

**NON-VOLUNTARY  
HOSPITALISATION AND  
THERAPEUTIC PRACTICE OF  
RESTRICTIVE MEASURES IN  
PSYCHIATRIC PATIENTS AND  
PERSONS WITH DEMENTIA**

**April 30  
*Bioethics Committee  
Of Catalonia***

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# 1. Introduction

Psycho-pathological decompensation, when serious, may lead to a situation, generally temporary, in which the competence to take decisions in full command of one's mental faculties is greatly impaired. In the treatment of severe psychiatric conditions, a patient sometimes needs to be hospitalised without his consent. Nevertheless, the patient's resistance to non-voluntary hospitalisation generally remits after a few hours or days, when he realises that treatment and hospitalisation will help him to recover stability.

The main aim of non-voluntary hospitalisation is for the patient to recovery his health and equilibrium. It is therefore neither logical nor suitable to try to have a person with behavioural problems admitted to hospital if he is not physically or mentally ill at the same time. In the course of a non-voluntary hospitalisation the establishment of certain restrictive measures may be inevitable, which may only be applied in very specific cases, and provided that they are part of the established therapeutic plan; when the patient may seriously jeopardise or hurt himself or others if he is not temporarily restrained and deprived of some of his rights. It is self-evident that in such circumstances strict compliance with suitable procedures is of the utmost importance, and to make sure that the principles of our professional and ethical behaviour are neither lost nor distorted. In all these cases the law provides for the participation of the legal authorities to safeguard the patient's welfare. Thus, there is a guarantee that the patient is not subjected to any arbitrary behaviour and that there is no possible abuse.

The reference legislation is clear enough, in general terms, and must help professionals when they have to work in what are often extreme conditions. But, furthermore, reflection on the values of our professional practice renders it possible for the actions of health personnel to lead to a benefit for the patient's health. Although the existing legislation is satisfactory enough for patients and health professionals, practice-based ethical reflection can also recommend that certain sections of the law in force be amended in the future.

Reflection driven by bioethical principles makes it possible to apply standards better and also act fittingly or accordingly in specific or special cases which the law cannot reach.

In the current legislation, the word *internment* is used to refer to hospital admission. In this guide we decided it would be a good idea to forego this word, since it is also used in other non-health situations, and we therefore employ the usual health terms: admission or hospitalisation.

One of the conclusions of the task force that drew up this guide attaches great importance to the fact that there must always be written protocols for therapeutic practices which are not very common and which may impinge open personal rights and dignity. In the hospitals and institutions where mental patients, people with psychic deficiencies and the demented are treated, as we state in this guide, these texts must always be available to patients, relatives and companions.

## 2. The legal framework of non-voluntary hospitalisation or hospitalisation without consent

The state and autonomous community legislation that regulates the non-voluntary hospitalisation of mental patients is contained in the following texts:

- The Spanish Constitution of 1978
- Law 9/1998, of July 15, on the Family Code

Article 255. Legal authorisation and communication of internment

1. The internment of a person due to a psychic disorder, at any age, in a suitable and closed institution, requires prior legal authorisation if the person's situation does not allow him to take the decision himself. On the other hand, this is not necessary if this measure has to be applied for emergency reasons. In such cases, the head of the centre where the internment is carried out must report the matter to the competent judge within a maximum term of twenty-four hours. The same obligation is applicable when the person voluntarily interned is in a situation in which he cannot freely decide by himself on continuation of internment.
2. When the application for internment has been made or communicated, the judge, after making the physical examination and listening to the finding of the doctor that is appointed, and the report from the public prosecutor, must decide, with due foundation, either to authorise or reject the internment or the continuation thereof. The judge must review the situation of the person interned every two months.
3. If medical treatment that may endanger the life or the physical or psychic integrity of the person affected is to be applied, the provisions of article 219 for these treatments will be applicable. The functions attributed by article 219 to the guardian, in this eventuality, must be exercised by the relatives of the person interned or, if there are none, by the judge.

Article 219, which refers to the prior authorisation, and article 234, which mentions the function of the board of guardianship, must also be considered.

- Law 1/2000, of January 7, on Civil Judgement (BOE [*Official State Gazette*] no. 7, of 8-1-2000)

Article 763 Non voluntary Internment for psychic disorder

1. The internment for psychic disorder of a person who is not in a position to decide for himself, and although he is subject to guardianship or tutelage, requires legal authorisation, which must be obtained from the competent court in the place where the person affected by the internment lives.  
The authorisation must be given prior to internment, unless there are urgent reasons which render it necessary to act immediately. In such a case, the person in charge of the centre where the internment has taken place must report to the competent court as soon as possible and in any case within twenty-four hours, for the purpose of the mandatory justification of this measure, which must be carried out within a maximum term of seventy-two hours as of notification thereof to the court.  
In urgent internment cases, the competence for the ratification of the measure corresponds to the courts of the place where the centre where the internment has taken place is located.  
This court must act, as applicable, according to the provisions of section 3 of article 757 of this Law.
2. The internment of minors must always be carried out in a mental health establishment suitable for their age, with the prior report of the services caring for the minor.
3. Before granting authorisation or ratifying an internment which has already been carried out, the court must hear the person affected by the decision, the Public Prosecutor and any other person whose appearance is deemed appropriate or is required to do so by the person affected by the measure.  
Furthermore, and without prejudice to any other tests that may be deemed relevant to the case being conducted, the court must examine, by itself, the person affected by the internment and listen to the finding of a physician appointed by it. In all

proceedings, the person affected by the internment measure must be represented and defended according to the terms and conditions provided for by article 758 of this Law.

In any event, an appeal may be lodged against the decision reached by the court on the internment.

4. The resolution granting the internment must also mention the obligation of the doctors looking after person interned to report regularly to the court on the need to maintain the measure, without prejudice to any other reports the court may require when it deems necessary.

The regular reports must be issued every six months, unless the court, in view of the nature of the disorder that led to the internment, indicates a shorter frequency.

Once the aforementioned reports have been received, the court, following any actions it may deem necessary, must decide on whether the internment should be maintained.

Without prejudice to the provisions of the preceding paragraphs, when the doctors that are looking after the person interned consider that internment is no longer necessary, they must discharge the patient and report this immediately to the competent court.

- Organic Law 1/1996, of January 15, on the legal protection of minors. Partial amendment of the Civil Code and the Law of Civil Judgement, article 271 and its twelfth final disposition (BOE no. 15, of 7-1-1996)

Article 271 The guardian needs legal authorisation:

1. To intern the ward in a mental health or special educational or training establishment.

### 3. Competence in persons with a mental disorder

Any action in the health setting requires the person affected, having been duly and suitably informed, to give his specific and free consent. This ethical and legal consensus is a fundamental aspect of the clinical relationship which the Health Authorities must guarantee. It is known as the doctrine on **informed consent** (also called **health care consent** by some) .

The acknowledged rights of patients include the right to refuse the diagnostic and therapeutic measures that may be proposed to them, and they may, should they wish, withdraw any consent given before.

