THE DANISH INSTITUTE FOR HUMAN RIGHTS

HUMAN RIGHTS AND COMPULSORY PSYCHIATRIC TREATMENT

RECOMMENDATIONS

HUMAN RIGHTS AND COMPULSORY PSYCHIATRIC TREATMENT RECOMMENDATIONS

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INTRODUCTION

USE OF COMPULSORY MEASURES IN PSYCHIATRIC TREATMENT

In Denmark, there is broad consensus that the use of coercive measures in mental health treatment must be reduced. Whether this effort is succeeding, however, is still controversial. Efforts are being made in many areas.

As a small contribution, the Danish Institute for Human Rights (DIHR) has examined the latest developments in human rights as they should be applied to psychiatric/mental health treatment. These developments in human rights thinking follow the European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities (the UN Disability Convention). This development has only just begun, but there is a clear trend towards increased protection of the citizen. This influences on what is required before coercive measures can be used in psychiatric treatment.

It is important that this international trend also has an impact in Denmark.

The provisions of the Danish Mental Health Act should not only be designed in accordance with human rights. They must, of course, be interpreted and applied as such in the everyday life of mental health treatment centres. The authorities handling complaints and monitoring of the mental health treatment system have a major influence on whether this will occur. Therefore, the DIHR has discussed developments with a number of these authorities. Specifically, the DIHR has held dialogue meetings with representatives from three mental health complaint boards under regional state administrations (now merged into the Psychiatric Patients' Complaint Committee in the State Administration), the Psychiatric Appeals Board and the Parliamentary Ombudsman. Prior to these meetings, the DIHR had discussed developments with, among others, the secretariat of the Ethics Council, various mental health advocacy groups and researchers.

In the following, Chapter 1 presents a survey of developments in relation to the European Convention on Human Rights and the UN Disability Convention.

Please refer to the attached background note containing a legal analysis of the European Convention on Human Rights and the UN Disability Convention. This legal analysis formed the basis for these dialogue meetings.

Chapter 2 examines issues emanating from the Institute for Human Rights' discussions and recommendations to the complaint and supervisory authorities working in the field of mental health.

Annual reports and other documents from the authorities have also been used as background for the meetings. From these documents, a general impression is gained that the authorities have maintained a very high professional level.

It has not been part of the DIHR's study to undertake a comprehensive analysis of whether the Danish Mental Health Act is consistent with human rights. However, as a consequence of the Institute's meetings with the various actors in the field of mental health, the Institute has offered a number of recommendations to the Parliament. These recommendations are presented in Chapter 3

Chapter 4 presents a summary of the recommendations presented by the Danish Institute for Human Rights.

It should also be noted that the Danish Institute for Human Rights cooperates with the Parliamentary Ombudsman in the work of preventing degrading treatment of detainees under a UN Protocol to the UN Convention against Torture (OPCAT). As part of this work, the Ombudsman undertakes inspections of the psychiatric wards.

It has not been a part of this report to examine the conditions in the psychiatric wards. For this reason, we have not included the monitoring reports of OPCAT or the Parliamentary §71 review.

CHAPTER 1

1 MORE PROTECTION THAN PREVIOUSLY

Coercion in mental health treatment affects some of the most fundamental human rights: the right to personal freedom and respect for physical and psychological integrity. Therefore, human rights places some limits on the use of compulsory treatment measures.

Previously, the use of forced immobilization in psychiatric treatment for a period of a few weeks would barely have raised eyebrows at the European Court of Human Rights. If the physician had approved the procedure and if it was otherwise consistent with common practice, there had to be a therapeutic justification. Today, the courts no longer accept such measures so easily.[1]

Developments are taking place in human rights case law as decided by the European Court of Human Rights . Several recent decisions emphasize an increased right of self-determination that now also includes people with a psychosocial disabilities (see further below). This means that the Court is more thorough, especially in assessing whether the use of forced measures is proportional to the individual's condition.

