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*CONSULTATION ON  
INVOLUNTARY  
TREATMENT FOR  
PERSONS WITH  
MENTAL  
DISORDERS OR  
SUBSTANCE ABUSE  
FOR THE CENTRAL  
ASIAN REPUBLICS*

Report on a Meeting

Chirchik  
26–28 August 1995

1996

EUR/HFA targets 12 and 17

## TARGET 12

### REDUCING MENTAL DISORDERS AND SUICIDE

*By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.*

## TARGET 17

### TOBACCO, ALCOHOL AND PSYCHOACTIVE DRUGS

*By the year 2000, the health-damaging consumption of dependence-producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all Member States.*

## ABSTRACT

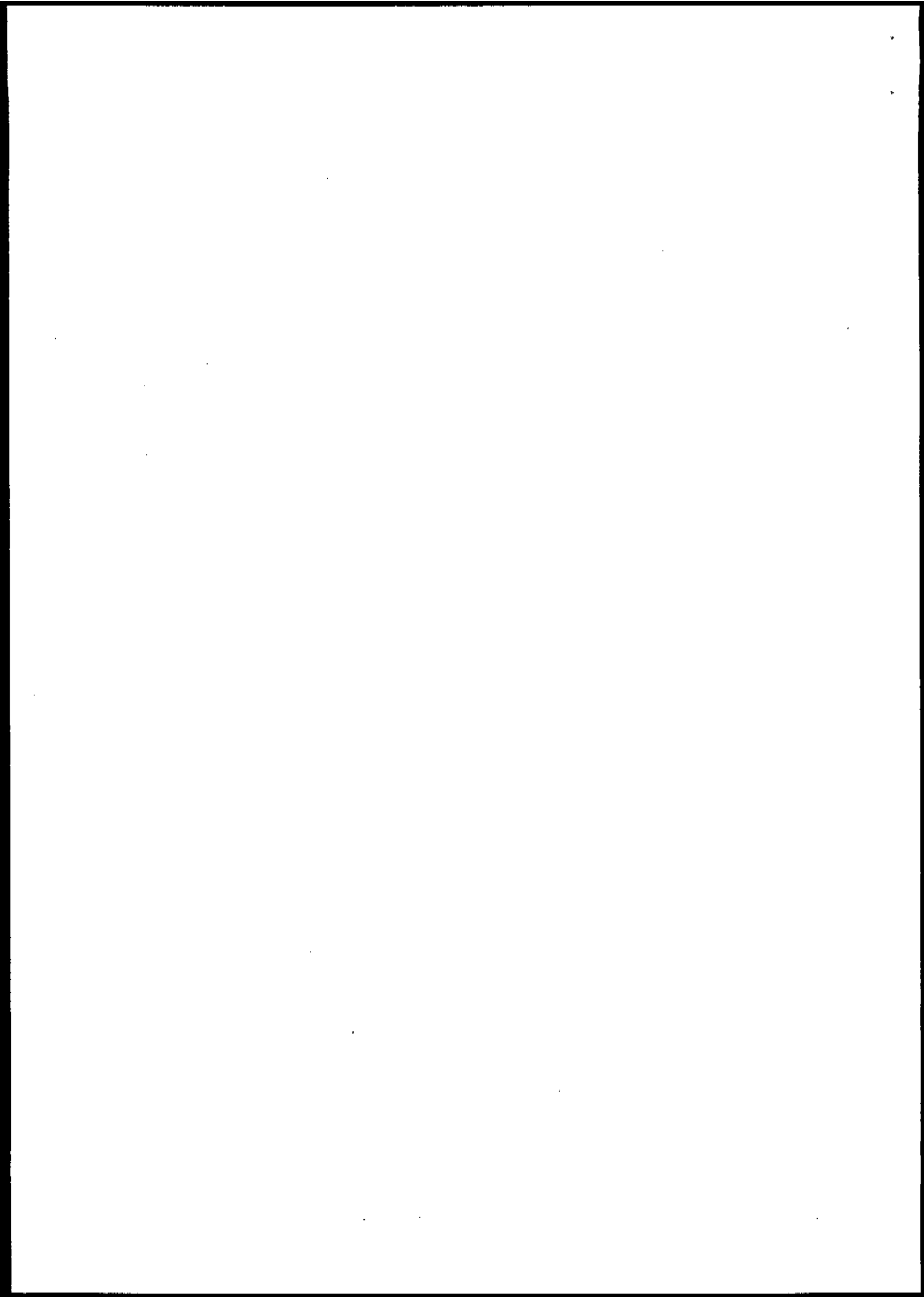
This document reviews the basic principles upon which involuntary treatment for persons with mental disorders or substance abuse should be based and discusses the action to be taken for legislation in this field and for reducing the need for involuntary treatment in the context of the Central Asian Republics. Detailed recommendations are put forward for the adoption of mental and substance abuse laws; for legislation on involuntary measures and for improving the mental health and substance abuse care systems in order to reduce the need for involuntary treatment.