Decision-making in the clinical health-care setting is the fruit, amongst other factors, of the relationship between the will of health professionals and the acceptance of their proposals by the patients or their representatives.

For the acceptance of the measures proposed by health-care professionals to be ethically and legally valid, the patient must take a decision independently; or in other words, there must have been suitable prior information and the patient must be involved of his own free will. However, the capacity to decide with full competence may pose problems, particularly in the case of the mentally ill, in whom the ability to take reasonable decisions may be seriously impaired.

#### **What do we mean by the competence of patients?**

The competence of patients refers to a patient's capacity to receive, understand and retain relevant information on his clinical situation, with the possibility of being able to make a choice between possible options and alternatives, in accordance with his personal system of values. We are appraising his mental capability to take these decisions.

Thus, the term **competence** applied to the clinical setting refers to the patient's ability or capacity and right to take decisions related to his health; or in other words, to consent to or reject the diagnosis or treatment measures proposed.

If the doctor in charge or health-care team that look after a patient consider that the latter is unable to understand the clinical situation because he is in a physical or psychic state that limits his capacity to understand and decide, consent must be secured from the relatives, representatives or the persons in some way linked to him.

Health-care professionals often have to face up to complex situations when there are real grounds for questioning the patient's capacity to give his consent. What we are evaluating is

the so-called **natural or de facto capacity**, which may be temporarily or definitively impaired, in the case of serious dementia. Another no less important issue, but which nonetheless must be addressed, is the so-called **legal capacity**. When, according to the criteria of the doctor in charge or the team of professionals looking after the patient, there is evidence of a serious mental incapacitation, the steps required to secure legal incapacitation must be posed.

#### **What must be borne in mind when assessing the competence of patients?**

- In clinical practice it is indispensable to work on the premise of the presumption of competence that is afforded to any adult patient (or mature minor). It is also very important not to be carried away by possible prejudices uncovered by a prior diagnosis, such as that of patients affected by psychiatric disorders. As is evident, the patient's lack of competence to be able to take decisions must be demonstrated with very convincing arguments.
- Patients are competent or not for taking concrete decisions. The fundamental question is to evaluate whether a certain patient in a certain situation can take a decision that the doctor or health-care team can respect without indulging in malpractice.
- When the relationship between potential risks and benefits is difficult to establish and the consequences that may arise are important, one must be very demanding in the assessment of the capacity to take decisions. A decision that entails clear benefits with scarce risks requires a lower standard of competence than in the opposite situation.
- The temporary lack of competence to take certain decisions in patients with what may be a transient mental disorder must also be addressed: for example a state of confusion, panic or pain, or other factors that may be reversible. In these cases, the professional duty is to try to establish, as soon as possible, the maximum level of his decision-making capacity.

## **4. Criteria for non-voluntary hospitalisation**

The WHO specifies the following criteria for when forced treatment must be authorised in psychiatry.

- a. The patient is not competent enough to understand and decide on his treatment.
- b. The treatment presupposes that the evaluation of the risk-benefit binomial is clearly favourable to the patient.
- c. The non-application of treatment could lead to greater damage to the patient, the family and/or to the community.

Moreover, in the European Convention, any non-voluntary treatment of a person who is not competent to give his agreement is only justified by the principle of protection of the health of the individual, and therefore a health need. The Council of Europe White Paper (see the reference documents) recovers, in a different order, the criteria adopted by the WHO, although it more clearly states the need for there to exist a mental disorder as the cause of the risk and furthermore that there are no less restrictive alternatives

The legal guarantees for the situation of non-voluntary hospitalisation are perfectly defined in the legislation in force. The affected person must be seen by a judge (normally with the forensic doctor) and that when the Public Prosecutor and any other person determined by the judge or the affected person have been heard, the judge will approve or reject the authorisation for admission.

In the area of psychiatric care, non-voluntary hospitalisation is understood as that which is indicated by a doctor and subject to the prior or posterior control of a judge, based strictly on the health needs of a patient who lacks the mental capacity needed to give his responsible consent.

Thus, the criteria for non-voluntary hospitalisation are:

- a. Existence of a serious mental disorder that entails a serious risk to the physical integrity, health, the life of family or relatives, or to the general interest of the actual person.

- b. In the situation as it stands, the mental state of the patient renders him unable to take a responsible decision befitting his own interests.
- c. According to available knowledge, the hospitalisation measure is reasonably more efficacious and beneficial for the patient than any other less restrictive therapeutic alternative.

These criteria are particularly applicable to acute situations. In them, the syndromic diagnosis gives us information on the mental state of the patient at the time, and, together with an evaluation of the risks and the efficacy of the hospitalisation measure, renders it possible to make a fairly close approach as to the most suitable type of internment.

## **5. Restrictive measures in the course of non-voluntary hospitalisation**

In psychiatric practice, restrictive measures are understood as a series of therapeutic procedures which temporarily limit autonomy and the right to freedom. In all circumstances there will be guarantee that the application of these measures does not jeopardise personal dignity.

Restriction measures can only be applied if they pertain to a therapeutic plan and the following criteria are met:

- An individualised clinical indication limited in time.
- An express need of a prior medical order. In an emergency situation and if the infirmary takes some type of action, the doctor in charge must be informed as promptly as possible for him to give his approval.
- Where the character is one of exception and for exclusively therapeutic ends, based on the principle of the benefit of the person.
- The previous measure must be reasonably effective and must very clearly offer more benefits than risks.
- There are no other less restrictive alternatives to offer the person according to the treatment he requires.
- In no event may they be used as a punishment or form of control.
- In no event may it be for extra-clinical reasons such as to make up for lack of staff.
- The action must be conducted by health personnel with a sufficient level of knowledge and training.
- The patient must be given exhaustive information, and his consent secured, in so far as this is possible. The family will also be informed, and an attempt should be made to get their collaboration in the treatment process.
- The actions will be performed always treating the patient with the utmost dignity and respect, safeguarding his constitutional rights.
- The restriction must always be based on a reduction in the mental competence of the patient due to his psychopathological condition. The idea that it is being done "for his own good" is not acceptable if his behaviour is responsible and the patient is competent.
- The restrictive measures indicated must always be recorded in the Clinical History.

### **Conversion of a voluntary hospitalisation into a non-voluntary hospitalisation**

Respect by the psychiatrist and all the personnel for the deed of consent already formalised with the patient must be a priority for everyone concerned and a guarantee for all patients. The possible change in the modality of non-voluntary hospitalisation can only be made if the patient's condition has changed in clinically evident fashion with regard to his status at the time the consent was given. The change in the modality of admission is performed when the clinical situation of the patient entails a risk to his own or other's physical integrity. The judge must evidently be informed.

### **Restrictive measures**

#### **I) Restraint**

This is the use of physical or mechanical procedures to limit the movements of part or all the body of a patient, with a view to controlling his physical activities and protect him and others from behaviour or the risk of violent behaviour leading to harm.

subjection must be used only in the therapeutic context and once all other possible alternatives have been exhausted. It is a last resort to control violent or high-risk behaviour threatening the health or the life of the individual, other interned patients or the personnel looking after the patients.

