people to be subjected to neglect and abuse and gives guidance on the assessment of torture and ill-treatment within mental health services. According to the Special Rapporteur, the decision if a treatment is to be considered inhuman or degrading particularly depends on “the acquisition or deterioration of impairment as result of the treatment or conditions of detention²”. In the present case, the arbitrary use of restraints results in Mrs. A’s death.

Not only is the use of restraint unjustified due to its purpose, it furthermore lacks appropriate safeguards. The routine control was held every two hours. Principle 11(11) of the MI Principles states seclusion and restraint shall be applied “only when it is the only means available to prevent immediate or imminent harm to the patient or others” and only to be conducted “under the care and close and regular supervision of qualified members of the staff.” Today’s international standards even promote ongoing personal contact as criteria for the use of restraints³. Meanwhile the use of restraints can be regarded as prolonged as it was applied over four days and restraints were only removed every 12 hours for a short period of time. The Interim Report highlights that “there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment.⁴” The use of restraints in Mrs. A’s case cannot be regarded as torture of the Convention on Torture, since no intent or purposes as defined in Article 1 can be proven. However, the measure can clearly be regarded as inhuman and degrading treatment and has violated Mrs. A’s right to freedom from torture or cruel, inhuman or degrading treatment or punishment promoted by Article 15 of the CRPD and Article 7 of the ICCPR.

² 2008 Interim Report on Torture, p. 11, sec.47.

³ WHO Resource Book on Mental Health, Human Rights and Legislation; p.64.

⁴ 2008 Interim Report on Torture, p.13, sec.55.

Analyze how this case would be managed in your country

In Germany three different legal bodies are essential for the regulation of involuntary admission and treatment and the application of seclusion and restraint:

- §§1904-1906 of the German Civil Code
- The Law on Jurisdiction over non-contentious Matters
- The federal state laws on mental health

The provisions laid out by §§1904-1906 of the **German Civil Code** regulate the involuntary admission and treatment of persons under guardianship. Since the case report does not give any evidence that Mrs. A was under guardianship when committed, these provisions will not be discussed in this assignment.

§§70-70n of the FGG, the law on jurisdiction over non-contentious matters, provides rules on the juridical procedures and safeguards involved in the application of involuntary admission. The report does not offer any details on the procedures for Mrs. A's admission; therefore the juridical matters regulated by the FGG will not be discussed further.

The legal framework of the involuntary admission and treatment of mentally ill people is mainly based on the different **state laws**. In twelve states, the regulations are integrated in the "Laws on the Support and Protection Measures for the Mentally Ill" (Psych-KG), which also contain provisions on other mental health issues such as the service organization and the promotion of community-based support. In four states the law focuses solely on the conditions and procedures for involuntary admission/treatment. Due to the federal systems, the provisions can vary, e.g. in regard to the criteria or objectives of involuntary admission. While the main criteria are the dangerousness to self or others, the definition of this term can be more or less precise. Two fundamental aspects that can be found to more or less extend in all state laws are the principle of the least restrictive alternative and the provision that the refusal of treatment alone cannot be a sufficient justification for involuntary admission or treatment. Since a nationwide overview on the conditions and legal provisions is extremely difficult due to the federal system, the following analysis is

based on the provisions of the PsychKG-NRW, the state law of North-Rhine-Westphalia⁵.

Involuntary admission: According to the provisions the PsychKG-NRW §11 “The involuntary admission is only legitimate, if and for as long as the person concerned poses an immediate and significant danger to him/herself or the fundamental legal interests of others⁶ that cannot be avoided by other means. The refusal of treatment alone does not justify an involuntary admission⁷.” The immediate danger may not be predictable but has to be expected. As reported the case of Mrs. A’s lacks evidence for such imminent danger. An involuntary admission therefore could not have been justified on the grounds of the state law.

Involuntary treatment: According to §18.4 of the PsychKG-NRW non-consensual treatment is only legitimate when the life of the person concerned is at risk or his/her health or the health of others is significantly endangered. As an additional safeguard, all coercive measures have to be ordered by the medical head of the facility or his/her representatives⁸ and can only be applied by medical doctors. The notion of significant danger for health is not defined in detail. For the forced administration of antipsychotic medication and sedatives as illustrated in Mrs. A’s case, additional medical evaluation of the need for this treatment would have been necessary after admission.

