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# GUIDELINES FOR THE PROMOTION OF HUMAN RIGHTS OF PERSONS WITH MENTAL DISORDERS

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DIVISION OF MENTAL HEALTH AND  
PREVENTION OF SUBSTANCE ABUSE

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WORLD HEALTH ORGANIZATION

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GENEVA

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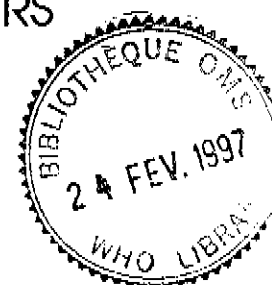
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# GUIDELINES FOR THE PROMOTION OF HUMAN RIGHTS OF PERSONS WITH MENTAL DISORDERS



This document contains instruments for the assessment and the promotion of the respect of human rights of people with mental disorders, and the improvement of mental health care, according to major international documents on this issue, particularly a Resolution adopted by the UN General Assembly in 1991.

KEY WORDS: human rights, mental disorders, persons with mental disorders, mental health legislation.

MENTAL DISORDERS CONTROL  
DIVISION OF MENTAL HEALTH AND  
PREVENTION OF SUBSTANCE ABUSE  
WORLD HEALTH ORGANIZATION  
GENEVA

1996

## ON THE INITIATIVE

WHO's "Initiative of Support to People Disabled by Mental Illness" is part of WHO's work on the prevention and treatment of mental disorders. It is an attempt to speed up the dissemination of information to governments and professionals about good community services for those with chronic mental illness and about new developments in this field. The Initiative aims to help in reducing the disabling effects of chronic mental illness and to highlight social and environmental barriers which hinder treatment and rehabilitation efforts and which add to the stigma of chronic mental illness. It also stimulates consumer empowerment and involvement with planning, delivery and evaluation of mental health services.

The following sites have officially joined the Initiative and have participated in its various activities:

- \* The Queensland Northern Peninsula and Mackay Region Mental Health Service (centred in Townsville, Australia).
- \* British Columbia Ministry of Health - Mental Health Services (Vancouver, Canada).
- \* Centro Studi e Ricerche Salute Mentale - Regione Autonoma Friuli Venezia-Giulia (Trieste, Italy).
- \* Highland Health Board - Mental Health Unit and Highland Regional Council (Inverness, Scotland, U.K.).
- \* SOGG (Rotterdam) / Ministry of Health (The Netherlands).

The Dowakai Chiba Hospital (Funabashi, Japan) also takes part in some of the Initiative activities; other centres are at different levels of discussion concerning their joining the Initiative.

Further information on this Initiative can be requested to:

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## INTRODUCTION

International instruments supporting even the most basic rights of persons with mental disorders have been very long in coming. On 17 December, 1991, the UN General Assembly adopted 25 Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, through Resolution 46/119. This was the culmination of fourteen years of work that began in 1978 when the Human Rights Commission of the United Nations requested the Subcommittee on Prevention of Discrimination and Protection of Minorities to study the question of the protection of those detained on the basis of mental illness. The draft resolution was finalized after more than a decade of debates and discussions at the Economic and Social Council.

Its final format - as Principles - and its length: 25 Principles, some of which are very detailed - made it slightly different from previous UN resolutions related to other diseases or disabilities. The issue of course, was how to breathe life into this Resolution. Otherwise, the human rights' interests in this worthwhile document were unlikely to be applied where they matter - in emergency rooms, hospital wards, outpatient treatment centres, courts and prisons. An additional tool which would facilitate its understanding and implementation was needed and there was general agreement that WHO should be in charge of the production of this tool. After consultations with experts and NGOs, a decision was made to produce guidelines, in the form of user-friendly questions to shed additional light on the Principles.

The Division of Mental Health and Prevention of Substance Abuse of the World Health Organization has produced the Guidelines appearing hereafter, by which Resolution 46/119 may be operationalized by its signatories. The Guidelines were drafted for an in-depth assessment of the conditions related to each one of the major Principles in Resolution 46/119, as well as on its several sub-headings. In addition to traditional civil and political rights, the right to sound mental health treatment is embodied in Resolution 46/119. As such, the Guidelines also address basic quality assurance issues in order to provide a baseline from which policy-makers and mental health care providers may evaluate mental health programmes at the local, regional and national level.

In order to provide for a very brief general assessment of the human rights' conditions of the mentally disordered at the country, regional or local level, a succinct Checklist derived from the Guidelines was also produced. Its main purpose is to allow for a quick assessment of the situation, as a companion tool to the more in-depth Guidelines.

Therefore, the present document is composed of three major parts: I. the Guidelines, in its full version; II. the Checklist; and III. the Appendices, including (i) the list of collaborators involved in the production of this document and (ii) some selected UN Declarations and Resolutions relevant to the mental health field in general.

In the text in Part I : Guidelines, we opted to include the highlighted text of the U.N. Resolution Principles, immediately followed by a series of relevant questions intended to

guide those interested in verifying the extent to which each Principle is applied. It is not a scale with precise, definite or right/wrong answers; it is a qualitative instrument intended mostly to provide alternative approaches to the monitoring of each principle, making room for local characteristics, traditions and resources.

These questions are meant to illustrate what are some of the practical facts of the Principles. They do not aim to be exhaustive. Rather, they purport to raise examples of items for consideration and review. It is essential to note that not all questions may apply or be relevant everywhere, depending on a variety of factors such as culture, development level, legal tradition, political and religious systems and others.

However, the mere existence of the resolution and of guidelines for its implementation does not necessarily guarantee that people will benefit from them. In most cases it will be necessary that some official body (e.g. the Parliament, the Ministry of Health or Welfare, the Medical Council) ratify the Principles, or formally adopt them at national level. Next comes the verification of its enforcement, a task which some NGOs concerned with mental health and human rights issues are in an excellent position to perform.

Mental health legislation - and its enforcement - is profoundly important to development. According to the World Development Report published by the World Bank in 1993, the economic and public health burden of mental illness, measured in terms of DALYs (Disability-adjusted life years), the cost of mental disorders and related conditions (such as intentionally self-inflicted death or injury) is greatly deleterious to the process of social development.

Furthermore, adherence to the Rule of Law is important for social development in that it provides a predictable and codified set of norms and institutions which may be relied upon. As such, adherence to the Rule of Law is a stabilizing force in society. Mental health legislation - precisely because it is aimed at a vulnerable population subgroup - is an important first step in establishing or reinforcing the Rule of Law and thereby fostering social development.

Many people were approached during the process for the preparation of this document. It must also be said that some experts who were contacted expressed their dissatisfaction with the final text of the UN Resolution and hence with the ensuing Guidelines for its implementation and monitoring. The standpoint of these experts, who, generally speaking, represent users' (i.e. people with mental disorders) interests, reflects the decades old debate about the importance given to civil and political rights as opposed to the States' rights to issue coercive norms regarding health policy. In their viewpoint, the UN Resolution should have concentrated on "people's basic human rights" and not on "treatment rights"; still in their view, the inclusion of treatment issues earlier during debates in the Subcommission on Prevention of Discrimination and Protection of Minorities (particularly the modifications from the Daes Report to the subsequent Palley Report, which were maintained in the Steel Report) distorted its original intention, widened its scope and diluted the interest users had in it. Without taking issue on this question, it must be considered, nevertheless, that the UN Resolution represents a major international step forward both in terms of civil and political

rights and of social, economic and cultural rights, and as such deserves to be given the appropriate means to be adequately disseminated and promoted, bearing in mind Chamberlin's words that:

"Perhaps someday it will be recognized that persons who have been diagnosed as mentally ill should have exactly the same rights as other citizens of their countries, most fundamentally the rights to live their lives as they choose and make their own decisions. Any special help or protection they may need as a result of disability should in no way alter their fundamental citizenship rights."

This document can only be useful if the above-mentioned conditions are satisfied and if it is widely available in local languages. Therefore, interested parties are encouraged to translate - and possibly adapt - it into local languages. The Division of Mental Health and Prevention of Substance Abuse would be grateful for copies of local editions, which should be forwarded to:

Dr J. M. Bertolote  
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Division of Mental Health and Prevention of Substance Abuse  
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## PART I

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## Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

*The present Principles shall be applied without discrimination on any grounds, such as disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.*

### DEFINITIONS

*In the present Principles:*

- (a) *"Counsel" means a legal or other qualified representative;*
  - (b) *"Independent authority" means a competent and independent authority prescribed by domestic law;*
  - (c) *"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;*
  - (d) *"Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;*
  - (e) *"Mental health practitioner" means a medical doctor, clinical psychological, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;*
  - (f) *"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;*
  - (g) *"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;*
  - (h) *"The review body" means the body established in accordance with principle 17 to review the involuntary admission of a patient in a mental health facility.*
1. Are definitions of the above expressions (or equivalent concepts) under the body of law in force in keeping with the above definitions?
  2. If variations exist between the above definitions and those under the body of law in force, is the body of law:
    - a. more or less protective of patients' rights than the Principles?
    - b. more or less aimed at the improvement of mental health care than the Principles?

## GENERAL LIMITATION CLAUSE

*The exercise of the rights set forth in the present Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the persons concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedom of others.*

1. Is the exercise of any of the rights set forth in the Principles subject to limitations and, if so, which Principle and to what extent?
2. Is the exercise of the rights set forth in the Principles only subject to limitations prescribed by law? If not, how are those limitations prescribed? Are they set in advance? Are they known to the public?
3. Is the exercise of the rights set forth in the Principles only subject to limitations as are necessary to protect the health and safety of the person concerned or of others?
4. Is the exercise of the rights set forth in the Principles only subject to limitations as are necessary to protect public safety, order, health or morals or the fundamental rights and freedom of others?
5. Which are the specific grounds, if any are known, to limit the rights set forth in the present Principles in order:
  - a. to protect the health and safety of the persons concerned?
  - b. to protect the health and safety of others?
  - c. to protect public safety?
  - d. to protect public order?
  - e. to protect public health?
  - f. to protect public morals?
  - g. to protect the fundamental rights and freedom of others?