It is indicated in exceptional situations only, generally in an emergency scenario. Indication requires knowledge and training of the personnel that are to carry it out and should not aggravate the behavioural alteration or agitation, which is always possible. Restraint must offer, at the same time, a limit that the patient may perceive in order to allay his anxiety and reassure him. A careful and serene staff attitude is required. Any response driven by impulses or unprofessional attitudes should be avoided.

The duration of restraint will be as brief as possible, being replaced by other psychopharmacological and/or psychological measures as soon as the patient's condition allows.

There is a point in Recommendation 1235 of the Parliamentary Assembly of the Council of Europe of 1994 that refers to the prohibition of using physical restraint or subjection in any case. The Council of Europe White Paper, which knows and cites this recommendation, has decided to suspend it. And it states "Considers that the use of short periods of physical restraint and isolation should be proportionate to the derived benefits and risks". The commission that wrote this brief treatise agrees with this standard, and it does not seem recommendable to follow a prohibition criterion. At the moment it is impossible, in some cases, to provide proper care without restraining the patient for a brief time and with all guarantees. For example, to inject a drug that tranquilises a patient it may be better to restrain him first if he is agitated, to avoid hurting him.

The restraint procedure must be recorded in the Clinical History of the patient, where the justification of the measure and the controls and monitoring required throughout the duration of the measure will be duly documented.

As a clinical indications, it is recommended in:

- Psychomotor agitation states
- Behaviour or high risk of self- and/or heteroaggressive behaviour.
- behavioural disorganisation in confusion states.

## **II) Isolation**

This is the reclusion of a patient alone in a closed room, which he will not be allowed to leave for a limited period of time. It may be indicated in situations of serious perturbation of the interactive sphere of a patient with other patients, when a temporary reduction of external stimuli is appropriate, when it requires safe limits that promote the remission of the behavioural disorganisation or of the psychic disintegration.

The isolation space must have suitable conditions to guarantee the patient's safety, as well as sufficient comfort.

As this measure is less coercive than restraint, it should be applied before the latter, provided that the patient's clinical status so permits.

It requires the same measures of accompaniment and control by the nursing staff.

A patient's stay in an isolated space will be limited to the time that is strictly necessary and will never be prolonged without medical indication.

## **III) Permanence in hospitalisation and/or observation room**

Generally speaking, over the first few days of admission, and depending on the patient's clinical condition, remaining in a hospitalisation and/or observation room may be indicated.

The indication for this measure stems from the following criteria:

- To offer safe limits for the patient.
- To controls perturbatory behaviour.
- To protect him from suicidal impulses.

## **IV) Restrictions on communication with the outside**

All patients admitted have the right to communicate with or receive communications from the outside. The patient must observe the rules of the hospital institution. The standards established must be framed within a therapeutic plan that takes into account the clinical condition of the patient and the limitations advisable to establish and maintain relationships oscillations without conflicts being created. In certain circumstances, it may be suitable to limit the use of these rights, particularly when the use thereof may be harmful to the actual patient or jeopardise the rights and freedoms of other people.

#### **a) Use of the telephone**

Bearing in mind the above considerations, it will not be difficult, in most cases, to establish some standards for the use of the telephone. A control should be agreed to with the patient, and prohibition avoided.

#### **b) Visits**

A patient should hardly ever be obliged to receive a visit against his will.

Visits may be restricted according to the rules of the institution and the patient's condition, if they may disturb the patient or have an unfavourable impact on treatment.

Sometimes, in the course of hospitalisation, and particularly in its initial phases, either the continuous company of relatives or a provisional distancing may be advisable, the latter in cases of a family relationship which has given rise to conflicts and ill-feeling.

On the other hand, we must also make sure that a possible provisional restriction on visits does not consolidate possible feelings of abandonment or jeopardise the persistence of social links when the latter are precarious.

#### **c) Interception of mail**

On receipt:

No case justifies the violation of privacy by intercepting mail addressed to the patient. Only momentary receipt would be justified:

- When there is justified suspicion that a toxic substance is being received from outside.
- When external persons may bring an influence to bear on decisions that the patient is incapable of taking for himself

On sending:

- It may be convenient to retain mail the patient wishes to send in the course of the admission, only in cases in which it is suspected that he may jeopardise his own interests in taking written decisions (e.g.: giving up work/a job).
- Writing and signature of compromising documents. In these cases, it may be convenient to delay formal situations that could jeopardise the patient's interests.

#### **Written protocols**

**It is very important, to prevent abuse and arbitrariness, for there to exist written protocols for each one of the restrictive measures. These documents will always be available to patients, relatives and companions.**

## **6. Consent in some cases of admission non-voluntary, minors people without capacity**

It should be borne in mind that most psychiatric disorders present an irregular and changing evolution that frequently entail changes in the mental state of the patients, both towards a more serious condition or incapacitation or towards improved equilibrium and recovery. From the subject's point of view, it is evident that the specific personality of each person will render him or her more vulnerable or more resistant to certain stimuli, and also more or less competent in the face of specific emotional situations or conflicts. It is also evident that

disease affects each person differently, depending on multiple variables: the type of disorder, the level of adaptation reached before the onset of the disorder, the specific family and social environment, the type of treatment received and onset, etc. It must be understood that as with other spheres of the recovery process, the beneficial influence of the relationship between the patient and the health-care services may also stimulate significant changes in the area of self-awareness which must be duly and expressly picked up on and evaluated if they are not to be wasted. What is more, rehabilitation is not possible without the recovery of a certain self-awareness as a person and as a citizen.

This idea is valid in itself for all cases, regardless of the seriousness or the degree of incapacity of a specific person. This has one immediate consequence for all mental health professionals: provided that a patient has the capacity to decide responsibly, he must do so; despite previous failures. As is always the case, on the basis of a prudent attitude, and using the benefits to the patient as his guide, the professional must evaluate the risks and benefits his clinical decision may have.

The European Convention on Rights Human and Biomedicine recommends the need to request consent for specific therapeutic situations, including non-voluntary hospitalisation. A commission of experts of the European Union is working in this same regard to propose a white paper. This document insists on the need for patient who is the object of a non-voluntary hospitalisation to be able to "*be involved in decisions, wherever possible*" (chap. 3), or "*continue the participation of the patient even in a non-voluntary hospitalisation*" (6.4.) or that, in a situation of forced hospitalisation "*the competence of the patient to give his consent must be verified for each form and course of treatment indicated*" (6.2.). A clear distinction is also made between non-voluntary *hospitalisation* and non-voluntary *treatment* whereby neither one necessarily involves the other. Thus, this means that it is possible for a treatment to be validly agreed to in a situation of non-voluntary hospitalisation.

Regrettably, neither the Spanish Civil Code nor the Catalan Family Code provide for these situations. At the moment, for the necessary legal protection of minors or incapacity, the laws provide for the obligatoriness of legal authorisation for the hospitalisation of these persons, therefore not recognising either the consent given by the interested party or by his legal representatives. Moreover, the legal world tends to regard any consent given in non-voluntary hospitalisation as invalid. When considered in detail, this legal element, as well as those mentioned above (minority and incapacity) does not involve (or should not necessarily involve) the denial of the person's civil rights, although it does involve tutelage or the protection in the exercise thereof. Among these rights, the capacity to choose should be relevant, provided that minimum conditions required for a responsible choice to be made concur.