Seclusion and restraint: The procedures and safeguards regarding seclusion and restraint are summarized as special protection measures in §20 of the PsychKG-NRW. Three measures are mentioned: the restriction of free movement; the detention in a special room and the use of physical restraints. They may only be applied in case of “imminent dangerousness of self harm or the immediate dangerousness to significant legal interests of others.” And only when certain safeguards are met: They have to be ordered and monitored by a medical doctor and – unless in the case of immediate danger – announced in prior. Furthermore the measure has to be timely restricted and ended as soon as the criteria of harm to self or others are no longer met. All measures have to be documented and the legal counsels and/or

⁵ Not only does the author live in NRW, but the PsychKG-NRW is also comparable to most of the other state laws in regard to its provisions on involuntary treatment and admission

⁶ German notion of „Rechtsgüter“

⁷ Translation by author

⁸ In case of his/her absence

guardian are to be informed. The application of physical restraints is only legitimate when a constant supervision can be guaranteed. The last safeguard is most important in this particular case, as the regular control every two hours would not have been sufficient under the state law of NRW. The use of restraint on Mrs. A therefore would have been arbitrary.

Suggest possible change in your country legislations about involuntary admission and treatment in order to better implement human rights issues raising from this case

The analysis of Mrs. A's case suggests that overall the regulations of the state law in NRW provide good protection against the abuse of coercive measures in the mental health field. An important step to insure the protection of the human rights of mentally ill people in Germany is the review and alignment of all state laws according to international standards.

Despite the relatively high safeguards of the PsychKG-NRW, cases like Mrs. A's and similar violations of mentally ill patient's rights in psychiatric facilities are known to take place in NRW and all over Germany. Statistics⁹ show that the numbers on involuntary admission and involuntary treatment have almost doubled since 1992. Many experts blame this significant increase on two factors: The increase of involuntary admission and treatment orders based on §1906 of the German Civil Code and the provision on coercive measures ordered for patients who are *not* admitted involuntarily, also based on §1906. Especially the second phenomena, often described as "hidden coercion", contributes to the increase of coercion overall. The involuntary medication or the use of seclusion and restraint on patients under guardianship who live in clinics, custodial institutions or other mental health facilities contribute to these numbers. These findings implicate the need to re-evaluate the provisions of the German Civil Code aiming at persons under guardianship.

Meanwhile the majority of orders for involuntary admission are based on emergency procedures which allow the detention of the mentally ill person for a maximum of 72 hours before a court order has to be handed in. These procedures were established for exceptional circumstances but in reality are applied in most of the cases. The

⁹ Statistics of the German Ministry of Justice

fact that the regular procedures are hardly applied indicates possible legal or administrative barriers which will have to be identified before they can be modified.

As involuntary admission and treatment have to be based on a juridical decision, the court procedures and the judges play a significant role in the process. Several user and support organizations criticize¹⁰ that procedural safeguards are often not complied sufficiently or even ignored. In 2008 the judge Michael Irming was taken to court after he admitted that he had ordered involuntary admissions without hearing the person concerned or other parties and the use of restraints without assessing the individual circumstances in 62 cases. The case triggered a public discussion on the practical problems of the juridical procedures regarding coercive measures. The fact that the judges generally are not specialized on the mental health area and often face excessive work demands aggravates the problematic situation. Legislation should promote awareness on human rights issues regarding involuntary admission and treatment and regulate the qualification of judges and other juridical professionals in the field of mental health. Meanwhile legislature could enforce the adherence of the procedural rules already existing by better monitoring functions.

In the last ten years, the numbers of reported cases of neglect and abuse within mental health facilities and custodial institution has increased despite of the rather consistent legal framework. In 2009 the poor conditions within psychiatric and particularly geriatric services was brought into the public eye, when a patient of a private psychiatric clinic¹¹ was killed by a fellow patient and another man was beaten up by another patient while restrained to his wheelchair. In the light of these tragic events, more and more family members of patients and former staff complained publicly about the inhuman conditions within the facility and the neglect caused by significant human resources shortages. While it is important to criminalize neglect and abuse of mentally ill people by legislature, the factor of staff shortage should not be ignored. Legislation should thus also address the issue of adequate human resources and appropriate qualification. Additionally, training in human rights issues for all mental health staff could be promoted.

¹⁰ The issue for instance was identified as a crucial human rights issue during the seminar of the all-Inclusive campagne

¹¹¹¹ Ameos Klinik Osnabrück; NRW, several reports in local press.