Is the coercion in reasonable proportion to the treatment outcome being sought? Would less restrictive measures be adequate? And is coercion being used to a greater extent than is necessary? Such assessments are also present in the Danish Mental Health Act (Psykiatriloven), which is the Danish legislation covering mental health treatment.

The European Court of Human Rights also examines whether coercion is an expression of the proper balance between society's responsibility to provide citizens with the best health care and the citizen's right to refuse hospitalization and treatment.

In the case of involuntary admission, the court examines whether hospitalization has been necessary and whether other solutions have been tried and have been assessed as inadequate.

As a point of departure, every individual has the possibility to refuse medical

treatment. Should there be compulsory medical treatment, the process may relate to 'clearly and strictly defined exceptional circumstances'. The Court investigates whether this has been the case.

In the case of forced restraints, the court investigates whether restraints has been used as a last resort, and whether it has been the only way to prevent immediate harm to the patient or to others. Forced restraints must not be routinely used or used simply because other resources are lacking.

In all cases, it plays an important role for the Court that the citizen has been consulted and that the individual's opinion has been assigned weight. In addition, it plays a role whether there has been a reasonable accommodation to the needs of people with disabilities, i.e., whether reasonable, appropriate attention has been given to their needs and desires. Thus, it should be considered how and to what extent there may be an accommodation to the situation, efforts made at appropriate communication, etc. in relation to the functional impairment -- the psycho-social disability -- which is part of the grounds for considering the use of compulsory measures.[2]

These latter conditions are closely linked to the UN Convention on the Rights of Persons with Disabilities. This convention is also a driving force behind developments in case law from the European Court of Human Rights. In several of the Court's recent judgments regarding the use of coercive measures, the Court makes reference to the UN Disability Convention.[3]

The Disability Convention offers a new understanding of what it means to have a disability. Traditionally, disability has been seen as a condition of the individual. The Convention presents disability as a result of the societal barriers encountered by people with disabilities. While the traditional view can give the impression that people with disabilities are a special group of citizens to whom society should primarily provide treatment and compensation, the new view emphasizes that persons with disabilities are equal citizens. It is society's task to adapt to the variation in people's conditions. Only in this way can we ensure that everyone can participate in society on an equal footing.

In the following, the term 'psychosocial disability' is used to emphasize that it is a group of people who have a disability that is either a long-term functional impairment due their mental illness or a disability that occurs in the encounter between their mental illness and negative attitudes or other barriers in society. The term 'psychosocial disability' is also used by the UN Disability Committee.

A large proportion of the persons in psychiatric treatment who are subjected to

compulsory measures may be said to have a disability in the sense of the UN Disability Convention.[4] Thus, the conditions that have traditionally been highlighted as subject to involuntary measures in psychiatric treatment may easily come to constitute indirect discrimination against persons with disabilities. Although mental illness is not always long-term, i.e. a disability, people with long-term mental illness will often be over-represented among the group subjected to coerced psychiatric treatment. The Mental Health Act requirement that it must be a case of people who are mentally ill, or who find themselves in a state that may be treated as such, will often imply that there is a long-term disability. Therefore, the use of coercion in psychiatric treatment must also respect the provisions of the UN Disability Convention. Several provisions of the Convention are of relevance here, but there is still debate about the extent to which they can be applied.

Article 12 of the UN Disability Convention emphasizes the obligation of states to apply supported decision-making rather than depriving persons with disabilities of their legal capacity. Compulsory treatment constitutes a form of deprivation of legal capacity in a narrow range, that is, in relation to the treatment of a mental illness. It follows, therefore, that states have a duty, to the greatest extent possible, to support the individual to make decisions about the treatment of his or her illness rather than utilizing coercive measures.