## PRINCIPLE 1 - FUNDAMENTAL FREEDOMS AND BASIC RIGHTS

*1. All persons have the right to the best available mental health care, which shall be part of the health and social care System.*

- 1.1 Do all persons have the right to the best available mental health care? What mental health care is available, and to whom? Is the entire country in question divided into catchment areas such that geographically, all regions are within a catchment area? Are the catchment areas funded proportionately?
- 1.2 What importance is attributed to mental health care within the health care system? How are mental health services financed, as opposed to general health services, as evidenced by funding, reimbursement by third party payers, limitations on treatment which is reimbursed for mental health problems?
- 1.3 How are mental health, social, and general health services linked or integrated? Are they located near one another? If so, how near? If not, is transportation provided? Are they linked by a telecommunication system? If not, are couriers available?
- 1.4 Are there social services departments in mental health treatment facilities? If not, is there some entity whose task it is to act as liaison with collaborating mental health, general health and other facilities?
- 1.5 What social services are aimed at providing support for persons with a mental disorder? (Before, during and after treatment).
- 1.6 What is the difference between various population groups or geographical areas regarding:
  - access to mental health care, for instance, how long is the average travel time to a mental health treatment facility in rural and urban areas?
  - staff/patient ratios in mental health treatment facilities?
- 1.7 Within a given geographic area, what are the staff/patient ratios in mental health treatment facilities as opposed to staff/patient ratios in other types of health treatment facilities?
- 1.8 What neuropsychiatric drugs are available within a one hour walk? (See Principle 10, below.)

*2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.*

- 2.1 Are all persons with a mental disorder treated with humanity and respect for their dignity?
  - 2.2 Are there laws to guarantee this?
  - 2.3 Are there ethical guidelines adopted by the professional societies of the various disciplines providing mental health care? What are the consequences of failure to respect these ethical guidelines?
  - 2.4 Are all persons with a mental disorder informed of their rights on a timely basis in a format or language which they can understand?
3. *All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*
- 3.1 Are persons with a mental disorder physically, sexually, economically or otherwise exploited? Conversely, how are they protected from such abuse?
  - 3.2 Are there laws prohibiting such exploitation and abuse? Are there civil, criminal and/or administrative penalties for this type of exploitation and/or abuse? Are the criminal penalties greater for such exploitation, i.e. are mentally ill persons a "protected class", as is generally the case for minors?
  - 3.3 Are there publicly available records of those who have been convicted of crimes involving the exploitation or abuse of members of a protected class, such that potential future employers have access to this information? (See also Principle 22.)
4. *There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion, or preference, undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.*
- 4.1 Is there evidence of discrimination (for example, in employment, in access to public services and amenities, in the criminal justice system) against persons with a mental disorder?
  - 4.2 Are there laws prohibiting such discrimination? If so, are they enforced?
  - 4.3 Are there any restrictions, in law or in practice, on the rights of persons with a mental disorder that do not exist for other members of the society, for

example, freedom from unwanted treatment, or any of the privacy rights discussed under Principle 1(5) below?

- 4.4 What are the methods by which such a determination can be made? For example:
    - a. Is there forced labour?
    - b. Is comparable labour remunerated at the same rate when performed by those who are not mentally ill?
    - c. What is the form of remuneration, i.e. is the patient ever paid with privileges, tokens for privileges or items, available for redemption only within the confines of the treating facility, or even freedom from punishment? In short, is the patient coerced into performing free or underpaid labour?
    - d. Assuming the patient is paid, is this payment made directly to the patient in the local currency? Is it paid to someone else, even for safekeeping?
  - 4.5 Are there affirmative action programs for those with mental disorders?
5. *Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonments.*
- 5.1 Are persons with a mental disorder able to exercise civil, political, economic, social and cultural rights, such as:
    - a. the right to marry?
    - b. the right to own property?
    - c. the right to freedom of thought, conscience and religion?
    - d. the right to vote?
    - e. the right to freedom of opinion and expression?
    - f. the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment?
    - g. the right to an education? (See also Principle 2, Protection of Minors.)
    - h. the right to have children and to maintain parental rights?
    - i. the right to freedom of movement and choice of residence (assuming the individual has not been involuntarily committed)?
    - j. the right to "qualified legal assistance to protect their rights, and to have their condition taken fully into account in any legal proceedings."<sup>2</sup>

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<sup>2</sup> See the United Nations' *Declaration on the Rights of Disabled Persons*, 1975, Principle 11, in Appendix 3.

- k. the right to access to one's own medical records? (See also Principle 19, below.)
- l. the right to freedom from cruel, inhuman or degrading treatment or punishment? (See generally, the *Declaration of the Rights of Disabled Persons*, in Appendix 3.)

6. ***Any Decisions that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.***

6.1 What is the concept of capacity, or the lack thereof, within the country's legal system?

6.2 How is the concept limited?

a. Incapacity to do what?

- i. stand trial?
- ii. write a will?
- iii. enter contracts?
- iv. make treatment decisions, including consent to release of information, experimental treatment or clinical trials?

b. For how long?

- i. Is there any provision or procedure for restoration to capacity?
- ii. Is the matter reviewed automatically? If so, how often? Conversely, is the matter reviewed only upon request? If so, upon whose request?

6.3 What is the procedure for the determination of a person's legal capacity?

6.4 What are the consequences arising out of the decision that a person lacks legal capacity?

6.5 Is the person represented at the capacity hearing? By whom is any such person represented?

- 6.6 What measures are taken in case the person lacks sufficient means to pay for representation?
  - 6.7 May the patient's counsel also represent any other interested party? For example, a mental health treatment facility (or its personnel) in the same proceedings, or a member of the person's family?
  - 6.8 Who makes determinations as to conflict of interest? Do they apply a standard in making this determination? If so, what standard is applied?
  - 6.9 Does the person have the right to an appeal? If so, what is the appeal procedure? Is the appeal made to the same body or to a higher authority? Are appeals accepted on the basis of substantive or procedural problems, or both?
  - 6.10 Does anyone else have the right to appeal? If so, then who else has the right to do so? (Other possibilities might include treatment facilities, relatives, heirs, representatives or guardians, or those acting on behalf of minor children of the person in question)
7. *Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.*
- 7.1 If a person is considered unable to manage his or her own affairs, what measures are taken to protect his or her interests? For example, the appointment of a guardian, a personal representative or a trustee?
  - 7.2 What are the fiduciary duties of this representative? What, if any, are the consequences of failure to fulfil any such fiduciary duty? Are there administrative, civil and/or criminal penalties in the event of the abuse or exploitation of the incapacitated person?

## PRINCIPLE 2 - PROTECTION OF MINORS

*Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.*

1. What, if any, are the special measures taken to ensure the protection of minors with mental disorder?
2. What are the diagnostic categories for children?
3. Are those mental health professionals who treat minors with mental disorders specifically trained to work with children?
4. Do minor children have additional rights to confidentiality, for example, are juvenile court records sealed until the minor attains majority?
5. At what age are minors deemed to be able to give informed consent to treatment? At what age are minors deemed to be able to give informed consent to release of information? Is this age different from the age at which a person is deemed to have reached majority for other purposes, for example, voting, military service, jury duty, etc.?
6. Is the appointment of a personal representative other than a family member possible? If so, in what event? If not, then are there any special provisions for children in abusive or exploitative families? Who is generally appointed as a personal representative in the event of orphanage, abandonment, or court ordered termination of parental custody?
7. What, if any, are the provisions for education for minors with mental disorders, both within mental health treatment facilities and in the community? Are these schools or programmes accredited in the same manner as are other schools in the community?
8. Is there any special provision for the minor children of the mentally ill? For example, how are they cared for during a parent's hospitalization or after the parent has been determined to lack the capacity to care for the child?



### PRINCIPLE 3 - LIFE IN THE COMMUNITY

*Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.*

1. Is every person with a mental disorder able to live and work outside the hospital, assuming that they are medically stable?
2. Specifically, are there living arrangements tailored to the needs of those with mental disorders? If so, do they exist in adequate quantity to fulfil the need within the community? Are these facilities public or private?
3. Are there possibilities for those with mental disorders to work outside the hospital? Are there vocational rehabilitation programs to foster independence?
4. Are these facilities and/or programmes within the financial reach of the population for which they were designed?
5. What is the average duration of an inpatient psychiatric hospitalization?
  - a. In a given facility?
  - b. In a given region?
  - c. In the country as a whole?
6. Is there a specific budget set aside by one or more ministries to support reintegration efforts? How is it allocated?
7. What are the measures taken for psychosocial rehabilitation during and after hospitalization?
8. What social and health services are available within the community?
9. Are patients oriented to the available social and health services in their community prior to discharge?
10. What are the contacts with other treatment facilities, schools or social agencies?
11. What are the living and aftercare arrangements for patients after discharge from an inpatient mental health treatment facility? For example, are there halfway houses, supportive apartments, community mental health centres, partial hospital or day programs, crisis centres? Are those available as parts of a gradual plan of social reintegration?

12. Are these facilities sufficient to meet the needs within the community?
13. Are these facilities inspected by the health authorities? If so, which ones?
14. Are these facilities accredited and/or licensed in the same manner as are hospitals?
15. What are the consequences, if any, of failure to achieve any such accreditation or license?
16. Are there opportunities for private housing initiatives to be state-funded? For example, are there municipal bonds issued for the construction and maintenance of such housing facilities?