There can be no doubt that situations of lack of protection and abuse in these groups of people may arise, although the inflexible nature of the law also poses a risk of abuse: the denial of the capacity of autonomy and consent that any person may have in a specific situation, and particularly when the latter pertains to a health problem. Furthermore, the right to give one's consent is a civil right, a fundamental element in the therapeutic and rehabilitation process.

## **7. Non-voluntary hospitalisation of minors**

Following the indications of the White Paper on the protection of human rights and the dignity of the person affected by mental disorders, in the case of admission to a psychiatric centre of a minor, the measures must be stricter than those which are applied in the case of adults, because:

- Minors may be unable to defend their interests, whereby they should have the possibility to receive aid from a person who will represent them, as of the beginning of hospitalisation (this function may be taken on by a relative or by the legal guardian).
- Their opinion must be taken into account accordingly and progressively according to their age and degree of maturity.
- Hospitalised minors must be treated in separate areas from adults.

- The minor's return to the school system must be carried out as soon as his psychopathological condition allows.

According to the Organic Law on the legal protection of minors, when the patient is a minor, the authorisation of the father or the mother or the person holding custody will not suffice for psychiatric hospital admission; legal authorisation, and a report from the professionals taking care of the minor, will also be required. Thus, admission for psychic disorder of a person who is not in a position to decide for himself requires legal authorisation, although this is subject to the person holding custody. This authorisation will be prior to internment, unless for emergency reasons it were necessary to take such measures immediately, with the judge notified within 24 h. The admission of minors must always be carried out in a mental health establishment suitable for their age, following a report from the services caring for the minor. Admission will be long-term only in exceptional cases and the patient will be discharged when treatment no longer makes sense.

Consequently, the law does not provide for the possibility of voluntary psychiatric hospitalisation of minors, either with the consent of the parents or legal guardians alone.

In daily practice, most hospitalisations are performed in emergency situations and therefore admission, stay and discharge all take on special connotations:

- Admission takes place immediately when necessary, as in the case of the adult patient, without legal authorisation. However, the judge must always be informed within 24 h.
- There being no legal authorisation, admission is conducted exclusively on the responsibility of the doctor (if any conflict on the hospitalisation arises the doctor must justify the reasons for the emergency).
- Discharge will be determined according to medical criteria, without the authorisation of the judge being necessary, although the court must be informed.
- In the event of a divergence between the opinion of the doctor and the parents or legal guardians the doctor's criteria will prevail. In the event of disagreement between the two parties the judge must be informed.
- In the case of treatments entailing some type of risk, however minor it may be, the person holding custody must give his written consent and, at the same time, a legal authorisation must be secured. However, "*minors have the right to receive suitable information regarding their overall medical treatment, according to their age, maturity and their psychopathological and emotional condition*".
- The opinion of the minor should always be taken into account, particularly in special situations when they refuse to receive visits or telephone calls from certain relatives.
- Regarding confidentiality and applications for medical reports, no information on the condition of the minor may be revealed without the authorisation of the person with custody, "*with the minor's prior knowledge and consent, taking into account his age, maturity and psychopathological condition*":
  - In the case of separated parents who share custody, both have the right to be informed.
  - When the legal custody is held by the General Board of Health Care of Minors (DGAM), any information given to parents must be approved by the DGAM first.
  - Custody by the General Board of Health Care of Minors does not pre-suppose the prohibition of visits, telephone calls and therapeutic permits with relatives, barring opposition from the minor or the DGAM.

The psychiatric admission of a minor is a source of major anxiety for the young patient and relatives alike, so the way he is received by the professionals involved and the collaboration of the parents and legal guardians are indispensable in establishing a good therapeutic bond. In this regard, they should be informed that admission is voluntary and what treatment is to be followed. They should be informed that the legal form of admission is to guarantee that there is no abuse or arbitrariness in the hospitalisation of children and young people.

They should be furnished with an informative leaflet or text containing the timetable for telephone calls and visits, to see the patient and the professionals, therapeutic and recreational activities, the centre's rules and any other information deemed suitable.

It is very important to remember at all times that the child or young person has the right to be informed on their disorder and treatment, as well as any guidelines recommended on discharge, in a way that they is understandable for them according to their age and the degree of maturity.

The attitude to children and adolescents must be utterly professional, without reaching extremes of protectionism or rigidity, and pitched to their age.

## **8. The non-voluntary hospitalisation of the patients with dementia**

This type of admission takes place when the seriousness of the cognitive deterioration evinces an evident incapacity to understand and decide on what is best for oneself in the event of an acute medical problem. In cases in which the clinical condition of the disease is a stage 7 in the *Global Deterioration Scale* or 3 in the *Clinical Dementia Rating*, there is a clear lack of competence. A diagnosis of seriousness can also be made following the usual manuals. Stages 6 and 2, respectively, or a moderate dementia diagnosis must be evaluated with greater care. In dementias that course with focal deficit, such as the vascular type or the atypical forms of Alzheimer's disease, as well as cases involving fluctuations in cognitive and behavioural deterioration, a broader assessment should be made to determine the degree of competence. As is evident, admission will not take place if there are less restrictive therapeutic alternatives, and it will also depend on whether the benefits of admission are evident, both for the well-being of the patient and that of his usual care-givers.

If the patient is legally incapacitated or has written an advance directive for a certain problem, the medical or social and health-care action may be conditioned by the will of the legal representative or the surrogate named in this document

In patients with dementia, two types of non-voluntary hospitalisation may occur: acute and scheduled. The former has nothing to do with the actual dementia, but rather with a complication that may be organic or mental. The only treatment in this case is an emergency admission.

When there is an advance directive, it is difficult for the behavioural disorders and other non-cognitive symptoms frequent in these diseases to be provided for. Generally speaking, people tend to worry about not having their life prolonged when they are in advanced or terminal stages of the disease. Ceasing to treat the non-cognitive symptoms of the dementia has nothing to do with these directives and may entail increased suffering of patient and family alike. In these cases, it must be made clear that a non-voluntary hospitalisation is due to a complication in the dementia and that once it has resolved the patient will have to be discharged. Every effort should always be made to ensure that these admissions for acute complications do not become permanent.

In persons with dementia, be it an acute or scheduled admission, it may be possible to foresee whether the stay will be long-term or may become permanent. In all cases, the formalities will be conducted according to the legislation in force: the doctor reports the fact and the judge decides whether or not to admit the patient. A decision can be taken later on possible formalities for legal incompetence. Unlike the psychiatric patient who on many occasions after specific treatment recovers a degree of competence that makes it possible to look after himself, the lack of competence is persistent and progressive in patients with dementia.