It is also important that the UN Disability Convention requires a reasonable accommodation to the needs of persons with disabilities. Accommodation consists of dealing with a concrete situation, where consideration is to be given to the individual's specific needs. For example, it may be that information about a proposed course of treatment be provided in a way that fully and completely takes into account the individual's special needs, language, etc. Failure to accommodate to special needs to a reasonable extent as related to a disability, including a psychosocial disability, may constitute discrimination.[5]

It is not only the European Court of Human Rights that is aware of the Convention and its significance. Of course, the UN Committee on the Rights of Persons with Disabilities and others in the UN system are also aware of this. New recommendations have emerged. In other instances as well, the Convention is used as a tool for psychiatry, which has more focus on individual rights. One example is a new supervisory guideline from WHO in psychiatry, a guideline based on the Convention. In the case of monitoring or inspection, for example, it should be considered whether the citizen has the possibility to exercise his or her legal capacity. Do staff communicate with the citizen in a respectful manner and do the staff show respect for the citizen's ability to understand information, to make their own choices and to have their decisions?[6]

It should also be noted that there may be issues of multiple discrimination on grounds of disability, ethnicity and gender, if the use of coercive treatment affects people with disabilities and also disproportionately affects those with a different ethnicity than ethnic Danes. Data indicate that patients from ethnic minority backgrounds are more likely to be subjected to involuntary commitment, forced treatment and the use of physical force under psychiatric hospitalization than ethnic Danish patients. This is particularly the case for men with ethnic minority backgrounds, who are over-represented.[7]

CHAPTER 2

2 COMPLAINT AND SUPERVISORY AUTHORITIES

Recommendation: Have human rights in mind in the future
Neither the annual reports of the five Psychiatric Patient Complaint Boards nor those of the Psychiatric Appeals Board provide examples of cases where direct reference is made to human rights considerations. The DIHR's impression is that several authorities handling complaints view the Danish Mental Health Act as being consistent with the human rights requirements, and that in specific cases, such as involuntary commitment or forced treatment, there is no further need to be aware of human rights.

Such a view can lead to insufficient attention being paid to developments in human rights. In addition, it follows from several decisions , including from the Parliamentary Ombudsman, that a public authority has the obligation to take human rights into account where it is relevant.[8] The view of the authorities, however, is somewhat understandable. The few times when psychiatry has been involved with particular human rights issues in relation to Denmark have usually been tied to legislative matters. Furthermore, until recently, the European Court of Human Rights, as mentioned above, has not provided strong protection in this area.

The new developments, however, have altered the situation.

Case law from the European Court of Human Rights is important for understanding the rules of the Danish Mental Health Act. This is particularly true in relation to the assessment of proportionality and the evaluation of whether less restrictive treatment measures should be used, as interpreted by both the Court of Human Rights as well as by the Danish authorities. The Court of Human Rights, in its practice, is helping to elaborate and develop these standards. If the Danish mental health authorities are not aware of human-rights case law, the risk is that the highest level of possible protection of the citizen is not achieved. In the worst case, it will be a case of a breach of human rights.

Several of the factors listed below concern such a risk.

Recommendation: Pay attention to the stricter proportionality assessment in cases of compulsory treatment measures applied under the treatment criterion
In Denmark, as in many other countries, coercive treatment can be used in two cases: first, if the individual is an imminent danger to self or to others (a danger criterion). Involuntary hospitalization occurs in order to effect treatment. Second, if the prospect of a cure or a substantial and significant improvement in the person's condition would otherwise be significantly impaired (a treatment criterion). Compulsory measures used under the treatment criterion can also be carried out in order to prevent a significant and acute deterioration of the patient's condition.

From a human rights perspective, it makes a difference whether coercive measures are based on the danger or the treatment criterion. Interference with personal freedom requires substantial justification. Such justifications have traditionally been based on the view that an individual is a danger to himself or others. If such a danger is not present, the balance between the society´s caring responsibilities and citizen's autonomy and integrity is in jeopardy. This is also an area where there is special risk of discrimination against people with disabilities. This would be the case, for example, for an individual who had a psychosocial disability and had difficulty expressing himself; see below.

This special risk of discrimination has meant that in their assessment of the proportionality of coerced treatment, the most recent practice from the Court of Human Rights has paid special attention to cases of force used based on the treatment criterion.[9]

That the proportionality assessment is stricter in cases of force based on the treatment criterion is not seen in the Mental Health Act. Lack of focus on human rights practices can therefore mean that there may be a lack of awareness of this issue. Ultimately, it may mean approval of decisions to use coercive treatment that should not have been approved.