## PRINCIPLE 4 - DETERMINATION OF MENTAL ILLNESS

1. *A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.*
  - 1.1 What are the standards for the determination of mental disorder?(ICD; DSM-IV, other?)
  - 2.1 In what way is every patient evaluated?
    - a. Who performs the evaluation?
    - b. Where are the evaluations performed?
    - c. Is there access to other assessment tools? For example, is there access to neurological testing? Is there access to psychological testing? Are there laboratory facilities equipped for urine and blood tests? Are medical records generally available, assuming the patient has given informed consent to their review?
2. *A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.*
  - 2.1 Does the political, economic or social status of the person have any bearing on a diagnosis of mental disorder?
  - 2.2 Does membership in any cultural, racial or religious group have any bearing on a diagnosis of mental disorder?
  - 2.3 Does any factor not directly relevant to the person's mental status have any bearing on a diagnosis of mental disorder?
  - 2.4 Is non-conformity with prevailing moral, social, cultural or political values considered to be a determining factor in the diagnosis of a mental disorder?
3. *Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in the diagnosis of mental illness.*
  - 3.1 Are family or professional conflicts considered to be a determining factor in the diagnosis of mental disorder?
  - 3.2 Are any other factors not directly relevant to the person's mental status considered to be a determining factor in the diagnosis of mental disorder?

4. ***A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.***

Does past treatment or hospitalization for mental disorder in itself justify any present or future determination of mental disorder?

5. ***No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.***

In summary, are people ever diagnosed as mentally ill for reasons other than mental status? Is there data available to establish the correlations listed above, if they should exist? For example, are there comparative studies of what groups have been hospitalized, under what conditions, for how long, which contain breakdowns of these factors, such as race, religion, language, political persuasion, etc?

## PRINCIPLE 5 - MEDICAL EXAMINATION

*No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.*

1. Is anyone compelled to undergo medical examination if legal provision governing this is absent?
2. Under domestic law, can a person be compelled to undergo a mental status examination (MSE)? If so, when? Examples might include an MSE being included as a part of emergency room procedure. Such an examination might also be made under court order to determine capacity, competency, parental fitness, parole status, etc.
3. Who performs such examinations?
4. Who pays for the performance of these examinations?
5. Is informed consent required prior to the MSE? Is informed consent obtained prior to the MSE?
6. Does the patient have the right and/or the opportunity to seek a second opinion?

## **PRINCIPLE 6 - CONFIDENTIALITY**

***The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected.***

1. Do all those with legal access to the patient and/or his records fully respect the patient's right to confidentiality?
2. Who specifically has the duty of maintaining confidentiality? (Consider information divulged in self-help groups or outside the normal treatment setting. Consider also information divulged to non-clinical staff of the treating facility.)
3. How is confidentiality protected?
4. Are written consent forms presented in a language and format that the patient can fully understand and required to be signed by the patient or his legal representative prior to any release of information?
5. If so, are the consents general or limited?
6. If they are limited, in what way are they limited? For example, can the patient control to whom his confidential information will be conveyed? Can the patient limit the subject matter of the information to be conveyed? Can the patient place a time limit on the consent? Can the patient limit the purpose for which the information can be used?
7. What are the consequences and/or penalties for failure to respect and protect a patient's confidentiality?
8. Under what circumstances can confidentiality be breached?
9. Under what circumstances *must* confidentiality be breached?  
(Justifiable circumstances for such a breach might include life threatening emergencies, public safety, or under court order.)

## PRINCIPLE 7 - ROLE OF COMMUNITY AND CULTURE

1. *Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.*
  - 1.1 How far away (consider both distance and difficulty of standard journey) from his home is the patient being treated? Do comparable facilities exist closer to the patient's home?
2. *Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.*
  - 2.1 How long after completed treatment does the patient return to the community?
  - 2.2 How is the patient reintegrated into the community? (See Principle 3, above.)
3. *Every patient shall have the right to treatment suited to his or her cultural background.*
  - 3.1 Is every patient treated taking into account his or her cultural background?
  - 3.2 How is this ensured?
  - 3.3 What are the limitations on this principle? For example, if a patient were to refuse treatment on religious grounds, carried a diagnosis of schizophrenia, and when unmedicated, suffered from religious delusions, would the patient's religious beliefs be respected, or would the treating facility request that a guardian be appointed in order to gain legal consent for treatment?

## PRINCIPLE 8 - STANDARDS OF CARE

1. ***Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.***

- 1.1 Are quality assurance standards being upheld? If so, what standards?<sup>3</sup>
- 1.2 Are there differences between the standards of social and health care for those who suffer from mental, as opposed to physical, disorders or illnesses?
- 1.3 Does every patient receive such health and social care as is appropriate to his/her health needs?
- 1.4 What are the standards of care compared to those for physically ill persons?
- 1.5 If patients are unable to care for their own hygiene, are they assisted in doing so?
- 1.6 As an outpatient, how long does it take for a person in need to be seen by a mental health practitioner?
- 1.7 What procedures are in place for emergency treatment?
- 1.8 Do psychiatric patients routinely receive a full medical examination on admission? If not, when do they receive one, if at all?
- 1.9 What is the frequency of medical examination thereafter for both chronic and acute patients?
- 1.10 Does every patient have some space which may be considered his/her own?
- 1.11 Are essential drugs for the treatment of mental disorders available? (See Principle 10, below.)

2. ***Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.***

- 2.1 How is each patient protected from harm, including unjustified medication?

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<sup>3</sup> Consider those set forth in *Quality Assurance in Mental Health Care - Vol. 1*, WHO - Division of Mental Health, Geneva, 1994.



- 2.2 How are treatment modalities monitored? Are treatment decisions, particularly medication review, plans for restraint or isolation, discussed in multidisciplinary staff meetings?
- 2.3 Are treatment decisions reviewed on a regular basis? If so, at what intervals? If not, how are they made? Are all staff members trained in appropriate and least restrictive methods of restraint, as well as cardio-pulmonary resuscitation and basic first aid? (See §§2.11-14, below.)
- 2.4 Which forms of restraint are allowed and which are not?
- 2.5 Are there written procedures for the use of isolation and restraint?
- 2.6 Are medication orders left such that nursing staff may administer drugs on an "as needed" basis? If so, is this practice ever abused for the convenience of staff?
- 2.7 Do all staff members routinely receive supervision from other staff members?
- 2.8 How is each patient protected from abuse by other patients or staff?
- 2.9 Are violent patients housed with non-violent patients?
- 2.10 What is the staff to patient ratio during the day shift? What is the staff to patient ratio during the night shift? Are these ratios adequate to cover the acuity of need on the unit or ward?
- 2.11 Is the unit overpopulated?
- 2.12 What are the provisions made for dangerous items or materials, "sharps"? Are they kept in a locked or inaccessible area?
- 2.13 Are patient's belongings searched upon admission and after off grounds passes?
- 2.14 Are patient's tested for communicable diseases prior to admission? In the case of the human immunodeficiency virus, is this considered violative of the patients human rights? Are universal precautions observed? Are safety measures taken against intimate contact between patients or between patients and staff?

## **PRINCIPLE 9 - TREATMENT**

1. ***Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.***
  - 1.1 Is each patient treated in the least restrictive environment which is medically necessary and with the least restrictive or intrusive form of treatment that is medically necessary? (See Principle 8, §§2.2-3, above.)
  - 1.2 How often is the need for restrictions re-evaluated?
2. ***The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.***
  - 2.1 Is there an individually prescribed plan for treatment and care?
  - 2.2 Is it discussed with the patient? Does the patient sign the treatment plan?
  - 2.3 Is the patient's care discussed with the family, after consent from the patient or personal representative? Upon request, or as a matter of course?
  - 2.4 Is the patient kept informed about his own progress?
  - 2.5 How often is the treatment plan reviewed? Is the treatment plan automatically reviewed periodically?
  - 2.6 How often are staff meetings held to discuss the patient's care plan?
  - 2.7 Is the treatment plan revised as necessary?
  - 2.8 Who provides the treatment?
  - 2.9 Is the treatment plan appropriate for the patient's culture, religion, clinical condition and age?
3. ***Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.***

- 3.1 What are the standards of ethics to which mental health providers refer?
  - 3.2 Is there evidence to suggest that mental health care providers have taken any part in torture or other cruel, inhuman or degrading treatment or punishment?
  - 3.3 Are mental health care providers required, under local law, to report torture or other cruel, inhuman or degrading treatment of patients of which they are aware? To whom?
  - 3.4 Is there any evidence which suggests that mentally ill patients are subjected to abuse more often than patients in general? What are the safeguards against such abuse? (See Principle 8, §2, above.)
  - 3.5 What are the consequences of established violations of the standards of ethics in force?
4. *The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.*
- 4.1 Does treatment of every patient preserve and enhance personal autonomy?
  - 4.2 To that end, are the rights of the patient safeguarded?
  - 4.3 Is individual empowerment a treatment priority? (See Principle 8, §1.9, above.)
  - 4.4 Is outpatient care preferred over inpatient care?
  - 4.5 Is community-based care preferred over institutional care?
  - 4.6 Do supportive living situations exist in the community so that those nominally able to live outside the hospital are provided with an opportunity to do so?

## **PRINCIPLE 10 - MEDICATION**

1. ***Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.***
  - 1.1 Are there any written guidelines on the indications and use of drug therapies?
  - 1.2 Does use of drug therapy follow internationally accepted guidelines for mental health care?<sup>4</sup>
  - 1.3 Is all medication employed of a known or demonstrated efficacy? Is it approved for use by local law? Is all medication approved for the specific purpose for which it is being employed?
  - 1.4 Is medication ever administered as a punishment or for the convenience of others?
  - 1.5 How is it ensured that medication is administered for therapeutic and/or diagnostic purposes only?
2. ***All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.***
  - 2.1 Who is responsible for prescription and administration of medication?
  - 2.2 Are staff members taking part in decisions regarding patient medication?
  - 2.3 Is all medication recorded? By whom?
  - 2.4 Where is all medication recorded?
  - 2.5 Which medical drugs are included in the basic drug supply of the mental health facility?
  - 2.6 Which psychiatric drugs are included in this basic drug supply?