Scheduled non-voluntary hospitalisation refers to the situation in which the family or the persons in charge of the medical care given to the non-incapacitated dementia patient, for family, social or health care reasons which cannot be covered in their usual setting, decides to commit the patient to a social-health care or psychogeriatric centre. In these cases, the formalities for having the patient declared incompetent and, as applicable, for applying for preventive measures, must be initiated prior to admission, because we are not talking about an acute medical problem.

## **9. The non-voluntary hospitalisation of the mentally retarded**

The mentally handicapped present a prevalence of mental disorders which is higher than that of the population at large. While their needs are different to those of people with other mental diseases, the use of emergency and acute care psychiatric services by these people is relatively frequent, particularly those with mild mental retardation.

Generally speaking, it may be said that the criteria and the admission procedures must be similar to those for other psychiatric patients; since cognitive deficit, compounded by a serious acute condition, entails greater difficulty in securing consent. The importance of disadaptive behaviours and the lack of control over impulses, when they arise, may render it even more necessary to increase the support and safety measures during admission.

Prolonged hospitalisation must be carried out in specific environments for this type of patient and generally speaking prior legal authorisation is recommendable. In these cases, the patient's incapacity should always be duly assessed, with a view to determining the convenience of legal custody.

## **10. The emergency services of a general hospital and the competence of patients affected by a psychiatric disorder**

The professionals who work in these emergency services often have to face up to situations in which the assessment of the patient's capacity to take important decisions is at stake. Sometimes behavioural disorders may hide physical or pharmacological organic causes. Moreover, something which may have initially seemed to be a somatic abnormality may be diagnosed as a psychiatric process after a suitable examination. Overwork, the speed with which action must often be taken and other factors that affect the organisation of emergency services make it difficult to assess patient competence.

The doctor and the nursing staff in charge of an anxious, agitated, frightened or depressed patient may prematurely rate him as competent, particularly if they lack the skill and experience needed to contain the situation in the interim, and make a subsequent evaluation of his capacity with greater tranquillity.

There are some occasions when the emergency services have to address clinical conditions that require taking measures that are close to the limits of ethics and rights. The indication of physical or pharmacological restrictive measures are good examples of this. In these circumstances it would be advisable to establish an indicator with the utmost possible correction, to be able to have an interdisciplinary assessment made, with the presence of a psychiatrist.

## **11. The everyday reality of the patient, nursing care and restrictive measures**

Looking after a patient whose movements are limited and/or whose behaviour is subject to special monitoring is a challenge to nursing care. Respect for the dignity of the individual is something that normally becomes apparent in everyday dealings.

There is a major risk involved if the patients are treated as if the incapacitation, which is always partial and relative, had to be applied to all aspects of everyday life. Quite the contrary, nursing care must see the patient's difficulty as something temporary and partial; furthermore, the relative capacity to decide reasonably does not persist permanently in most cases, and neither does it apply to all the aspects of the person's life.

To provide good and safe care there must be a desire to gradually increase the patient's competence. We must make sure that the patient takes decisions in aspects of daily life, respecting his habits, values and beliefs. When we find it impossible to act as above, we must give him the necessary explanations, and if the family is present, we have to engage

them to the extent that they are able. Furthermore, we must always strive to help relatives to face up to the situation as best as they can.

Moreover, the importance of the current environment of patients in health-care establishments should also be considered. We must be careful so as not to increase the patient's confusion. All available resources must be mobilised to ensure that the setting is as comfortable and healthy as possible, preventing anything that may generate anguish, confusion, fear, etc. For example, if a lot of people are involved in the care given to the patient, identification must be correct and clear; care must be taken to remove any unnecessary elements with which the patient could hurt himself, etc..

The humanisation of care, respect for the individual rights of the person, the reduction of negative psychological impacts and coverage of basic needs are key objectives in nursing care, whatever the care framework may be. By the humanisation of health care we mean a professional attitude that makes it possible to put ourselves in the other's position and become aware of his needs and limitations. We must always remember that we are dealing with people, never with their bodies.

The humanisation of health care will almost always avert undesired effects in the application of care and treatments. Undesired effects are the negative consequence that may be caused by bad treatment given with certain negligence, for example:

- Considering that the patient is unable to take a decision on any aspect of clinical care;
- Considering him incapable of facing up to his health problem;
- Making value judgements on him, his behaviour or family;
- Limiting his communication with other people unnecessarily;
- Not ensuring that the setting will not perturb or agitate him;
- Violating the privacy and the dignity of the patient, in terms of handling his body when taking care of the basic needs of evacuation and hygiene;
- Violating confidentiality;
- Adopting paternalistic or maternalistic attitudes that lead to adults being treated as if they were a child;
- Failing to provide information on his condition and treatment;
- Providing health care using unqualified personnel; etc..

The planning and follow-up of nursing care for patients in these situations may require special and concrete considerations. They have to be assessed as high-risk persons, as their clinical situation is highly vulnerable they have a high level of dependence, so nursing care in these cases is not unlike intensive care. If physical restraint proves necessary, it must never be a measure that induces professionals to reduce the care, monitoring and control of the patient. Quite the contrary, physical restraint increases the cost of nursing care, as it increases workload. Furthermore, therapeutic success is greatly conditioned to the way the restraint is initiated and how follow-up, control and withdrawal are conducted.

Neither should it be forgotten that restrictive measures may give rise to more or less intense states of agitation than the damage they are supposed to correct, and that the benefits depend, to a large extent, on a careful and suitable follow-up, and on the expertise of the nursing care provided.

Nursing data make it possible to contextualise the clinical status of the patient's risk situation and therefore may be decisive in the prescription of possible restrictions. These data tend to be of help in taking decisions on prescriptions, once the therapeutic effects of the restrictive measures and possible undesired consequences have been weighed up.

## **12. Clinical and bioethical reflection on the legal framework regulating non-voluntary hospitalisations**

Legal intervention in the authorisation of non-voluntary hospitalisations must be seen as a guarantee of the defence and preservation of the basic rights of the individual: the right to freedom, but also the right to life (without which no other right can be used), the right to health and the right to safety, all of them contained as basic rights in the Spanish Constitution of 1978.

At the moment, the legal regulation of non-voluntary hospitalisations is determined by article 763 of the Law of Civil Judgement, the Organic Law on the legal protection of minors and, in Catalonia, by article 255 on the Family Code.

These laws address the need for a legal authorisation before any admission for psychic disorder when the person is not in a position to take the decision by himself, barring emergency situations, when the measure is adopted by virtue of medical criteria. In this case, the court must be informed in a maximum term of 24 hours.

In emergency cases where there is no prior authorisation, the judge is obliged to ratify any non-authorised admission within 72 hours.

In all these situations, hospitalisation status must be reviewed by the judge every 2 months. The legal texts do not make it completely clear if the eventual measure of ratification has to be adopted by the judge on the basis of a direct legal examination of the person or on the basis of the report by the doctors dealing with the case.

Article 255 of the Family Code also introduces the doctor's obligation to apply for legal authorisation when treatments to be applied may entail a serious risk to the life or the physical integrity of the patient.

Finally, the legislation clearly expresses that the discharge of the patient will be based on purely medical criteria.