Recommendation: Patients' refusal of treatment should not be grounds for coercion (circular arguments)
The stricter assessment of proportionality in cases of forced treatment based on a treatment criterion have led to the European Court of Human Rights ruling in the Plesó case that authorities must be careful not to interpret a refusal to be treated as a sign that a citizen necessarily lack insight into their state of health, rather than as an expression of the citizen's use of the right to self-determination. A citizen's rejection of treatment may not constitute grounds for using involuntary and forced treatment.[10] Similarly, it also follows from the Court held that a citizen's resistance to being restrained may not constitute

grounds for the use of forced immobilization.

This problem is also known in Danish practice. For example, the Psychiatric Patient Complaint Board of the Capital Region State Administration, in a case concerning coercive detention, has emphasized -- as one of several criteria – that coercive detention was justified because the patient 'did not have disease-understanding and recognition of the need for treatment'. The Psychiatric Appeals Board, in a case concerning the approval of continued compulsory treatment, has emphasized a patient's 'lack of disease awareness' as a valid criteria for the use of force.[11] This is a difficult issue because lack of disease awareness is often seen as a symptom of a number of mental illnesses [12] However, it should be considered whether it should continue to form the basis for a decision on the use of coercive measures. In the two decisions cited above, a number of other considerations were included. It may also be considered whether a distinction should be made between lack of disease awareness and inadequate understanding of the need for treatment. The latter is a more controversial justification for compulsory treatment measures.

Recommendation: Greater awareness of supported decision-making and the right to reasonable accommodation

According to Article 12 of the UN Disability Convention, states are obliged to promote the individual's self-determination and where necessary, exercise of individual self-determination should take place with support from the state. This obligation to provide support for decision-making is also relevant in specific situations where the alternative is a violation of the individual's right to self-determination. The UN Disability Convention also obliges Member States to ensure access to reasonable accommodation to the needs of a disabled person in specific situations. Accommodation to a reasonable extent may comprise, for example, communication in a way that takes into account the individual's specific circumstances.

The Mental Health Act states that coercion must not be used until everything possible has been done to obtain the patient 's voluntary participation. Here may be included considerations regarding supported decision-making. To some extent, the idea of reasonable accommodation is already known within the Danish health sector. It follows from the Health Act (Sundhedsloven) that information must be provided in a considerate manner, tailored to the individual's age, maturity, experience, etc.

If an individual with a disability finds it difficult to express him- or herself and does not receive the necessary assistance for this, there is a risk that relevant factors will not be included in the balancing of society's caring responsibilities

and the citizen's right to self-determination. In other words, decisions are taken with regard to coercive treatment which could have been avoided.

Recent research shows that people with serious mental illness are in many cases receptive to and able to participate in joint decision-making.[13] In general, people with mental disorders desire to have more influence in taking part in decisions regarding the treatment of their disease. This is either because they want to recover and move on with their lives after a mental illness, or because they have bad experiences from previous treatments. Greater inclusion has a positive effect. However, we lack knowledge about 'decision aids', i.e., specific tools and instruments that can enable the individual patient to reach the necessary basis for decisions. A trend has begun, however. Internationally, there are, for example, electronic programs that can help citizens identify treatment preferences and communicate them to health professionals.[14]

In annual reports of the complaint boards it is clear that major emphasis is placed on the citizen being informed and motivated. However, there does not seem to be a particular focus on how the information and motivation has been given, i.e. whether there has been an accommodation to the needs of the citizen, and whether 'decision aids' have been considered.

In the dialogue meetings with the complaint boards, the DIHR expressed the view that the tendency towards greater autonomy makes this an area towards which the boards should pay more attention. This applies especially in view of the recent advances in the development of 'decision aids' and the like. In practice, the Parliamentary Ombudsman has provided many examples of the need for authorities to take human rights considerations into account when making their decisions.[15]

In the view of the DIHR, it is realistic to foresee that a greater focus on supported decision making and accommodation in some cases could lead to a change from involuntary commitment based on the treatment criterion to voluntary treatment.