## Keywords

MENTAL DISORDERS – prevention and control  
SUBSTANCE ABUSE – prevention and control  
PATIENT ADVOCACY  
EUROPE  
NIS

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## **INTRODUCTION**

A consultation on involuntary treatment for persons with mental disorders or substance abuse in Central Asian Republics, was held 26–28 August 1995 in Chirchik, Uzbekistan. The meeting was organized by the Regional Office for Europe, in collaboration with the Ministry of Health of Uzbekistan. A total of 27 temporary advisers and observers participated, three from Kazakhstan, four from Tajikistan, two from Turkmenistan, 13 from Uzbekistan, one from France, one from the Russian Federation, one from Ukraine, one from the United Kingdom and one from WHO Regional Office for Europe.

The aim of the meeting was to review the present conditions for appropriate follow up, treatment and care of persons with mental disorders or substance abuse, and its implications for the issuing of compulsory treatment legislative measures. In particular the meeting was intended to cover the treatment and care in community-based, non hospital, facilities and in other sectors of the health care system, and to put forward recommendations for specific legislation in this domain.

## **BACKGROUND**

Following up a request from Ministries of Health of Central Asian Republics, a consultation on mental health legislation was held from 18 to 20 July 1994 in Dushanbe, Tajikistan. One of the recommendations of the meeting was to request WHO to organize a meeting on legal provisions for the involuntary treatment of persons with mental disorders or substance abuse.

Recently, drafts of mental health laws were prepared in Kazakhstan, Tajikistan and Uzbekistan. Turkmenistan has already adopted a new mental health law largely in line with the Russian Federation Law adopted in 1992. No specific substance abuse legislation has been adopted in any of the Central Asian Republics besides the existing laws on traffic and use of illegal drugs.

## **INVOLUNTARY TREATMENT: BASIC PRINCIPLES DISCUSSED**

Involuntary treatment should be seen in the context of the right to treatment. People suffering from conditions which can be cured or alleviated have a right to be treated. This includes the right not to be left at risk of harming themselves or others. They have these rights even when their illnesses prevent them from understanding that they need treatment, or cause them to believe that they ought to suffer. But, by definition, involuntary treatment creates conflict between two fundamental rights: the right to treatment and the right to autonomy. Sometimes the right to treatment must prevail, but other important human rights must not be set aside. Rather, they must be carefully safeguarded. This is made clear in relevant international human rights documents; see in particular United Nations Resolution 46/119 (copy annexed).

Laws permitting involuntary treatment are not a substitute for good quality mental health services, as far as possible delivered to people in their own homes and communities, in the ways that are culturally and socially most acceptable to them, and including after-care and

assistance with rehabilitation and reintegration. If services are developed in these ways, the need for involuntary treatment will be reduced; and for people who nevertheless require involuntary treatment, the duration of involuntary treatment will often be reduced.

Involuntary treatment can only be justified in the context of the right to treatment. The right to treatment requires that appropriate services be provided, in the ways described above. Delegates agreed the need to develop services in their countries, but economic difficulties create serious limitations. It was acknowledged that humanitarian aid is more likely to be forthcoming if legislation governing involuntary treatment is enacted and observed, with appropriate safeguards for the rights of patients. The right to treatment also requires that patients make use of available services. Delegates reported reluctance by patients and their families to access psychiatric services, and prevalent use of alternative methods. In this respect also, matters are likely to be improved if patients and families can be assured that their rights are protected by laws which comply with accepted international norms on human rights.