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<sup>4</sup> Consider, for instance, *Essential Drugs in Psychiatry*, WHO, Geneva, 1994.

- 2.7 Does the supply include the psychoactive essential drugs listed by WHO?<sup>5</sup>
- 2.8 Which neuropsychiatric drugs are available within one hour's walk?
- 2.9 Who prescribes them?
- 2.10 What is the nature of administration? Is medication administered in a clinic, a hospital, in the patient's home, group home or supportive apartment?
- 2.11 What quality assurance measures are taken to assure proper administration?
- 2.12 What follow up care is provided? For example, are periodic blood samples taken to determine lithium levels, are depressed patients monitored routinely for suicidality, are those receiving antipsychotic medications routinely monitored for EPS?
- 2.13 Are routine medication inventories conducted in order to detect theft or unauthorized use? Are they performed by different people?

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<sup>5</sup> Amitriptyline and/or imipramine, biperiden, carbamazepine, chlorpromazine and haloperidol, clomipramine, diazepam, fluphenazine, lithium carbonate, and phenobarbital. (WHO. *The use of essential drugs* (WHO Technical Report Series No. 850). Geneva, WHO, 1995.

## **PRINCIPLE 11 - CONSENT TO TREATMENT**

**1. *No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.***

- 1.1 Is the patient's informed consent requested prior to treatment?
- 1.2 Do patients give informed consent prior to treatment? If not, is the refusal to consent respected, or is treatment administered against the patient's will?
- 1.3 Is the patient requested to sign a consent form? Do patients generally sign consent forms?
- 1.4 Is the patient informed that the treatment cannot be legally administered without his or her consent?
- 1.5 Is the patient informed that the consent is revocable?
- 1.6 How is the consent obtained?

**2. *Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:***

- (a) *The diagnostic assessment;*
- (b) *The purpose, method, likely duration and expected benefit of the proposed treatment;*
- (c) *Alternative modes of treatment, including those less intrusive;*
- (d) *Possible pain or discomfort, risks and side-effects of the proposed treatment.*

- 2.1 Are patients entitled to consent to treatment freely? Are threats or improper inducements made to patients to lead them to consent to treatment? (Examples include undue threat of reducing one's access to treatment, undue threat of altering one's living conditions and undue inducements by reference to the impact of declining treatment on third parties.)
- 2.2 Are patients informed of a diagnostic assessment?
- 2.3 Are patients informed of the purpose, method, likely duration and expected benefit of the proposed treatment?
- 2.4 Are patients informed of alternative modes of treatment?
- 2.5 Are patients informed of the possible pain or discomfort, risks and side effects of the proposed treatment?

- 2.6 In what form or language is this information conveyed?
- 2.7 Does all this information exist in writing in an appropriate language? If so, is this documentation given to the patient? Can the patient in question read? If not, is this document read to him or her?
- 2.8 What are the instruments put into place to foster adequate information for patients?
- 2.9 Is the patient competent to give informed consent? If not, then who is, and is that individual or body consulted in accordance with local law? (See Principle 1 ( 6), above.)
3. *A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.*
  - 3.1 Is the patient guaranteed the right and time to request the presence of a person or persons of his or her choosing during the procedure for granting consent?
  - 3.2 Who may be present during the procedure for granting consent?
  - 3.3 May the patient consult with the person or persons in private prior to granting such consent?
4. *A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient.*
  - 4.1 Is the patient informed that he has the right to refuse or stop treatment?
  - 4.2 Is the patient informed about the consequences of refusing or stopping treatment?
  - 4.3 Are patients ever made to fear retribution for refusal of treatment?
  - 4.4 Can treatment be compulsory? If so, when?
  - 4.5 Is all involuntary treatment (and justification) documented in the patient's record?
5. *A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.*

- 5.1 Are patients ever invited or induced to waive the right to informed consent?
- 5.2 What protections exist to prevent this practice?
6. ***Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:***
  - (a) ***The patient is, at the relevant time, held as an involuntary patient;***
  - (b) ***An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;***
  - (c) ***The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.***
- 6.1 Is treatment ever given without consent? If so when?
- 6.2 If there is treatment without consent, are the following three conditions satisfied?
  - a. Is the patient involuntary?
  - b. Is an independent authority satisfied that the patient lacks the capacity to give or withhold informed consent or that the patient unreasonably withholds such consent?
  - c. Is the independent authority satisfied that the proposed treatment is in the best interests of the patient's health needs?
- 6.3 In what percentage of all treated cases is mandatory treatment administered?
- 6.4 Are there studies or data available which demonstrate the long-term efficacy of involuntary as opposed to voluntary treatment?
- 6.5 What of the possibility of restoration to capacity? Is it likely? If so, could the contemplated treatment be delayed until such time as capacity is restored, without undue harm as a result of such delay? (See Principle 11(9), below.)
7. ***Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf.***



- 7.1 Is the personal representative authorized to consent, on the patient's behalf, to:
  - a. Sterilization?
  - b. Medical or surgical procedures?
  - c. Psychosurgery or other intrusive and irreversible treatments for mental disorder?
  - d. Clinical trials and experimental treatment?
- 7.2 If the personal representative withholds consent, is this decision respected?
- 7.3 Is there an appeal process regarding the personal representative and/or his/her decisions? Who may make such an appeal? Possibilities include the patient, the treating facility, the clinician, the patient's family members, etc.
8. *Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.*
  - 8.1 Who may determine the emergency status of a situation? How many signatures are required in order to involuntarily commit a person? Whose signatures are required?
  - 8.2 What is considered to be an emergency situation? Is the concept of emergency or urgency limited to imminent danger of harm to self or others? If not, what standard is applied?
  - 8.3 Does the category of emergency involuntary treatment specifically exclude:
    - a. Sterilization?
    - b. Psychosurgery or other intrusive and irreversible treatments for mental disorder?
    - c. Clinical trials and experimental treatment?
  - 8.4 How long is such treatment extended?
  - 8.5 Does involuntary commitment require a court order?
  - 8.6 What are the time limits on involuntary commitment? Are these fixed by statute and reviewed periodically as a matter of course? Conversely, are time limits set by the court, the personal representative, or by the clinicians authorising the involuntary commitment?

9. *Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.*
  - 9.1 Having been given treatment without consent, is the patient nevertheless informed about the nature of the treatment, including any side effects, and any possible alternatives?
  - 9.2 How has the patient been involved in the development of the treatment plan to the extent possible?
10. *All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.*
  - 10.1 Is all treatment recorded?
  - 10.2 In what format?
  - 10.3 Where?
  - 10.4 When?
  - 10.5 By whom?
  - 10.6 Are there recognized standards of documentation, especially regarding medication?
11. *Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.*
  - 11.1 Under what circumstances is physical restraint or involuntary seclusion employed?
  - 11.2 What are the specific objectives of the use of physical restraint or involuntary seclusion?

- 11.3 How long are patients restrained or secluded? Is the practice restricted to a necessary period?
- 11.4 Is every incident of physical restraint or involuntary seclusion documented? Does this documentation include the justification for, and the nature and extent of the restraint or seclusion? Where is this documentation placed?
- 11.5 Under what conditions is the restrained patient kept?
- 11.6 Who is informed about the patient's physical restraint or involuntary seclusion? After what period of time?

**12. *Sterilization shall never be carried out as a treatment for mental illness.***

- 12.1 Is sterilization performed as a treatment for mental disorder? If so, under what circumstances?
- 12.2 How often has this happened recently (e.g. during the last 18 months)?
- 12.3 Does this occur more or less frequently than it has in the past?
- 12.4 Is sterilization performed as a treatment, or for other stated purposes, on any group disproportionately?

**13. *A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.***

- 13.1 In case a major medical or surgical procedure is carried out on a patient with a mental disorder, does the patient give his informed consent?
- 13.2 What is done if the patient is unable to do so?
- 13.3 What are the reasons for this procedure?
- 13.4 Is the procedure necessary immediately, or could it be delayed until the patient is restored to capacity to make this sort of decision independently without causing the patient undue harm? Who makes the determination?

**14. *Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health***

*facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.*

14.1 When are psychosurgery and other intrusive and irreversible treatments generally performed?

14.2 Is it ensured that the patient is not an involuntary patient?

14.3 Who gives approval?

14.4 Can a guardian or personal representative's authority extend this far?

15. *Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.*

15.1 Are patients with mental disorders participants in clinical trials or experimental treatment? If so, when?

15.2 Is informed consent required? (See Principle 11(1).) Does the patient give informed consent?

15.3 If the patient is unable to do so, who gives approval?

15.4 Does a personal representative or guardian have the authority to consent to the patient's participation in clinical trials or experimental treatment?

16. *In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.*

16.1 Are patients treated without informed consent? ( See also Principle 11(1).)

16.2 Are psychosurgery and other irreversible or intrusive treatments carried out on patients?

16.3 If the answer to 16.1 and 16.2. is "yes", then:

Who is given the right to appeal to an authority? In the event that the court determines that the actions taken were not warranted or were improperly authorized, what are the consequences of such a determination? For example, in the event that irreversible treatment has been carried out, does the patient or his family have an actionable claim in civil court against the treating facility and/or clinicians? Is such treatment considered illegal? If so, can criminal penalties be enforced against the facility and/or clinician in the event that the process was only invasive and not irreversible?