Obviously, increased awareness of how supported decision-making is given and whether there has been a reasonable degree of accommodation to special needs is not a task that the appeal boards can take on alone. The mental health centers must continue the work already being done, and the supervisory authorities must follow up on this. In addition, Parliament also has a necessary role here; see below.

Recommendation: Monitoring documentation deficiencies in decisions on involuntary treatment

According to the European Court of Human Rights, it is crucial for citizens' legal protection that the different approaches to treatment are carefully documented, including an explanation for why coercive measures were used. Without such evidence, it is often not possible to determine whether the use of force was proportionate.

After reviewing the complaint boards' annual reports, it was the Danish Institute for Human Rights' impression that there is an essential need for the mental health centers to become more aware of the need for record-keeping of measures taken prior to an eventual decision that uses coercion. The Institute's view has been confirmed in several of the dialogue meetings. For example, Psychiatric Patient Complaint Board in the North Jutland State Administration, in its annual report for 2011, cites a 'significant need for hospitals to become more careful and systematic with regard to the record-keeping of information given to and the motivation of the patient'.[16]

Here we are talking about a problem of which the monitoring authorities must be aware, including the psychiatric department's own internal monitoring.

To the extent that the requirements for documentation are also perceived as being too costly, work must be done to develop tools and procedures that can ease the routine work of documentation.

Recommendation: Monitoring of whether the new practices have been implemented

In the same track as above, the Institute believes that some mental health centres or departments have failed to fully implement the directives issued by the complaint authorities. Despite clear decisions from the complaint board on the impropriety of a given practice in the context of a coercive measure, the disapproved practices continue.

Many cases contain difficult assessments of a number of conflicting issues. Hence, it is not necessarily a legal problem that mental health centres are overruled by the complaint board about the same issue in several cases. However, it is different in the case of a completely unambiguous practice. For example, according to a case mentioned in the annual report for 2012 from the Psychiatric Appeals Board of the Capital Region State Administration, the Board has ruled on several occasions regarding forced restraints that when a restraining belt is already being used, special grounds are required for applying additional hand or foot restraints. In this case, no such special justification was

given.

Generally, it is worrying that in recent years, all the psychiatric patient complaint boards have had a high proportion of their forced restraints decisions reversed. Some of these reversals are due to procedural irregularities, but forced restraints is not an area where there should be so much doubt about the rules in the psychiatric wards.

It should also be mentioned that, according to a case from the same annual report, it was the board's consistent practice that a patient is entitled to three-day decision period before deciding to accept or refuse treatment, unless specific conditions are stated. In this particular complaint case, the patient had had only had a single day to consider whether to accept treatment, and no specific conditions were given. Hence, the board did not approve the compulsory treatment that was used in this case.[17]

Inadequate implementation of the new practice has been partially confirmed during the dialogue meetings. In this context, it is the opinion of the DIHR that there have been totally unnecessary violations of human rights in so far as there has been unlawful coercion, which could and should have been avoided.

Here, too, it is a problem about which the monitoring authorities and the internal monitoring units should be aware. It should be ensured that all sites of treatment have an effective procedure for implementing new practices from the complaint boards, the courts, etc.

Recommendation: Ensure that the merger of the psychiatric patient complaint boards leads to a uniform practice

Human rights contains a requirement of predictability. It should be possible for an individual to gain a clear picture of when an involuntary commitment will be legal or illegal. During some of the dialogue meetings, the DIHR has raised the issue of differences between the psychiatric patient complaint boards in the state administrations on the basis of statistical data showing the proportion of decisions on involuntary commitment, forced treatment and forced immobilization were not approved.

For example, for the period 2009-2012, the Psychiatric Patient Complaint Board in the State Administration of North Jutland did not have any of its involuntary commitment decisions reversed. By comparison, the Psychiatric Patient Complaint Board in the Zealand State Administration 11% of its decisions were reversed in 2009, 15% in 2010, 16% in 2011 and 0 in 2012.