## CONCLUSIONS AND RECOMMENDATIONS

### 1. For the adoption of a mental health law

- Urge governments of Central Asian countries to speed up the adoption of general health care laws in order that specific mental health legislation is also issued as a part of this general law or as a specific law on mental health.
- In countries where there is no law drafted, a national working group should be appointed to draft a proposal for the law.
- WHO assistance in the preparation of the draft laws by providing international expertise to comment on the law content on the grounds of international experience in this domain.

### 2. For legislating on involuntary measures

Involuntary measures should constitute a special section of the mental health law. It was agreed that involuntary treatment should be governed by law, which should be included in general mental health legislation. The meeting considered in particular the criteria for involuntary treatment, procedures, and the rights and status of patients. These topics are covered under separate headings below, not in the form of draft legislation, but outlining particular matters to be included in legislation.

It is recommended that legislation on involuntary treatment should apply to all patients, including those receiving psychiatric and narcological care, those in social asylums, those in any other form of care or in the community, and those subject to the jurisdiction of police, prosecuting authorities, or courts, or in prison.

It was agreed that provisions regarding involuntary treatment should also apply to other involuntary measures, including detention in hospital. Delegates reported that in some of their countries progress with mental health legislation was delayed pending enactment of general health laws. Delegates sought the support of the World Health Organization in urging

governments to enact general health laws and mental health laws. It would be appropriate for the World Health Organization to support the enactment and implementation of laws on involuntary treatment which comply with all the recommendations in this report, provided that this is coupled with a commitment to develop appropriate services, including rehabilitation and community services, to the maximum extent possible within available resources.

It was agreed that involuntary treatment (including detention and other involuntary measures) should only be authorized or continued on the basis of (a) specific criteria, (b) procedures, (c) rights of patients and (d) other general measures.

*(a) Criteria for involuntary treatment*

- If the patient suffers from a severe mental disorder, diagnosed and certified by at least two psychiatrists; and
- as a result of that mental disorder, either there is immediate or imminent danger of the patient harming himself or others, or the patient's judgement is impaired, the patient is refusing treatment, and failure to treat is likely to result in serious deterioration in the patient's condition; and
- medical treatment is necessary to remedy or control such dangerous conduct or to prevent or limit such deterioration; and
- no less restrictive solution is available, and such treatment cannot be given unless involuntary measures are authorized.

*(b) Procedures*

Sections (1), (2) and (3) below describe existing procedures/proposals. Section (4) describes additional elements which should be included.

*1. Emergency*

- 1.1 Patients may be detained and treated involuntarily on the certificate of one psychiatrist, for a maximum of 72 hours over weekends and a maximum of 48 hours at any other time. Wherever possible, the psychiatrist must discuss the case with the patient's family and seek their agreement to involuntary measures. If the family do not agree with the proposed involuntary measures, the psychiatrist must give careful consideration to the family's views but may still certify if he remains of the opinion that the criteria (section (a) above) apply.
- 1.2 The certificate must be in writing. It must state whether the family were consulted, and whether they were in agreement. It must confirm that in the psychiatrist's opinion the criteria apply, and specify the basis for that opinion. It must be recorded by the hospital on admission. The patient and his family must be immediately notified of the decision, its effect and their rights.
- 1.3 If, following such certification, a second psychiatrist disagrees, the case must be immediately referred to a third psychiatrist, and compulsory measures may only continue if the third psychiatrist certifies that the criteria apply.

- 1.4 On expiry of the 48 (or 72) hour period, the patient must be released from all involuntary measures unless further involuntary measures have been authorized by a commission of three psychiatrists under section (2) below. Immediate repetition of an emergency order is not permissible.

## 2. *Long term*

- 2.1 Patients may be detained and treated involuntarily on the certification of a commission of three psychiatrists, for a maximum of one month. The commission must include the chief psychiatrist of the hospital or his deputy. All three must certify in writing that the criteria apply. The certificate must be immediately recorded by the hospital. The patient and his family must be immediately notified of the decision, its effects, and their rights.
- 2.2 The same procedure may be followed to renew involuntary measures for successive periods of one month each up to six months, and thereafter for successive periods of six months each.