- 16.4 What is the appropriate authority for such an appeal?

## PRINCIPLE 12 - NOTICE OF RIGHTS

1. ***A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.***
  - 1.1 Is the patient in a mental health facility informed about all his/her rights?
  - 1.2 When is the patient informed?
  - 1.3 Is the patient provided with this information in a format and language he/she can understand?
  - 1.4 Does the patient know how to exercise these rights?
  - 1.5 Does a patient with the necessary capacity have the right to nominate a person who should be informed on his/her behalf?
  - 1.6 Does the patient have the right to nominate a person to represent his/her interests with the authorities of the facility?
  - 1.7 Is the patient free from punishment or legitimate fear of retribution with regard to the exercise of his or her rights?
  - 1.8 In case the patient is unable to understand such information, who is informed on his/her behalf?
2. ***If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.***
  - 2.1 Who is informed on the patient's behalf?
  - 2.2 Who represents the patient with the authorities?
    - a. a friend?
    - b. a defined personal representative?
3. ***A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.***
  - 3.1 Who appoints this representative?
  - 3.2 What are the substantive and temporal limitations on the authority of this personal representative? (See also Principle 1(7), above.)

## PRINCIPLE 13 - RIGHTS AND CONDITIONS IN MENTAL HEALTH FACILITIES

1. *Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:*
  - (a) *Recognition everywhere as a person before the law;*
  - (b) *Privacy;*
  - (c) *Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;*
  - (d) *Freedom of religion or belief.*
- 1.1 Are internationally-accepted guidelines for mental health care being followed?<sup>6</sup>
- 1.2 Is there full respect for recognition of the patient as a person before the law?
- 1.3 Is there full respect for the patient's privacy? For example:
  - a. Can toilets and bathrooms be locked from the inside?
  - b. If body inspection or urine screens are necessary, is full respect for the person's privacy accorded?
- 1.4 Is there full respect for the sexual autonomy of the patient? Is sexual harassment or abuse of patients tolerated?
- 1.5 Is there full respect for the patient's freedom of communication, for instance:
  - a. Does the patient have the right to communicate with other persons in the facility?
  - b. Is the patient free to send and receive uncensored private communication?
  - c. Is the patient free to receive, in private, visits from counsel or a personal representative and from other visitors?
- 1.6 Is the patient free to express and practice his/her religion or belief?
- 1.7 Is the patient free to access newspapers, radio and television?

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<sup>6</sup>Consider, for instance, Essential Treatments in Psychiatry WHO, Geneva, (1994).

**2. *The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:***

- (a) *Facilities for recreational and leisure activities;***
- (b) *Facilities for education;***
- (c) *Facilities to purchase or receive items for daily living, recreation and communication;***
- (d) *Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.***

2.1 Are the living conditions in a mental health facility as close as possible to those of the normal life of persons of similar age?

2.2 What are the possibilities for recreational and leisure activities within the mental health facility?

2.3 What are the possibilities for education? Are there special requirements for the education of minors? (See Principle 2, § 7, above.)

2.4 Can patients purchase or receive items for daily living, recreation and communication?

2.5 What are the possibilities provided for a patient's active occupation? Is the occupation suited to his/her social/cultural background?

2.6 Do guidelines exist to indicate the range of activities available to patients?

2.7 How is the patient encouraged to make use of such possibilities?

**3. *In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.***

3.1 If a patient wishes to work, is he/she allowed to choose the kind of work to be performed?

3.2 Are patients subjected to forced and/or unpaid labour?

3.3 What remuneration does the patient receive for his/her work? What form does it take? ( See Principle 1(4), § 4.4, above.)



4. *The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.*
- 4.1 What is done to promote reintegration into the community?
- 4.2 What are the measures taken for psychosocial rehabilitation?
- 4.3 Is there vocational guidance and training?
- 4.4 Are there placement services to enable patients to secure or retain employment in the community?
- 4.5 What linkage exists between mental health care facilities and:
- patients' employers?
  - schools and other social agencies in the facility's area?

## **PRINCIPLE 14 - RESOURCES FOR MENTAL HEALTH FACILITIES**

**1. *A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:***

- (a) *Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;***
- (b) *Diagnostic and therapeutic equipment for the patient;***
- (c) *Appropriate professional care;***
- (d) *Adequate, regular and comprehensive treatment, including supplies of medication.***

1.1 What are the resources for the mental health facilities in comparison to those for other health facilities? What is the access for mental health treatment relative to treatment for physical disorders?

1.2 What is the staff member/patient ratio? (In general and in a given facility in particular)

1.3 Is there reasonable space for indicated treatment procedures, recreational activities and receiving visitors? (In general and in a given facility in particular)

1.4 Is each patient provided with privacy and a programme of appropriate and active therapy? (In general and in a given facility in particular)

1.5 Is funding for mental health services dependent, in any way, on political allegiance or persuasion?

1.6 Is funding for mental health services dependent, in any way, on religious belief or persuasion?

**2. *Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the present Principles.***

2.1 By whom is the mental health facility inspected?

2.2 How frequently is the mental health facility inspected?

2.3 What are the accreditation requirements and procedures? What are the standards used? What are the consequences of accreditation or the lack thereof?

2.4 What percentage of institutions is denied accreditation?

## PRINCIPLE 15 - ADMISSION PRINCIPLES

**1. *Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.***

- 1.1 Is there a voluntary admission procedure available and in use?
- 1.2 Are involuntary admissions avoided? If so, what is done to avoid involuntary admission?
- 1.3 What is the proportion of voluntary to involuntary admissions?
- 1.4 How often did involuntary admission happen recently (e.g. during the last 18 months)? Under what circumstances?
- 1.5 What are the options to involuntary inpatient admission (e.g. outpatient treatment, halfway houses, supportive apartments, partial hospitalizations)?

**2. *Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.***

How is access to a mental health facility administered? What, if any, are the differences in administration for:

- a. Voluntary vs. involuntary patients?
- b. Insured vs. uninsured patients?
- c. Public vs. private patients?
- d. Forensic vs. general population patients?
- e. Violent vs. non-violent patients?

**3. *Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.***

- 3.1 Is every voluntary patient free to leave the mental health facility at any time? What limitations are placed on this freedom? For example, if a patient wants to leave the grounds of the facility, must he/she request a pass? Are pass requests generally approved? If the patient wishes to discharge himself against medical advice, what is the procedure by which he may do so?
- 3.2 Is he/she informed of the right to request passes or to seek discharge, even against medical advice?

- 3.3 Under which circumstances is a patient not free to leave the mental health facility?
- 3.4 Are newly-arrived inpatients made to feel welcome on admission?
- 3.5 How are they informed about the main rules of the facility?
- 3.6 How are they informed of their rights? When are they informed of their rights? Are patients' rights listed and posted in a prominent place accessible to patients? (See also Principle 12, § 1, above.)
- 3.7 Is the discharge plan discussed by all staff and with the patient concerned?
- 3.8 Whenever a patient is referred to another facility:
- is there a standard information form given to the patient?
  - is such an information form sent to the facility?
- 3.9 What follow-up measures are taken? Are patients oriented in terms of other health and social services available in their communities?
- 3.10 Is medication adequately followed up - i.e. are prescriptions transferred? Are medical records transferred, particularly the medication records? Assuming a discharge to the community, is the patient aware of the procedure by and location from which he/she may obtain his/her medication? Is there direct contact between clinicians in the transmitting and the receiving facility? What, if any, are the fallback procedures?

## PRINCIPLE 16 - INVOLUNTARY ADMISSION

1. *A person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:*
  - (a) *That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or*
  - (b) *That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.*

*In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.*

- 1.1 Who makes the decision on a person's involuntary admission?
- 1.2 What are the reasons for an involuntary admission?
- 1.3 Are second opinions required in order to authorise involuntary admission? If so, then
  - who chooses this second mental health practitioner?
  - is there a separate mental status examination?
  - are the two examinations held and documented separately?
  - is the second mental health practitioner from a different treatment facility?
  - does the second mental health practitioner have access to all records, or is such access deemed prejudicial?
- 1.4 Are the local laws drafted in such a way as to encourage involuntary admissions? For example, if a voluntary patient cannot be retained in the hospital as an involuntary patient, but rather must be discharged against medical advice and subsequently re-admitted on an involuntary basis, then, as a practical matter, the impetus is to admit on an involuntary basis initially, whether the status is justified or not.

2. ***Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.***

2.1 How long are patients retained involuntarily? Is this period of time determined, or limited, by statute?

2.2 Does the patient know the grounds of his/her admission?

2.3 Who else is informed of an involuntary admission? Is the patient's consent to this required? What is the procedure for minors who are involuntarily admitted? Are parents or guardians routinely informed?

3. ***A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.***

3.1 Has the mental health facility receiving involuntary patients been designated by an authority competent to do so?

3.2 What is the competent authority to designate a mental health facility as appropriate to receive involuntary patients of specific classifications? For example, is the facility specifically designated as properly equipped to house and treat forensic patients?

## PRINCIPLE 17 - REVIEW BODY

1. *The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.*

- 1.1 What is the nature of the body which reviews the involuntary admission or retention of a patient in a mental health facility?
- 1.2 What is the composition of this review body? Are members appointed, elected, hired? By whom?
- 1.3 Does the review body get any advice? From whom? In what form? For example, records' review, history, independent testimony?
- 1.4 How is this advice being applied?

2. *The initial review of the review body, as required by paragraph 2 of Principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.*

What is the delay for an initial review after the decision to admit or retain a person?

3. *The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.*

Is the review body bound to issue its decision within a specified time frame? If so, how long? If not, what is the typical time period in which the review body issues its decision?

4. *An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.*

At what intervals does the patient have the right to apply to the review body for release or voluntary status?