It should be noted that there may be good reasons for this variation (some boards, for example have very few cases within a given area). Nevertheless, the DIHR has seen a possible problem of due process herein.

The five complaint boards are now combined into a single complaint board under the State Administration with regional offices. One reason for the merger was to eliminate differences in practice between the boards.

The Institute for Human Rights hopes that the merger will lead to a more uniform practice.

Recommendation: Supervision should be organized so that systematic over-medication or medication errors are detected and stopped

In the past few years, there have been periodic media reports of systematic over-medication or errors in medication of patients being treated in mental health centres. Probably the most striking example is the case of the over-medication of patients at the Psychiatric Center Glostrup.[18]

Common to many of these cases is that the problems have been known for years, without any kind of intervention having taken place. The DIHR is puzzled that the supervisors -- both internal and external -- have not been able to detect such cases and intervene in a timely manner.

As a consequence of the case in Glostrup, the Capital Region has carried out a critical review of its mental health inspection system. This has resulted in a number of initiatives -- including a closer monitoring of the individual patient's medication and ward rounds with clinical pharmacologists who assess patients' overall consumption of medication.[19]

The Danish Institute for Human Rights believes that the many cases lead to all the oversight authorities, both external and internal -- as has occurred in the Capital Region -- consider what measures are necessary for the inspections to be organized so that they are sufficiently fine-tuned to detect and prevent systematic over-medication or errors in medication.

Recommendation: Greater attention to possible multiple discrimination

As mentioned, it follows from Denmark's human rights obligations that Denmark has a duty to prevent indirect discrimination on grounds of disability, ethnicity and gender. Unfortunately, the data on compulsory treatment show a disproportionate number of men with ethnic minority backgrounds. There may be a good explanation for this, but it should encourage the authorities to pay particular attention to whether sufficient efforts have been made to avoid

coercion, in this case, coercion used against men with an ethnic minority background.

CHAPTER 3

3 THE PARLIAMENT

Recommendation: Integrate human rights into the Mental Health Act
In light of what has been discussed in these pages, it is the view of the Institute for Human Rights that the Danish Mental Health Act should contain a reference to human rights.

Such a reference would stress the importance of respecting human rights in the practical work of health professionals and regulatory bodies.

Recommendation: Support for more autonomy, obligation to supported decision-making and accommodation
As mentioned above, many persons with serious mental illnesses have both the desire and capacity to have more influence on their treatment process. However, there is a lack of knowledge of about 'decision aids', i.e., specific tools that enable the individual patient to reach the necessary basis for making decisions. Developments in this direction have begun, however.

It is the DIHR's view that the human rights tendency towards greater emphasis on self-determination and the commitments embedded in the UN Disability Convention on supported decision-making and accommodation to individual needs should be supported by the Parliament as much as possible.

It should therefore be considered whether the obligation to supported decision making and accommodation should be expressed more clearly in the Mental Health Act.

In this connection, it is hardly a step in the right direction that in 2010, a maximum time-limit of three days for the patient to consider treatment was added to the Mental Health Act. Previously, there had been agreement on a consideration time of 2-3 weeks.[20]

As mentioned above, the Mental Health Act does not indicate that the proportionality assessment under human rights law practice is stricter when coercive treatment is used on grounds of the treatment criterion than under the danger criterion. The Danish Institute for Human Rights recommends that

consideration be given to writing inserting a provision in the Mental Health Act underscoring the need to make the proportionality assessment more strict when the treatment criterion is applied.

Recommendation: Greater attention to possible multiple forms of discrimination

As mentioned above, Denmark shall ensure that there is no indirect discrimination on grounds of disability, ethnicity and gender. Data relating to compulsory procedures, unfortunately, shows a predominance of men from ethnic minority backgrounds among those subjected to coercive treatment measures. This should stimulate the Parliament to support specific actions in relation to this group. For example, consideration may be given to developing tools for supported decision-making specifically directed toward the needs of men from ethnic minority backgrounds.