## 3. *Appeals*

- 3.1 The patient and the patient's family have the following rights of appeal against involuntary measures. The family may appeal against a decision not to apply involuntary measures.
- 3.2 An appeal may be lodged with the chief specialist of the city. The chief specialist must arrange for the patient to be examined within three days by a commission of three psychiatrists from outside the hospital where the patient was certified. All involuntary measures must cease unless this commission certifies that the criteria apply.
- 3.3 A further appeal may be lodged with the chief specialist of the republic, who must arrange for a further review by a fresh commission of three psychiatrists.
- 3.4 Complaints of procedural irregularities may be lodged with the public prosecutor. The public prosecutor investigates all procedural aspects, is entitled to examine the case history and all other relevant records, and must be provided with all information requested from the hospital and health authorities. He does not review the medical diagnosis and may not release the patient from involuntary measures. He may however report any irregularities to the chief specialist of the republic, who may in turn order release of the patient from involuntary measures or take other action.

## 4. *Further recommendations*

- 4.1 It was agreed that the courts should have a role in any deprivation of liberty, imposition of involuntary treatment, or other involuntary measures. A court decision should be required to continue involuntary measures beyond a specified period (such as one month). There should be right of appeal at all times (including within the first month) to the courts; the courts shall order release of the patient unless satisfied that the criteria (section (a) above) apply.

- 4.2 It was agreed that there should be an independent authority which should be empowered to review imposition and conditions of involuntary treatment. The independent authority should have real independence and real control. Its membership should include people who are not psychiatrists. It is recommended that the principles and powers set out in section (e) should apply to the independent authority.

*(c) Status and rights of patients*

*Treatment*

1. Treatment without consent may only be given to patients if the criteria (section (a)) apply and the procedures to authorize involuntary measures (section (b)) have been followed. It may not be given to voluntary patients.
2. Only treatment for the patient's mental disorder may be given without consent. However, even in the case of patients subject to involuntary measures, certain treatments may not be given without the patient's consent. These include insulin treatment, electro-convulsive therapy, and (if not prohibited altogether) Sulfosin.
3. It is recommended that for both voluntary and involuntary patients, the procedures listed in section (e) paragraph 7 should be prohibited except with the prior approval of the independent authority.
4. It was agreed that treatment programmes, including expected duration, should be explained to and discussed with all patients.

*Other rights*

1. The difference between involuntary and voluntary patients is that involuntary patients may be detained and treated without consent, whereas voluntary patients may leave at any time and may refuse any treatment. All patients, both voluntary and involuntary, should have the other rights set out in this section.
2. Delegates recommended, and it was agreed, that all patients should have the following rights:
  - to be fully informed of their status (voluntary or involuntary) and rights;
  - to choose the doctor who should be in charge of their treatment, and to request a change;
  - to request transfer to another hospital;
  - to obtain an independent opinion on their condition and treatment;
  - to correspond and communicate, and to have privacy of correspondence and communication respected.
3. The meeting considered the various rights of patients contained in United Nations Resolution 46/119 "The Protection of Persons with Mental Illness and the Improvement of Mental Health Care" adopted by the General Assembly

18 February 1992. A copy of the Resolution is annexed to this report. It was agreed that patients should have the rights set out in the following principles of the Resolution, namely: principles 1, 6–10 inclusive, 12–14 inclusive, 15 (15.3 applies only to voluntary patients), 16.2, and 18–21 inclusive.

*(d) General*

The foregoing principles and recommendations should be applied to precise laws for each republic which should be included in mental health legislation. It is recommended that specific proposals for mental health legislation for each republic should take account of the following factors:

1. The existing pattern of mental health services, and planned developments.
2. Existing patterns, and planned developments, of related services, including social services, rehabilitation, education and training, housing, employment, and welfare benefits.
3. Existing patterns of informal care of people with mental illness, for example by families; and services to support informal carers, including respite and voluntary services.
4. Social, cultural and religious factors which may influence choice of the most acceptable methods of making decisions and (where necessary) imposing involuntary treatment.
5. Existing general laws on consent to treatment (i.e. all medical treatment, not only psychiatric treatment), and circumstances in which treatment may be given without consent; and any proposed reforms.
6. Relevant provisions of criminal law; and any proposed changes.
7. Existing laws on personal decision-making and management for people with mental disabilities (see footnote).
8. Availability of legal services to people with mental disabilities (including availability of free legal aid and patient advocacy services).