5. ***At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of principle 16 above are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.***

Under what conditions will the patient be discharged?

6. ***If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.***

6.1 Are mental health care providers *required*, by local law, to change the patient's status from involuntary to voluntary should the underlying conditions which justified the involuntary retention no longer be satisfied?

6.2 Are mental health care providers *allowed* by local law, to change the patient's status from involuntary to voluntary should the underlying conditions which justified the involuntary retention no longer be satisfied?

7. ***A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.***

7.1 Do patients or their guardians have the right to appeal the decision on admission to or retention in a mental health facility?



## PRINCIPLE 18 - PROCEDURAL SAFEGUARDS

1. *The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.*
  - 1.1 How is the patient represented in any complaint procedure or appeal?
  - 1.2 How is this representation financed?
2. *The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.*
  - 2.1 If a patient does not have an adequate command of the official language of the court, will the services of an interpreter be made available to the patient, without payment if necessary?
3. *The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.*
  - 3.1 Does the patient or his/her counsel have the right to request at any hearing an independent mental health report and other reports together with oral, written and other evidence? Who would pay for this independent assessment?
4. *Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.*
  - 4.1 Are copies of the patient's records (and any reports and documents to be submitted) given to the patient and to the patient's counsel as a matter of course?

- 4.2 If not, why?
- 4.3 If yes, when? Is the documentation provided sufficiently in advance of the hearing to provide adequate opportunity for review?
- 4.4 Is any document which is not given to the patient given to the patient's personal representative and counsel? If so, under what circumstances?
- 4.5 In case of withholding a document or part of a document, will the patient be informed?
- 4.6 Who else will be informed?
- 4.7 Are the reasons for this withholding given?
- 4.8 Is this withholding subject to a judicial review?
5. ***The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.***
  - 5.1 Does the patient have the right to attend, participate and be heard in a meaningful manner in any hearing?
  - 5.2 Who else has this right?
  - 5.1 Does the patient have the right to produce any evidence at any hearing?
6. ***If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.***
  - 6.1 Who may be present at a hearing?
  - 6.2 Who appoints the persons present at a hearing?
  - 6.3 Is the patient's request for the presence of a particular person at a hearing respected?
  - 6.4 Who else is entitled to make such a request and will such a request be respected? If not, why?
7. ***Any decision on whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.***

- 7.1 What are the rights of a patient in a hearing? Is the hearing public or private?
- 7.2 Who decides on this issue?
- 7.3 Is the patient's privacy respected and confidentiality maintained?
- 7.4 Is the privacy of other parties respected?
- 7.5 What are the personal representative's and the counsel's rights?
- 7.6 How is the patient or his/her representative informed about these rights?

8. *The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.*

- 8.1 In what form is the decision arising out of the hearing expressed?
- 8.2 How are the reasons for the decision given?
- 8.3 Who decides on the publication of the decision?
- 8.4 Does the patient receive copies of the judgment?
- 8.5 What is done to prevent intimidation of the patient?
- 8.6 What is done to make the patient feel at ease?

## PRINCIPLE 19 - ACCESS TO INFORMATION

1. *A patient (which term in the present Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.*
  - 1.1 Can patients access their medical records upon request?
  - 1.2 If not, why is this information withheld?
  - 1.3 If any information is withheld from the patient, who will receive notice of this?
  - 1.4 If not given to the patient, to whom, if anyone, is any such information given?
  - 1.5 Do patients review their records with a mental health practitioner, or independently?
  - 1.6 If any information is withheld from the patient, what sort of judicial procedure, if any, will result?
2. *Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.*
  - 2.1 What information does the patient's record include?
  - 2.2 Is information recorded in a legible format and does it ensure full confidentiality?
  - 2.3 May the patient or his personal representative insert comments or other documentation into his own record, provided he/she does not alter the existing record?

## PRINCIPLE 20 - CRIMINAL OFFENDERS

1. *The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.*
  - 1.1 Who is considered a criminal offender?
  - 1.2 Is there a status for those deemed not guilty by reason of insanity(NGRI)?
  - 1.3 If so, what are the specific procedures for those deemed to be NGRI?
  - 1.4 What about mentally ill persons out on bond? Can they be forced to seek treatment as a condition to their freedom? How is this treatment verified? Is there an adequate parole function so that orders for treatment are followed?
2. *All such persons should receive the best available mental health care as provided in Principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1 above.*
  - 2.1 Within the prison system, what is the nature of the health care for prisoners?
  - 2.2 Is health care guaranteed to prisoners?
  - 2.3 Is there a hospital section within each individual prison?
  - 2.4 Is mental health care guaranteed to prisoners?
  - 2.5 Is there a specific forensic hospital in which mentally-ill prisoners are treated locally?
  - 2.6 Are mentally-ill patients kept with the general prison population, or are they placed in private or semi-private cells or within the hospital section of the prison, assuming one exists?
3. *Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.*

- 3.1 May prisoners be admitted to mental health facilities?
- 3.2 If so, which ones, and for what purpose?
  - a. Restoration to competency? Before or after trial?
  - b. As part of sentencing? May part or all of the sentence be served within the mental health facility?
- 3.3 If the answer to 3.1 above is "yes", by whom may they be admitted?
- 3.4 Is the prisoner's right to informed consent to treatment respected in any case? How is the voluntariness of treatment safeguarded in light of restoration to competency to stand trial? For example, if the prisoner is deemed not competent but restorable, may he refuse the treatment which it is assumed would restore him to competence?

4. *Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.*

- 4.1 What are the special safeguards regarding the personal integrity of the mentally disordered prisoner, particularly with regard to limits on personal restraint and privacy?
- 4.2 Are the guards and prison officials trained to be aware of the basic symptoms of mental disorders?
- 4.3 Are the guards and prison officials trained to be sensitive to the needs of those with a mental disorder?
- 4.4 Are people with mental disorders disproportionately represented in the local prison system? Given that there is co-morbidity that exists naturally, are local ratios disproportionate to the representation of the mentally ill in other places? In other words, is mental disorder, in effect, being criminalized?
- 4.5 Is the prison system, as opposed to the health care system, being used to house and protect mentally-ill people?

## PRINCIPLE 21 - COMPLAINTS

*Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.*

1. What procedures exist by which a patient may make a complaint about his experience in the mental health system?
2. Are there written procedures available for dealing with complaints from patients and facilities?
3. Is submission, investigation and resolution of complaints guaranteed?
4. What level of authority deals with complaints?
5. Is there a follow up procedure whereby cases are reviewed in order to safeguard against retribution towards patients for filing complaints?

## PRINCIPLE 22 - MONITORING AND REMEDIES

*States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.*

1. What is done by the state to promote compliance with the present principles?
2. Is there an inspection scheme for mental health facilities?
3. What is the procedure in case of professional misconduct or violation of the rights of a patient?
4. Does compliance with the present principles affect accreditation or professional licences?
5. What are the consequences of lack of compliance? For example, can facilities be closed, denied reimbursement by third party payers or placed under guardianship?
6. Are there criminal penalties as well as administrative ones available? Are they enforced?
7. Are intra- and international records kept and cross-indexed so that a person deemed to have been abusive of or negligent toward a mental patient does not simply enter another state or province or obtain another license to practice?

## **PRINCIPLE 23 - IMPLEMENTATION**

**1. *States should implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.***

- 1.1 What measures (legislative, judicial, administrative, educational and others) are taken to implement the present principles?
- 1.2 How frequently are these measures reviewed?
- 1.3 Is there a strategy to ensure implementation and continued adequate enforcement of the present principles?
- 1.4 How is mental health promoted?
- 1.5 Who participates in the preparation and maintenance of mental health programmes?
- 1.6 Is there a specific governmental body whose task it is to promote and maintain quality of mental health treatment?

**2. *States shall make the present Principles widely known by appropriate and active means.***

- 2.1 How are the Principles disseminated?
- 2.2 Is there a dissemination strategy?
- 2.3 Are the contents of the Principles made known in laymen's terms?
- 2.4 Are the contents of these Principles made known in any local language?



## **PRINCIPLE 24 - SCOPE OF PRINCIPLES RELATING TO MENTAL HEALTH FACILITIES**

*The present Principles apply to all persons who are admitted to a mental health facility.*

1. Do the present Principles apply to all persons who are admitted to mental health facilities?
2. If not, to which types of patients are the present Principles inapplicable, when, under what circumstances, for how long, etc.?

## **PRINCIPLE 25 - SAVING OF EXISTING RIGHTS**

*There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that the present Principles do not recognize such rights or that they recognize them to a lesser extent.*

1. Are these Principles seen as a minimum standard or threshold to be met in terms of the rights of the mentally ill, or are they seen as a ceiling?
2. Has the enactment of the present Principles served in any way to limit, restrict, or lower the standards of the rights and treatment of the mentally ill?

1. The first step in the process of the development of a new product is the identification of a market need.

2. The second step is the selection of a product concept that meets the market need.

3. The third step is the development of a product prototype that can be used to test the product concept.

4. The fourth step is the testing of the product prototype to determine if it meets the market need.

5. The fifth step is the development of a final product that meets the market need.

6. The sixth step is the marketing of the final product to the market.

7. The seventh step is the evaluation of the product's performance in the market.

8. The eighth step is the modification of the product if necessary.

## PART II

10/10/10

# Checklist

	YES	NO
1. Can persons with mental disorders exercise their civil, economic and cultural rights, e.g.		
1.1 the right to marry.		
1.2 the right to own property		
1.3 the right to vote.		
1.4 the right to have children and to maintain parental rights.		
1.5 the right to access to one's own medical records.		
1.6 the right to freedom from cruel, inhuman or degrading treatment or punishment?		
2. Are there laws prohibiting discrimination against persons with a mental disorder? If YES, please, specify:		
3. Is there legislation governing mental health care? If YES, please, specify:		
4. Is there legislation governing the commitment of patients( to treatment and/or to admission)? If YES, please, specify:		
5. Is there a specific government body responsible for promoting and maintaining the quality of mental health care? If YES, please, specify:		
6. Are there provisions for education for minors with mental disorders? If YES, please, specify:		
7. Are there standards for the determination of mental disorders (e.g. ICD; DSM)? If YES, please, specify:		
8. Are the standards of care for people with mental disorders comparable to those for physically ill persons?		