There is no doubt that the application of legal measures benefits the person affected, since the legal follow-up of non-voluntary hospitalisation is a necessary procedure to protect the basic rights of the patient. Certainly, the function of the judicature must be limited to verifying the non arbitrariness of a certain admission and it is very doubtful that it should have to monitor that the therapeutic process followed by the patient is correct.

In the new Law of Civil Judgement there seems to be a certain legal analogy between the situation of the patient involuntarily admitted to hospital and that of the person who has been arrested. This may entail a purely normative interpretation of the function of the judge in psychiatric internment which could be comparable to those of the penitentiary judge.

The involuntary hospitalisation of a patient affected by a mental disorder cannot be compared to that of a person who has been arrested, on the basis of the notion of deprivation of freedom. Such a comparison would not be reasonable because non-voluntary hospitalisation is always performed in pursuit of an exclusively therapeutic objective based on the benefits to the person, when there are no other less restrictive alternatives.

Failing to distinguish very clearly between the notion of a sentence, or in other words, of serving time for an offence committed, and the dimension of a transient restrictive measure that is only based on a therapeutic approach in the person's best interests may eventually lead to a dangerous dilution of the health care function of the psychiatric institution.

If the role of the judge has to be able to regulate, with the utmost rigour, cases of non-voluntary hospitalisation, to preserve the rights of the citizen, great care will also be required to prevent this from straying towards an abusive supervision of clinical practice. Attitudes of interference entering the doctor-patient relationship would ruin the process of quality control and of making protocols that must come from health-care echelons, and could lead to a defensive exercise of the medical profession.

Perhaps the legal regulation of certain therapeutic procedures for psychiatric patients admitted against their will would be even worse, leading to a possible positive discrimination which, rather than protecting mental patients, would aggravate the stigmatisation of their differences.

It seems clear that there may be areas of major complexity in the development of clinical practice where ethical, medical-legal and judicial aspects frequently contradict each other.

When faced with the temptation - already seen at other points in history - to seek the convergence of legal and psychiatric practices in a sphere where the ethical principles of the doctor-patient relationship could easily be distorted, psychiatry and judicial practice must preserve their own specific spaces of action. The law, as a regulatory social principle, and as a principle that helps to structure the psyche of the subject, must remain in an independent position, without becoming unduly mixed with clinical practice.

## **12. Reference Documents**

- Universal Declaration of Human Rights approved and proclaimed by the General Assembly of United Nations on December 10, 1948
- European Convention for the Protection of Human Rights and Fundamental Freedoms. Rome, 1950
- Principles for the protection of the mentally ill and improved care in mental health. Resolution 46/119 of the General Assembly of the United Nations, 1991
- *Declaration on the Promotion of Patients Rights in Europe. WHO European Consultation on the Rights of Patients meeting. Amsterdam from 28 to 30 March 1994*
- Resolution 1029 (1994) and Recommendation 1235 (1994) on psychiatry and human rights of the Council of Europe+++
- European Convention on Biomedicine and Human Rights of the European Council for the Protection of Human Rights and Dignity of the Human Being with regard to the application of biology and medicine, 1997
- *White Paper of the protection of the human rights and dignity of people suffering from mental disorder especially those placed as involuntary patients in a psychiatric establishment CM (2000) 23 Addendum 10 2 2000. Committee of Ministers. Council of Europe*
- [www.cm.coe.int/reports.old/cmdocs/2000/2000cm23add.htm](http://www.cm.coe.int/reports.old/cmdocs/2000/2000cm23add.htm)

# Annex I

## Evaluating mental competence for a health-related decision

All psychic functions are compromised in decision-making. Special relevance to: orientation, care, memory, abstract thought, judgement of reality, reasoning.

Exploring:

15. What is his mental functioning like?

*Explore the aforementioned functions; if necessary, go on to a Mini Mental.*

16. Does the patient understand the information?

*Have him explain, in his own words, what the disease consists of, what tests have been proposed, the risks and the benefits of each alternative, what will happen if we do nothing.*

17. Can he appreciate the information with regard to his own circumstances?

*Ask why we have given him all this information. Ask him what affects him most with regard to the above information.*

18. Can he reason on the basis of the information?

*What made him take this decision? What factors did he rate most?*

19. Can he express a choice?

*Ask him*

We must remember how the patient functions with regard to the functional demands involved in a specific choice (different for each decision), and particularly check whether the patient realises the consequences of his choice (the more negative and serious they are, the more the requirements needed to be competent). The reassessment of competence must be continuous, and whenever:

- An abrupt change takes place in the mental state.
- When the professional honestly understand the reasons for a rejection of treatment.
- When the patient over-readily gives his consent for an operation entailing a special risk or discomfort, or else when he retracts on a previous and recent decision without offering any rational reasons.
- When the problem or the demand to be decided upon changes.

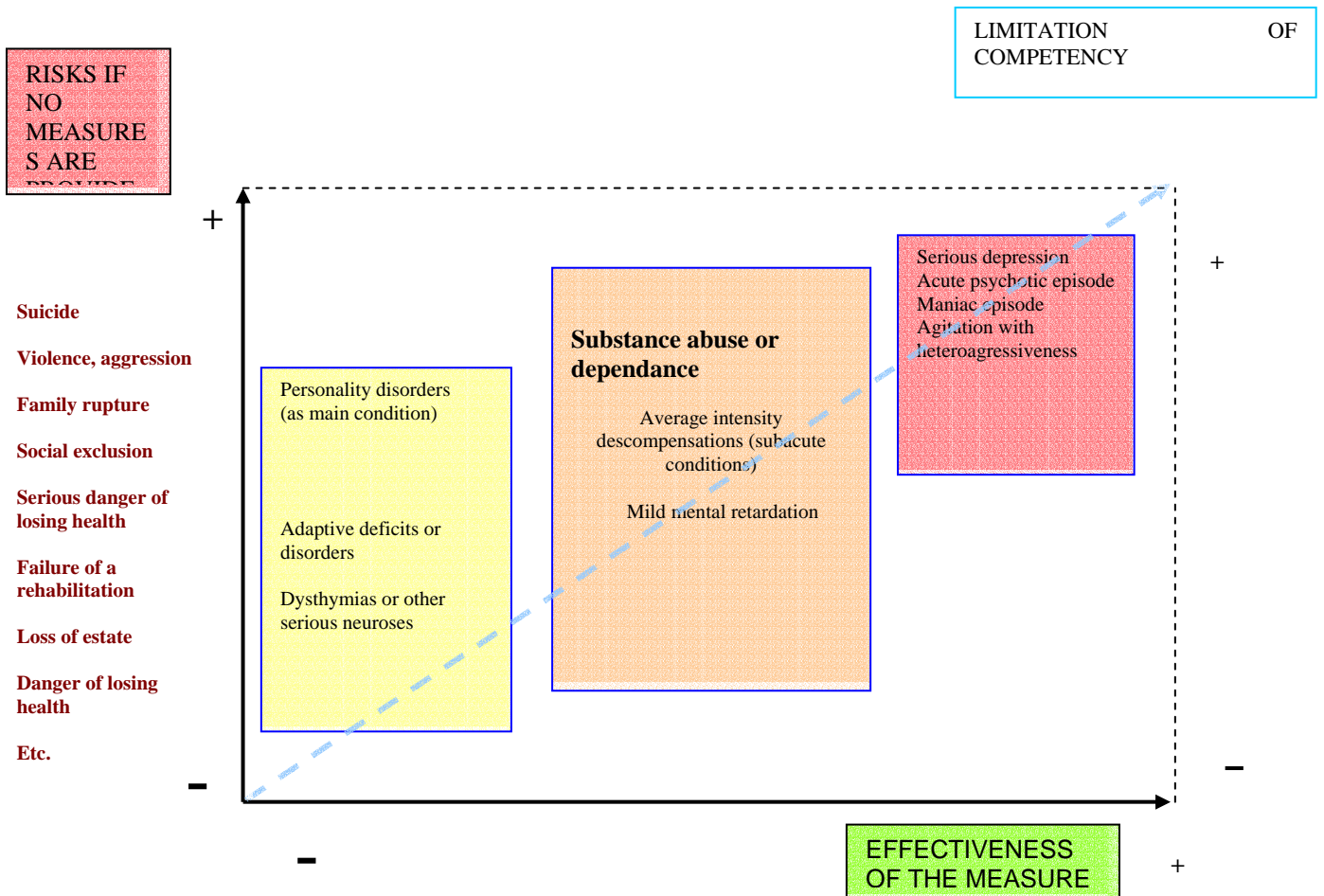
Organic mental disorders, psychomotor agitation, acute psychosis and serious depression are very important limiting factors. We must also be on the lookout for other risk factors, which may be psychological, situational, etc...