Recommendation: Cessation of (long-term) forced restraints

In the past few years, we have seen a negative trend: There is an increasing frequency of forced restraints in mental health treatment. In an increasing number of cases, forced restraint with belts is supplemented by foot and hand restraint.

Nor is there any reason for optimism when considering the duration of the belt immobilizations. In 2012, there were 715 instances where restraints lasted more than 48 hours. Of these, 542 lasted over three days. In 2011, the corresponding figures were 675 and 460.

From a human rights perspective, special attention has been given to the use of forced restraints because it can easily be a case of degrading treatment. According to the practice of the Court of Human Rights, even a brief period forced restraints can be degrading. In addition, there is a risk of abuse – i.e., that forced restraints will be used routinely. According to human rights understandings, a lack of sufficient resources cannot serve as a justification for forced restraints. The Danish situation regarding forced restraints has been under scrutiny on several occasions. The European Committee for the Prevention of Torture, for example, has pointed out to Denmark that the use of physical restraints over several days cannot have a medical justification and constitutes degrading treatment.[21]

The DIHR recommends that the regulations on forced restraints be reviewed. Such a review should consider alternatives to immobilization and as a minimum, set an absolute limit on the duration of forced restraints.

Recommendation: More focus on conditions before and after the use of involuntary measures

At the Institute's meetings, additional issues besides those mentioned above were discussed.

The DIHR has not investigated these matters further, but they deserve mention here:

Legislation requires that alternatives to forced treatment be considered. In many cases, however, the relevant alternatives are not available or there is no more capacity to accept new patients. Another problem is that physicians may not have adequate knowledge of available alternatives.

Follow-up of cases of involuntary admission has previously lagged a great deal. Citizens released from treatment are in need of assistance in the form of a coordinated effort. For example, they may need to contact the public housing association, physician, municipality, job centre, etc. If the citizen is not offered such help, there is a risk of relapse. At the moment, there is little knowledge as to whether the effort is sufficient. The DIHR recommends further investigation of whether local and regional authorities are doing enough to prevent new involuntary admissions.

Recommendation: Periodically review the current Mental Health Act in relation to the UN Disability Convention

As outlined, developments in human rights are moving toward increased protection of the citizen. It is a trend that is being born particularly by the UN Disability Convention. A number of questions about the importance of the Convention are still pending. Current discussions centre around the issue of the use of compulsory measures on the basis of the treatment criterion.

It is requested that the Parliament pay continuous attention to whether the Danish Mental Health Act and the criteria for involuntary commitment and forced treatment are ensuring adequate respect for the individual's autonomy.

As discussed above, there are existing legislation issues that can be considered. Other issues can also be mentioned. The increased emphasis on self-determination, for example, entails a renewed discussion of the use of declarations of intent in Denmark.

In a number of countries, different types of declarations of intent or 'mental health living wills' have become popular as a binding instrument enabling the patient to opt out of certain kinds of potential treatment. As an examples of the

statements that are binding to a degree is the case of *Zock vs. Germany*. A woman had written a living will, in which she had refused any form of treatment with antipsychotic drugs. When she was subsequently treated with antipsychotics without any regard to her living will, she brought the case to the European Court of Human Rights. The case was settled out of court, and as part of the settlement, Germany acknowledged that there had been a violation of the woman's human rights.[22]

CHAPTER 4

4 THE DANISH INSTITUTE FOR HUMAN RIGHTS RECOMMENDS

Complaint and supervisory authorities

- Have human rights in mind in the future
- Pay attention to the stricter proportionality assessment in cases of compulsory treatment measures applied under the treatment criterion
- Patients' refusal of treatment should not be grounds for coercion (circular arguments)
- Greater awareness of supported decision-making and the right to reasonable accommodation
- Monitoring of documentation deficiencies in decisions on involuntary treatment
- Monitoring of whether new practices have been implemented
- Ensure that the merger of the psychiatric patient complaint boards leads to a uniform practice
- Supervision should be organized so that systematic over-medication or medication errors are detected and stopped
- Greater attention to possible multiple discrimination

