



Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

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Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent*

I. Introduction

1. The present document is issued in accordance with the mandate of the Subcommittee set forth in article 11 of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
2. The Subcommittee has a mandate to visit places where persons are deprived of their liberty. This includes health-care settings, as defined in paragraph 4 of the Optional Protocol.
3. During its visits, the Subcommittee has documented numerous human rights violations in health-care settings where persons are held and treated without informed consent. Furthermore, it has encountered situations in which the nature of the treatment provided, and the manner in which it is provided, falls short of the requirements of international human rights law. This also includes situations where persons are involuntarily restrained by mechanical or chemical means.
4. The purpose of the present document is to contribute to the prevention of torture and cruel, inhuman and degrading treatment by setting out the Subcommittee's views on the rights of persons who are in detention owing to their health status.

II. Involuntary confinement and restraints in health-care settings

5. Involuntary confinement of any person is a form of arbitrary detention unless it is ordered by a competent and independent judicial authority through due process, which must include close and constant review. States should develop and make available alternatives to

* Adopted by the Subcommittee at its twenty-seventh session (16-20 November 2015).



confinement such as community-based treatment programmes, which are particularly appropriate for avoiding hospitalization and for providing care for persons upon their discharge from hospitals.

6. The Subcommittee has observed situations in which State agents represent confinement as voluntary and present registries or legal decisions to that effect. It is concerned that in some of those instances those safeguards were practised as a mere formality. Confinement and institutionalization are voluntary only when the person concerned has decided on it upon informed consent and retains the ability to exit the institution or facility.

7. If involuntary confinement seems to be appropriate and proportional on a legal basis, such confinement should never directly include the formal right for medication to be administered without informed consent.

8. When a person who is detained by the State suffers serious mental disorders, involuntary confinement may be judicially ordered to provide timely access to appropriate expert care and specialist medical treatment. In such cases, placement in a psychiatric facility may be necessary to protect the detainee from discrimination, abuse and health risks stemming from illness, provided that all guarantees are respected and that the treatment offered is equal to that offered to other patients and corresponds to the health needs of the person and that the placement of the person is subject to constant judicial review. As specified in article 14 (b) of the Convention on the Rights of Persons with Disabilities, the existence of a disability should not be the justification for a deprivation of liberty.

9. Restraints, physical or pharmacological, are forms of deprivation of liberty and, subject to all the safeguards and procedures applicable to deprivation of liberty, should be considered only as measures of last resort for safety reasons. The State must take into account, however, that there is an inherently high potential for abuse of such restraints and as such these must be applied, if at all, within a strict framework that sets out the criteria and duration for their use, as well as procedures related to supervision, monitoring, review and appeal. Restraints must never be used for the convenience of staff, next of kin or others. Any restraint must be recorded precisely and be subject to administrative accountability, including through independent complaint mechanisms and judicial review.

10. Solitary confinement must never be used. It segregates persons with serious or acute illness and leaves them without constant attention and access to medical services. It should be differentiated from medical isolation. Medical isolation requires daily monitoring in the presence of trained medical staff and must not deprive the person of contact with others provided that proper precautions are taken. Any isolation must be imposed for the shortest possible period of time, be recorded precisely and be subject to administrative accountability, including through independent complaint mechanisms and judicial review.

11. In connection with deprivation of liberty and health-care settings, the Subcommittee recognizes that States parties should revise outdated legislation and practices in the field of mental health in order to avoid arbitrary detention. Any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the person in question from harm or preventing injury to others. It must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law.¹

¹ Human Rights Committee, general comment No. 35 (2014) on liberty and security of person.

III. Medical treatment of persons deprived of liberty and informed consent

12. Informed consent is a decision made voluntarily on the basis of comprehensible and sufficient information regarding potential effects and side effects of treatment and the likely results of refraining from treatment. Informed consent is fundamental to respecting an individual's autonomy, self-determination and human dignity.

13. Every person deprived of liberty who requires medical treatment should be fully informed about the diagnostic reasons for recommending a particular medical treatment and about existing alternatives, and given the opportunity to decline or receive the suggested treatment or other form of intervention.

14. Exceptionally, it may be necessary to medically treat a person deprived of liberty without her or his consent if the person concerned is not able to:

(a) Understand the information given concerning the characteristics of the threat to her or his life or personal integrity, or its consequences;

(b) Understand the information about the medical treatment proposed, including its purpose, its means, its direct effects and its possible side effects;

(c) Communicate effectively with others.

15. In such a situation, the withholding of medical treatment would constitute inappropriate practice and could amount to a form of cruel, inhuman or degrading treatment or punishment. It may also constitute a form of discrimination. The measure must be a last resort to avoid irreparable damage to the life, integrity or health of the person concerned, and must be mandated by a competent authority within a strict framework that sets out the criteria and duration for the treatment and review and supervision mechanisms.

16. Medical treatment without informed consent should be subject to review before an independent authority and/or a complaint mechanism as soon as this is practicable. It must never be used for the convenience of staff, next of kin or others. Further, the administration of any medication without informed consent must be precisely recorded and subject to administrative accountability and judicial review.

17. Only in situations of emergency care may a decision about any necessary intervention be made by the medical professional alone.

18. An expert decision regarding psychiatric disease cannot in itself override the right to refuse medical treatment.

19. A person deprived of liberty who has been subjected to treatment without informed consent and to restraints must be debriefed by a medical doctor as soon as her or his condition permits it; she or he must have access to the medical record and must be informed of complaint mechanisms and means of redress.

IV. Duties of States parties

20. States parties are encouraged to review their mental health legislation and public policies with respect to the legality of involuntary interventions for persons with mental disabilities, with the following objectives:

(a) Developing restrictive criteria for the use of involuntary interventions, which must make explicit that the use of such interventions is limited to cases in which less

intrusive means are not likely to be effective and the person is incapable of providing informed consent;

(b) Promoting appropriate measures to provide persons with disabilities with access to the support they may require in exercising their legal capacity;

(c) Establishing procedures designed to protect the rights of persons with mental disabilities, including impartial judicial or administrative review of decisions regarding findings of incapacity and requests for involuntary hospitalization and involuntary treatment, and a system of periodic review of such decisions;

(d) Providing mechanisms to investigate improprieties and abuses in the use of involuntary interventions, with appropriate penalties.