It may be very important to improve the conditions in which the evaluation is to be made: the most "significant" professional for the patient may not be the doctor, so if necessary the presence and participation of a relative or a friend may be assessed or requested, the final decision delayed, if possible, etc..

(Written by J.Ma. Llovet, psychiatrist. San Joan de Dios, mental health services)

# Annex II

**Hospitalisation of acute patients: clinical condition and relationship between the risk of not implementing the measure and therapeutic efficacy in cases where the condition limits mental competence**



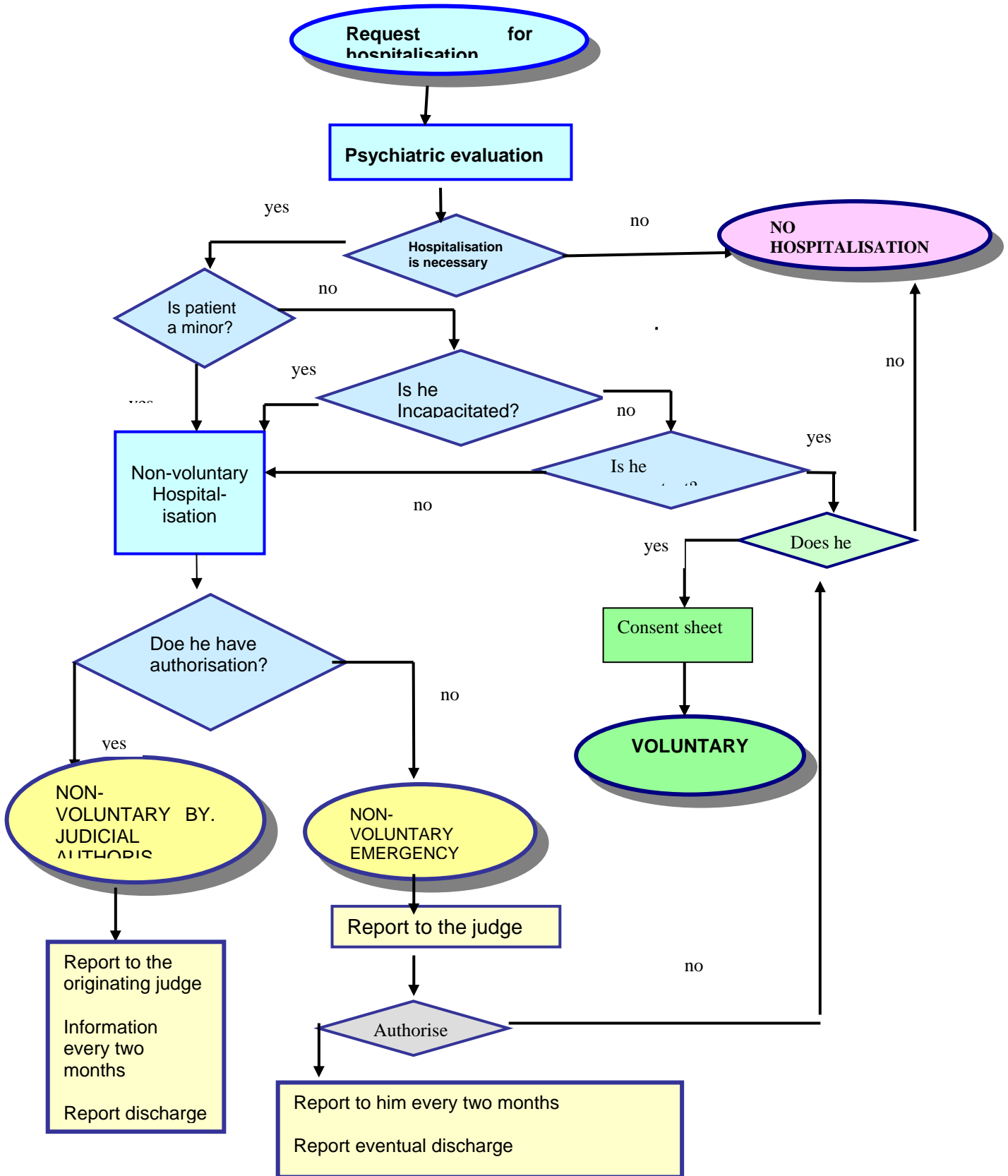
The figure clearly shows that risks and effectiveness peak in serious depression, in the acute psychotic episode, maniac episodes or agitation with auto or hetero-aggressiveness, regardless of what the disorder triggering the clinical manifestations is. In these conditions in which the risk is serious and therapeutic measures are very efficacious, the arguments a patient would have to give to be able to decide between accepting or rejecting them would have to be very clear and convincing. Generally speaking, in these cases mental state is greatly altered.

On the other hand, there are situations of little risk and in which mental competence has been conserved, where short-term hospitalisation is of little efficacy. In these cases hospitalisation must be agreed to between patient and psychiatrist, with a therapeutic contract freely agreed to.

In intermediate situations, there are other pathological conditions where complementary criteria can be brought in; for example, examining the clinical history of the patient to check whether he has been in other establishments or hospitals other than the present one.