Parliament

- Integrate human rights into the Mental Health Act
- Support for more autonomy, obligation for supported decision-making and accommodation
- Greater attention paid to potential multiple forms of discrimination
- Cessation of (long-term) forced restraints
- More focus on conditions before and after the use of involuntary measures
- Periodically review the current Mental Health Act in relation to the UN Disability Convention

END NOTES

[1] ECHR Herczegfalvy v. Austria, nr. 10533/83.
[2] The Court's new practice is clearly expressed in ECHR Stanev v. Bulgaria, nr. 36760/06, ECHR Plesó v. Hungary, nr. 41242/08, ECHR X v. Finland, nr. 34806/04, ECHR D.G. v. Poland, ECHR nr. 45705/07 and ECHR Bures v. The Czech Republic 37679/08.
[3] This is especially true, for example, in the Stanev and Plesó cases.
[4] Persons with disability include persons having a long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers can prevent them from full and effective participation in social life on an equal basis with others; cf. The UN Disability Convention, Art. 1.
[5] Cf. D.G. v. Poland, ECHR nr. 45705/07
[66] WHO QualityRights Tool Kit , 'Assessing and improving quality and human rights in mental health and social care facilities', 2012.
[7] See the DIHR Status Report, 2012, section on 'Racial and Ethnic Origin'.
[8] Parliamentary Ombudsman's report 2005, page 425: One board expressed the view that it might be assumed that a law passed by Parliament was in accord with human rights, and that the board therefore did not need to consider human rights. The Ombudsman considered such a view incompatible with the regulatory authorities' general obligation to contribute to the fulfilment of international obligations, stating that the Board, in deciding individual cases, should include human rights if it was relevant to the case. The decisive factor was whether the outcome of the decision might be in violation of the state's obligations (individual rights)
[9] ECHR Plesó v. Hungary, nr. 41242/08.
[10] In the Plesó case, there were grounds for a decision for involuntary commitment to place substantial emphasis on the citizen's refusal to receive treatment. The refusal was taken as a sign that the citizen lacked insight into his state of health, rather than an expression of the citizen's exercising his right to self-determination. In other words, the citizen's refusal was viewed as justification for carrying out involuntary admission.
[11] The Capital Region State Administration's annual report to the Mental Health Patient Complaint Board, 2011, p. 41. The Mental Health Appeals Board, annual report, 2011, p. 28. As this is only one of several criteria, it is not the case that the decisions are wrong.
[12] See for example http://www.vidensnetvaerket.dk/handicap-sygdom/psykiske-sygdomme/psykoser-paranoid-psykose.

[13] See for example the presentation by Lisa Korsbæk, senior researcher, Capital Region Mental Health Department: http://www.regioner.dk/Aktuelt/Arrangementer/Afholdte+arrangementer/Arrangementer+2012/~/media/Arrangementer/Sundheds%20%20og%20Socialpolitisk%20kontor/Brugerinddragelse%20i%20sundhedsv%C3%A6senet%2030.%20oktober%202012/Lisa%20Korsbek%20-%20A.ashx.
[14] See for example www.vibis.dk.
[15] Hans Gammeltoft-Hansen et al., *Forvaltningsret*, 2nd ed., (2002), p. 347ff.
[16] Annual Report, 2011, Mental Health Patient Complaint Board for North Jutland State Administration, p. 17f.
[17] Annual Report, 2012, Mental Health Patient Complaint Board for Capital Region State Administration, p. 35, and p. 4- with references to pp. 20-22.
[18] See for example http://politiken.dk/indland/ECE1774400/livsfarlig-overmedicinering-kendt-i-aarevis/.
[19] Capital Region Mental Health Department, press release no. 27, November 2012.
[20] See also Annual Report 2012, Mental Health Patient Complaint Board for Capital Region State Administration, p. 25ff., in which developments concerning the patients' motivation time are labeled as thought-provoking.
[21] Report to the Government of Denmark on the visit to Denmark carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 11 to 20 February 2008.
[22] Zock v. Germany, application no. 3098/08