9. Are the resources (human, financial and material) for mental health facilities comparable to those for other health facilities?		
10. Are patients always asked for an informed consent prior to the beginning of a treatment?		
11. Are there forms of restraint which are allowed and which are not? If YES, please, specify:		
12. Does use of drug therapy follow internationally accepted guidelines for mental disorders? If YES, please, specify:		
13. Are there essential drugs widely available (e.g. within one hour's walk for all patients) for the treatment of mental disorders? Please, specify:		
14. Is there an operational system to protect confidentiality? If YES, please, specify:		
15. Can patients access their medical records upon request?		
16. Is a patient treated in a mental health facility always informed of his/her rights?		
17. Is there a voluntary admission procedure?		
18. Is there a time limit on involuntary commitment? If YES, please, specify:		
19. Do patients have the right to appeal a decision on involuntary admission? If YES, please, specify:		
20. Is the patient represented in any complaint procedure or appeal? If YES, please, specify:		

21. Are there living arrangements (both in institutions and in the community) tailored to the needs of those with mental disorders? If YES, please, specify:		
22. Are there specific programmes or measures taken for psychosocial rehabilitation? If YES, please, specify:		
23. Are prisons or jails being used to house people with mental disorders?		
24. Is there a specific forensic hospital for mentally-ill prisoners?		
25. Is mental health care guaranteed to prisoners?		
26. How far away from home is the majority of patients being treated?		
27. What is the average duration of an inpatient psychiatric hospitalization?		
28. What is the proportion of voluntary to involuntary admissions?		
29. How many signatures (and of whom?) are required for involuntarily commitment?		
30. What authority reviews involuntary admissions?		





### PART III



## SELECTED REFERENCE DOCUMENTS

In the following pages a few selected documents relevant to the human rights of persons with mental disorders, with an international coverage, are transcribed in full.

In addition to them, there are several other documents, not transcribed here for reasons of space, which are also relevant to this domain. Among these are:

- Universal Declaration of Human Rights, adopted and proclaimed by the United Nations General Assembly resolution 217 A (III) of 10 December 1948.
- Declaration of Helsinki (on human experimentation), amended by the 29th World Medical Assembly, Helsinki, Finland, in 1975, and by the 35th World Medical Assembly, Venice, Italy, in 1983.
- Declaration on the Promotion of Rights of Patients in Europe (Doc.: ICP/HLE/121). World Health Organization, Regional Office for Europe.
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the United Nations General Assembly resolution 46/96 of 20 December 1993.

1. What is the main purpose of the study?

2. What are the research objectives?

3. What is the significance of the study?

4. What is the scope of the study?

5. What is the methodology?

6. What are the results?

7. What are the conclusions?

8. What are the limitations of the study?

## **Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care**

*Adopted by General Assembly resolution 46/119 of 17 December 1991*

### *Application*

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

### *Definitions*

In the present Principles:

"Counsel" means a legal or other qualified representative;

"Independent authority" means a competent and independent authority prescribed by domestic law;

"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

"Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

"Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

"The review body" means the body established in accordance with principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

### *General limitation clause*

The exercise of the rights set forth in the present Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

*Principle 1*

***Fundamental freedoms and basic rights***

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.
6. Any Decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.
7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

## *Principle 2*

### *Protection of minors*

Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

## *Principle 3*

### *Life in the community*

Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.

## *Principle 4*

### *Determination of mental illness*

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.
3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in the diagnosis of mental illness.
4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

## *Principle 5*

### *Medical examination*

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

### *Principle 6*

#### *Confidentiality*

The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected.

### *Principle 7*

#### *Role of community and culture*

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background.

### *Principle 8*

#### *Standards of care*

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

### *Principle 9*

#### *Treatment*

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as



the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly.<sup>7</sup> Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

### *Principle 10*

#### *Medication*

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.
2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

### *Principle 11*

#### *Consent to treatment*

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.
2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:
  - (a) The diagnostic assessment;
  - (b) The purpose, method, likely duration and expected benefit of the proposed treatment;
  - (c) Alternative modes of treatment, including those less intrusive;
  - (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.
3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

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<sup>7</sup> Resolution 37/194, annex.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient.
5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.
6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:
  - (a) The patient is, at the relevant time, held as an involuntary patient;
  - (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;
  - (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.
7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf.
8. Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.
9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.
10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.
11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this

purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

### *Principle 12*

#### *Notice of rights*

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

### *Principle 13*

#### *Rights and conditions in mental health facilities*

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
  - (a) Recognition everywhere as a person before the law;
  - (b) Privacy;
  - (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
  - (d) Freedom of religion or belief.
2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:
  - (a) Facilities for recreational and leisure activities;
  - (b) Facilities for education;
  - (c) Facilities to purchase or receive items for daily living, recreation and communication;
  - (d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.
3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.
4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

## *Principle 14*

### *Resources for mental health facilities*

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
  - (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
  - (b) Diagnostic and therapeutic equipment for the patient;
  - (c) Appropriate professional care;
  - (d) Adequate, regular and comprehensive treatment, including supplies of medication.
2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the present Principles.

## *Principle 15*

### *Admission Principles*

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.
2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.

## *Principle 16*

### *Involuntary admission*

1. A person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

### *Principle 17*

#### *Review body*

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The initial review of the review body, as required by paragraph 2 of principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.

5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of principle 16 above are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.
6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.
7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

### *Principle 18*

#### *Procedural safeguards*

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.
4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.
5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.
6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

7. Any decision on whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

### *Principle 19*

#### *Access to information*

1. A patient (which term in the present Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

### *Principle 20*

#### *Criminal offenders*

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of principle 1 above.



3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.

### *Principle 21*

#### *Complaints*

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

### *Principle 22*

#### *Monitoring and remedies*

States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

### *Principle 23*

#### *Implementation*

1. States should implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make the present Principles widely known by appropriate and active means.

### *Principle 24*

#### *Scope of Principles relating to mental health facilities*

The present Principles apply to all persons who are admitted to a mental health facility.

### *Principle 25*

#### *Saving of existing rights*

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that the present Principles do not recognize such rights or that they recognize them to a lesser extent.

## **Declaration on the Rights of Disabled Persons**

**PROCLAIMED BY GENERAL ASSEMBLY RESOLUTION 3447 (XXX) OF  
9 DECEMBER 1975**

*The General Assembly,*

*Mindful* of the pledge made by Member States, under the Charter of the United Nations to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

*Reaffirming* its faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

*Recalling* the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons, as well as the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

*Recalling also* Economic and Social Council resolution 1921 (LVIII) of 6 May 1975 on the prevention of disability and the rehabilitation of disabled persons,

*Emphasizing* that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

*Bearing in mind* the necessity of preventing physical and mental disabilities of assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life,

*Aware* that certain countries, at their present stage of development, can devote only limited efforts to this end,

*Proclaims* this Declaration on the Rights of Disabled Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities.

2. Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.
3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.
4. Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.
5. Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.
6. Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthotic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration.
7. Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.
8. Disabled persons are entitled to have their special needs taken into consideration at all stages of economic and social planning.
9. Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.
10. Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.
12. Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.
13. Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.

## **Declaration on the Rights of Mentally Retarded Persons**

PROCLAIMED BY GENERAL ASSEMBLY RESOLUTION 2856 (XXVI) OF  
20 DECEMBER 1971

*The General Assembly,*

*Mindful* of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

*Reaffirming* faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

*Recalling* the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

*Emphasizing* that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

*Bearing in mind* the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

*Aware* that certain countries, at their present stage of development, can devote only limited efforts to this end,

*Proclaims* this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.
2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.
4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.
5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.
6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.
7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict to deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

## Declaration of Caracas

The following Declaration was adopted by acclamation on 14 November 1990 by the Regional Conference on Restructuring Psychiatric care in Latin America, which was held in Caracas, 11-14 November 1990, under the auspices of the Pan American Health Organization/WHO Regional Office for the Americas:

"The legislators, associations, health authorities, mental health professionals, and jurists assembled at the Regional Conference on the Restructuring of Psychiatric Care in Latin America within the Local health Systems Model,

### *Noting,*

1. That conventional psychiatric services do not allow for attainment of the objectives entailed in community-based care that is decentralized, participatory, integrated, continuing, and preventive;
2. that the mental hospital, when it is the only form of psychiatric care provided, hampers fulfilment of the foregoing objectives in that it:
  - (a) isolates patients from their natural environment, thus generating greater social disability;
  - (b) creates unfavourable conditions that imperil the human and civil rights of patients;
  - (c) absorbs the bulk of financial and human resources allotted by the countries for mental health care;
  - (d) fails to provide professional training that is adequately geared to the mental health needs of the population, the general health services, and other sectors.