It is necessary to decide whether mental health legislation shall apply only to adults, or also to children. What appropriate separate provisions under child law exist, or are planned? If mental health legislation is to apply to children, it is necessary to consider what additional protections and provisions (including recognition of the rights and responsibilities of parents) are required, and how they will inter-relate with other provisions of child law and education law.

It is necessary to ensure that the legislation complies with national constitution and international obligations, and with international human rights documents, including the provisions of UN Resolution 46/119.<sup>1</sup>

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<sup>1</sup>Copies of "A New View: Mental Handicap Law for Eastern Europe" Adrian D. Ward, International League of Societies for Persons with Mental Handicap, 1993 (Russian language edition 1995) were circulated to delegates, and provided further information and suggestions on several of the above matters.

(e) *Independent authority*

1. The following model is recommended for an independent authority. The purposes of the authority should be seen as including:
  - exercising protective functions in relation to all people with mental disabilities, whether in institutions or elsewhere;
  - promoting good practice, the development of appropriate models of care, and multi-agency communication, coordination and cooperation;
  - protecting patients, and also assisting and protecting doctors and other health care professionals by exercising an authoritative role for purposes of reporting, validation, guidance and authorization;
  - identifying and investigating issues of general concern or importance, and thereafter promulgating information, advice, guidance, etc.
  - providing information and advice to government, health authorities, local authorities, etc.
2. The authority must be, and must be seen to be:
  - independent
  - effective
  - of high professional competence
  - fair.

In these matters it must achieve standards which earn the confidence and respect of patients, and their families and carers, professionals, managers, authorities, voluntary organizations, and the general public.

3. To achieve the above, it is suggested that the best model is the entirely separate authority, appointed by central government but acting independently. Such an authority can then independently investigate and supervise institutions run by local authorities and government departments, and the conduct of anyone employed by a local authority or government department.
4. The authority should be truly multi-disciplinary. It should contain people from many different professional backgrounds, without being orientated towards any particular profession. It could contain psychiatrists, psychologists, nurses, social workers, lawyers and others. It could also contain people from different working backgrounds, such as those working in large institutions (both health and social care), in rehabilitation, in community facilities and community services, for voluntary bodies, and for local authorities or government departments. A group from varied professions and backgrounds, working together as a team, can be very effective.
5. The authority should be permitted to determine its own organizational structure, and to alter that structure from time to time. There should be discussion about whether the authority should be empowered to co-opt additional members to assist, for example by serving on local committees of the authority.

6. The independent authority should have duties and powers conferred by law. Possible duties and powers include:
- a general duty to protect people who are not fully able to safeguard themselves because of mental disability;
  - a general duty to promote standards, encourage rehabilitation, and encourage multi-agency cooperation;
  - duties to visit people subject to involuntary measures, or under guardianship, at specified frequency;
  - duties to monitor any medical treatment of such people, given without their consent;
  - powers to authorize specified categories of treatment (see paragraph 7. below);
  - powers to discharge people from involuntary measures or guardianship if the criteria (section (a)) no longer apply;
  - unrestricted access to all parts of institutions, hospitals or other facilities (including health and social care facilities), even without giving any notice beforehand;
  - similar access to all medical records and other patient records;
  - power to make decisions about conditions of health care;
  - power to regulate principles and decisions regarding transfer from one category of care to another;
  - power to institute procedure for personal or management orders, or to have this done;
  - power to carry out formal enquiries, with the same powers as courts to compel witnesses to attend and give evidence;
  - power to order necessary remedial action, or alternatively power to report matters to appropriate authorities, so that those authorities may take necessary remedial action;
  - power to take any other initiatives which it considers will be conducive to achieving any of the purposes set out in paragraph 1 above.
7. Specified categories of treatment should be prohibited except with the prior approval of the independent authority. It is suggested that this should apply to all patients, both voluntary patients and involuntary patients, and whether they consent or not. In all cases, the independent authority should be required to verify the appropriateness of the proposed treatment. Where the patient consents, the independent authority should be required to verify that the consent is valid and fully informed. Examples of such categories of treatment are:
- any high risk procedure
  - long-term administration of drugs
  - sterilization
  - hormone or similar treatment to reduce sexual drive
  - any treatment limiting liberty
  - destruction of brain tissue.