# Annex III

## CLINICAL AND LEGAL PROCEDURE FOR PSYCHIATRIC ADMISSION



## Annex IV

| <b>GLOBAL DETERIORATION SCALE (GDS), Reisberg (1982)</b> |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>STAGE</b>                                             | <b>CLINICAL PHASE</b>                    | <b>CLINICAL CHARACTERISTICS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| GDS 1<br>Absence of Cognitive deficit                    | <i>Normal</i>                            | No subjective or objective cognitive deterioration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| GDS 2<br>Very mild cognitive deficit                     | <i>forgetfulness</i>                     | Complains of loss of memory, basically to locate objects, names of relatives, appointments... The deficit is not seen in the clinical interview or in the social and job setting                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| GDS 3<br>Deficit Cognitive<br>Mild                       | <i>MCI (AMAE-DECAE) Initial dementia</i> | Early manifestation in more than one area:<br><ul style="list-style-type: none"> <li>- Spatial disorientation</li> <li>- Evidence of low work performance</li> <li>- Difficulty to remember names, evident to relatives</li> <li>- After reading he recalled relatively little material</li> <li>- Forgets location of object of value</li> <li>- Concentration deficit is evident to clinician</li> <li>- Mild or moderate anxiety</li> <li>- Denial is started as a mechanism of defence</li> </ul>                                                                                                                                                     |
| GDS 4<br>Moderate Cognitive Deficit                      | <i>Mild Dementia</i>                     | Manifest deficits:<br><ul style="list-style-type: none"> <li>- Forgets everyday or recent events</li> <li>- May present memory deficit of his personal history</li> <li>- Difficulty to remember names, evident in subtraction operations</li> <li>- Unable to plan trips, social and work life or perform complex tasks</li> <li>- Blunting of emotional lability</li> <li>- The mechanism of denial dominates the symptoms</li> <li>- Conserves orientation in time and person, recognition of familiar faces and persons, and the ability to visit to known places</li> </ul>                                                                          |
| GDS 5<br>Moderately serious cognitive deficit            | <i>Moderate dementia</i>                 | <ul style="list-style-type: none"> <li>- Needs help in certain tasks: does not need help in cleaning and meals, but does to choose clothes</li> <li>- Unable to recall important aspects of his daily life</li> <li>- Frequently has disorientation in space and time</li> <li>- Has difficulties in counting in reverse order from 40, in 4s or from 20 in 2s</li> <li>- Is able to recall his name and those of his wife and children</li> </ul>                                                                                                                                                                                                        |
| GDS 6<br>Serious cognitive deficit                       | <i>Moderately serious dementia</i>       | <ul style="list-style-type: none"> <li>- Forgets the name of spouse and recent events</li> <li>- Recalls some data from the past</li> <li>- There is disorientation in time and space</li> <li>- Finds it difficult to count in 10s, either forward or back</li> <li>- May require help in everyday activities and presents incontinence</li> <li>- Remembers his name and can distinguish between relatives and people he does not know</li> <li>- There is a disorder of the daytime rhythm</li> <li>- Presents personality and emotional changes (delirium, obsessive symptoms, anxiety, agitation or aggressiveness and cognitive abulia )</li> </ul> |
| GDS 7<br>Very serious cognitive deficit                  | <i>Serious dementia</i>                  | <ul style="list-style-type: none"> <li>- Loss of all verbal capacity (language may be reduced to shouting, grunting...)</li> <li>- Urinary Incontinence</li> <li>- Need for help in personal hygiene</li> <li>- Loss of psychomotor functions</li> <li>- Neurological signs frequently observed</li> </ul>                                                                                                                                                                                                                                                                                                                                                |

## Annex V

| Clinical correlation matching the <i>Brief Cognitive Rating Scale (BCRS)</i> |                                                                                                 |                                                                                               |                                                                                                                                                 |                                                                                                                                          |                                                                                                                                                                          |                                                                  |                                                        |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|
| Level                                                                        | Concentration                                                                                   | Recent memory                                                                                 | Past memory                                                                                                                                     | Orientation                                                                                                                              | Language                                                                                                                                                                 | Functioning                                                      | Calculation                                            |
| 1                                                                            | No subjective or objective deficits apparent                                                    | No subjective or objective deficits apparent                                                  | No objective or subjective alterations evident                                                                                                  | No deficit in memory for time, place, identify of self or others.                                                                        | No objective alterations                                                                                                                                                 | No changes objective or subjective                               | No objective or subjective changes                     |
| 2                                                                            | Subjective alterations. Easily distracted                                                       | Subjective deterioration is evident                                                           | Only subjective impairment (e.g. he recalls the name of two or more school teachers)                                                            | Only a subjective worsening (knows time to nearest hour, location...)                                                                    | Subjective difficulty for recalling names of people and objects                                                                                                          | Can draw a cube                                                  | Can subtract 17 from 43                                |
| 3                                                                            | Minor defects (e.g. series of 7 as of 100)                                                      | Defect in recalling specific details. No deficit in recall of major recent events             | Some gaps in past memory (e.g. can recall at least one teacher and/or one childhood friend)                                                     | Mistakes in two or more hours, in some or more days with regard to present and in three or more days with regard to the day of the month | Manifest difficulty to find the right words, with frequent interruptions or slight stutter                                                                               | Finds it difficult to draw a cube with the right perspective     | Can subtract 14 from 39                                |
| 4                                                                            | Moderate Deficit (e.g. marked difficulty in the 7 series ; frequent in the 4s as of 40)         | Cannot recall major events in past weeks or weekends (not detailed)                           | Clear deficits. There are also confusions in the chronological location of past events (cannot recall teacher's name, but remembers the school) | Confusion in ten or more days and some or more months with regard to the current date                                                    | Defects of verbalisation are evident to relatives, but generally speaking not visible in the clinical interview. Becomes more reticent or alternatively tends to digress | Can draw a rectangle                                             | Can subtract 6 from 15                                 |
| 5                                                                            | Marked deficiencies (e.g. giving months backwards or serials 2s from 20)                        | Unsure in time and space                                                                      | Unable to recall important past events (school where he studied, place where he did his Military service)                                       | Doubts on current month, year or season and the place where he is                                                                        | Markedly poor spontaneous language, evident during interview. Can finish a saying                                                                                        | Can draw 2 concentric circumferences                             | Can subtract 4 from 9                                  |
| 6                                                                            | Forgets the task (begins to count forward from 1 to 10 when asked to do it the other way round) | Occasionally recalls some recent events. Absolute or serious disorientation in time and space | Some residual memory: recalls country of birth, first job, the name of parents                                                                  | No idea of date, identifies spouse but may no recall name, although knows own name                                                       | Cannot finish a saying. Responses limited to one or a few words                                                                                                          | Can draw a circumference or a line. Doodles                      | Can add 8 plus 7 or 3 plus 4                           |
| 7                                                                            | Marked Difficulty counting forward to 10 in 1s                                                  | No knowledge of recent events                                                                 | Total loss                                                                                                                                      | Cannot identify spouse and may be unsure of own identity                                                                                 | Loss of verbal skill or vocabulary limited to one or two words. Has logorrhoea. Merely grunts or calls                                                                   | cannot write anything at all, although can hold the pen properly | Can sometimes add one plus one. He cannot can 1 plus 1 |