### *Considering,*

1. That Primary Health Care is the strategy that has been adopted by WHO and PAHO and endorsed by all the Member States as the means for attaining the goal of Health for all by the Year 2000;
2. that the Local Health Systems model has been implemented by the countries of this Region as the means for reaching that target through the provision of better conditions for the development of programs that are based on the health needs of the population and that emphasize decentralization, social participation, and the preventive approach;
3. that mental health and psychiatric programs must incorporate the principles and guidelines on which these strategies and models of health care delivery are based,

**DECLARE**

1. That the restructuring of psychiatric care on the basis of Primary Health Care and within the framework of the Local Health Systems model will permit the promotion of alternative service models that are community-based and integrated into social and health networks.
2. That the restructuring of psychiatric care in the Region implies a critical review of the dominant and centralizing role played by the mental hospital in mental health service delivery.
3. That the resources, care, and treatment that are made available must:
  - (a) safeguard personal dignity and human and civil rights;
  - (b) be based on criteria that are rational and technically appropriate; and
  - (c) strive to ensure that patients remain in their communities.
4. That national legislation must be redrafted if necessary so that:
  - (a) the human and civil rights of mental patients are safeguarded; and
  - (b) that the organization of the services guarantees the enforcement of these rights.
5. That training in mental health and psychiatry should use a service model that is based on the community health center and encourages psychiatric admissions in general hospitals, in accordance with the principles that underlie the restructuring movement.
6. That the organizations, associations, and other participants in this Conference hereby undertake to advocate and develop programs at the country level that will promote the restructuring desired, and at the same time that they commit themselves to monitoring and defending the human rights of mental patients in accordance with national legislation and international agreements.

To this end, they call upon the Ministries of Health and Justice, the Parliaments, Social Security and other care-providing institutions, professional organizations, consumer associations, universities and other training facilities, and the media to support the restructuring of psychiatric care, thus assuring its successful development for the benefit of the population in the Region."



## DECLARATION OF HAWAII/II

*as approved in 1992 by the General Assembly of the*

### WORLD PSYCHIATRIC ASSOCIATION

Ever since the dawn of culture, ethics has been an essential part of the healing art. It is the view of the World Psychiatric Association that due to conflicting loyalties and expectations of both physicians and patients in contemporary society and the delicate nature of the therapist-patient relationship, high ethical standards are specially important for those involved in the science and practice of psychiatry as a medical speciality. These guidelines have been delineated in order to promote close adherence to those standards and to prevent misuse of psychiatric concepts, knowledge and technology.

Since the psychiatrist is a member of society as well as a practitioner of medicine, he or she must consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal responsibility of every man and woman.

Even though ethical behaviour is based on the individual psychiatrist's conscience and personal judgement, written guidelines are needed to clarify the profession's ethical implication.

Therefore, the General Assembly of the world Psychiatric Association has approved these ethical guidelines for psychiatrists, having in mind the great differences in cultural backgrounds, and in legal, social and economic conditions which exist in the various countries of the world. It should be understood that the World Psychiatric Association views these guidelines to be minimal requirements for ethical standards of the psychiatric profession.

1. The aim of psychiatry is to treat mental illness and to promote mental health. to the best of his or her ability, consistent with accepted scientific knowledge and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfil these aims requires continuous research and continual education of health care personnel, patients and public.
2. Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings. When the psychiatrist is responsible for treatment given by others he owes them competent supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help of another colleague.
3. The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, cooperation and mutual responsibility. Such a relationship may not be possible to establish with some patients. In that case, contact should be established with a relative or other person

close to the patient. If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

4. The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives, and of the possible outcome. This information must be offered in a considerate way and the patient must be given the opportunity to choose between appropriate and available methods.
5. No procedure shall be performed nor treatment given against or independent of a patient's own will, unless because of mental illness, the patient cannot form a judgement as to what is in his or her own best interest and without which treatment serious impairment is likely to occur to the patient or others.
6. As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent. The psychiatrists should inform the patient and/or relatives or meaningful others, of the existence of mechanisms of appeal for the detention and for any other complaints related to his or her well being.
7. The psychiatrist must never use his professional possibilities to violate the dignity of human rights of any individual or group and should never let inappropriate personal desire, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.
8. Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary, in these cases, however, the patient should be informed of the breach of confidentiality.
9. To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case-history is released for scientific publication, whereby all reasonable measures must be taken to preserve the dignity and anonymity of the patients and to safeguard the personal reputation of the subject. The patient's participation must be voluntary, after full information has been given of the aim, procedures, risks and inconveniences of a research project and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study. In clinical research every subject must retain and exert all high rights as a patient. For children and other patients who cannot themselves give informed consent, this should be obtained from the legal next-of-kin. Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research program in which he or she participates. This

withdrawal, as well as any refusal to enter a program, must never influence the psychiatrist's efforts to help the patient or subject.

10. The psychiatrist should stop all therapeutic, teaching or research programs that may evolve contrary to the principles of this Declaration.

## **Recommendation 1235 (1994) on Psychiatry and Human Rights**

### **PARLIAMENTARY ASSEMBLY OF THE COUNCIL OF EUROPE - 1994 SESSION**

1. The Assembly observes that there is no overall study on legislation and practice with regard to psychiatry covering the member states of the Council of Europe.
2. It notes that on the one hand, a body of case-law has developed on the basis of the European Convention on Human Rights and that on the other, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has made a number of observations with regard to practices followed in the matter of psychiatric placements.
3. It notes that, in a large number of member countries, legislation on psychiatry is under review or in preparation.
4. It is aware that, in many countries, a lively debate is currently focused on problems associated with certain types of treatment such as lobotomies and electroconvulsive therapy as well as on sexual abuse in psychiatric care.
5. It recalls Recommendation No. R (83) 2 of the Committee of Ministers to member states concerning the legal protection of persons suffering from mental disorders placed as involuntary patients.
6. It considers that the time has come for the member states of the Council of Europe to adopt legal measures guaranteeing respect for human rights of psychiatric patients.
7. The Assembly therefore invites the Committee of Ministers to adopt a new recommendation based on the following rules:
  - (i) *Admission procedure and conditions:*
    - (a) compulsory admission must be resorted to in exceptional cases only and must comply with the following criteria:
      - there is a serious danger to the patient or to other persons;
      - an additional criterion could be that of the patient's treatment: if the absence of placement could lead to a deterioration or prevent the patient from receiving appropriate treatment;
    - (b) in the event of compulsory admission, the decision regarding placement in a psychiatric institution must be taken by a judge and the placement period must be specified. Provision must be made for the placement decision to be regularly and automatically reviewed. Principles established in the Council of Europe's forthcoming convention on bioethics must be respected in all cases;

- (c) there must be legal provision for an appeal to be lodged against the decision;
  - (d) a code of patients' rights must be brought to the attention of patients on their arrival at a psychiatric institution;
  - (e) a code of ethics of psychiatrists should be drawn up *inter alia* on the basis of the Hawaii Declaration approved by the General Assembly of the World Psychiatric Association in Vienna in 1983.
- (ii) *Treatment:*
- (a) a distinction has to be made between handicapped and mentally ill patients;
  - (b) lobotomies and electroconvulsive therapy may not be performed unless informed written consent has been given by the patient or a person, counsellor or guardian, chosen by the patient as his or her representative and unless the decision has been confirmed by a select committee not composed exclusively of psychiatric experts;
  - (c) there must be an accurate and detailed recording of the treatment given to the patient;
  - (d) there must be adequate nursing staff appropriately trained in the care of such patients;
  - (e) patients must have free access to a "counsellor" who is independent of the institution; similarly, a "guardian" should be responsible for looking after the interests of minors;
  - (f) an inspection system similar to that of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment should be set up.
- (iii) *Problems and abuses in psychiatry:*
- (a) the code of ethics must explicitly stipulate that it is forbidden for therapists to make sexual advances to patients;
  - (b) the use of isolation cells should be strictly limited and accommodation in large dormitories should also be avoided;
  - (c) no mechanical restraint should be used. The use of pharmaceutical means of restraint must be proportionate to the objective sought, and there must be no permanent infringement of individuals' rights to procreate;
  - (d) scientific research in the field of mental health must not be undertaken without the patient's knowledge, or against his or her will or the will of his or her representative, and must be conducted only in the patient's interest.

(iv) *Situation of detained persons:*

- (a) any person who is imprisoned should be examined by a doctor;
- (b) a psychiatrist and specially trained staff should be attached to each penal institution;
- (c) the rules set out above and the rules of ethics should be applied to detained persons and, in particular, medical confidentiality should be maintained in so far as this is compatible with the demands of detention;
- (d) sociotherapy programmes should be set up in certain penal institutions for detained persons suffering from personality disorders.



## **INITIATIVE OF SUPPORT TO PEOPLE DISABLED BY MENTAL ILLNESS**

### **LIST OF PUBLICATIONS**

1. Initiative of Support to People Disabled by Mental Illness (WHO/MNH/MEP/88.6)
2. Consumer Involvement in Mental Health and Rehabilitation Services (WHO/MNH/MEP/89.7)
3. Proposal for a Multisite Research and Action Programme on Consumer Participation in Services (MNH/MEP/89.8)
4. Schizophrenia: Information for Families (WHO/MNH/MND/92.8)
5. Innovative Approaches in Mental Health Care: psychosocial interventions and case management (WHO/MNH/MND/92.11)
6. Descriptive Study of Centres Participating in the Initiative of Support to People Disabled by Mental Illness (MNH/MND/93.13)
7. Transition from Hospital to Community: a literature review on housing (WHO/MNH/MND/93.17)
8. Innovative Approaches in Service Evaluation: consumer contribution to qualitative evaluation and soft indicators (WHO/MNH/MND/93.19)
9. Essential Treatments in Psychiatry (WHO/MNH/MND/93.26)
10. Essential Drugs in Psychiatry (WHO/MNH/MND/93.27)
11. Psychosocial Rehabilitation: a consensus statement (WHO/MNH/MND/96.2)

### **FORTHCOMING ISSUES**

Vocational Rehabilitation to People Disabled by Mental Disorders

Essential Psychological Interventions in Psychiatry

Essential Psychosocial Interventions in Psychiatry