In the case of long-term administration of drugs, an alternative would be to require that this be reported to the independent authority, rather than that it should require prior permission. Possible additions should be considered, having regard to any particular national circumstances. (For example, electro-convulsive therapy might be included in the list in any republic where there are concerns about inappropriate use of that procedure.)

8. Whenever an order for involuntary measures (emergency or long-term) or a guardianship order is made or renewed, the independent authority should be told. There should be a duty to notify the order to the independent authority. If legislation permits treatment in emergency without first following prescribed formalities, there should be a duty to notify the independent authority.
9. There should also be legal duties to provide all necessary information and assistance to the independent authority. In the case of institutions which house people with mental disabilities, everyone concerned with running these should have such duties. Guardians, managers and relevant local authorities and government departments should have similar duties.
10. Anyone subject to compulsory measures, or under guardianship, should have the right to ask to be seen by a member of the independent authority.

#### *Voluntary sector*

Several delegates expressed interest in developing the voluntary sector. Associations of users, families and others prepared to assist have a valuable role to play, particularly in situations where resources are scarce, rehabilitation and community services are under-developed, and perceptions of mental disorder and of mental health services are poor. It is recommended that the voluntary sector be actively encouraged and developed. It was suggested that initial steps might be (a) to identify among families known to services people who might have the capacity and motivation to take a leading role; and (b) to bring such people together and provide them with guidance, assistance and encouragement. The role of professionals should be unobtrusive but supportive.

### **3. Measures to improve the mental health care system and reduce the need for involuntary treatment.**

#### **3.1 Conclusions and recommendations of discussion group on narcological care**

To urge Central Asian Republics to adopt specific legislation on narcological care, as none of them have passed laws until now. This law should be separated from the mental health legislation, but the recommendations in section 2, on legislating for involuntary measures, should apply.

Particular attention needs to be given in the law to the following issues:

- human rights of the patients and confidentiality;
- enhance the quality and range of treatments available, including psychological and social oriented interventions, and rehabilitation;
- establishment of narcological care in the network of primary care services;

- development of primary preventive programmes, particularly in schools, as a means to reduce involuntary treatment;
- adequate training of narcological specialists;
- comprehensive home care programmes;
- enhance cooperation with community based social networks and social resources such as families, voluntary religious organizations;
- development of detoxification centres, rehabilitation services, day hospitalization facilities;
- involuntary treatment, including outpatient treatment;
- establishment of departments/directorates of narcology at ministry level urged by WHO;
- change negative public attitudes through mass media programmes;
- study the implications for narcological care of the introduction of health insurance models of care financing;
- consider discontinuing the payment of salary for patients under narcological treatment.

### **3.2 Conclusions and recommendations of discussion group on psychiatric care**

Measures for reducing the need for involuntary interventions and develop community based mental health care.

WHO to urge Central Asian countries to adopt mental health laws as soon as possible. These laws should take into consideration the cultural and socio-economic specificities of each country and give particular attention to the regulation of involuntary interventions.

To reduce the need for involuntary measures through:

- development and strengthening of the capacity of intervention of community based services such as mental health centres, day hospitals, home care, psychiatric units in general hospitals and the network of primary health care facilities;
- ensuring an appropriate supply of psychotropics to inpatient and outpatient services. Special attention needs also to be given to the supply of anti-convulsants. In this respect the role of WHO in assisting to prepare and develop special humanitarian projects for the supply of psychotropics to Central Asian Republics was stressed;
- providing means and opportunities for psychosocial rehabilitation of persons with serious mental illness.

Urge WHO to:

- provide technical assistance in drafting mental health laws;
- strengthen international contacts and collaboration between experts from Central Asian Republics and European colleagues;
- reduce the present lack of information on mental health and psychiatric fields by establishing a WHO Information Centre, serving the Central Asian Republics and located in Tashkent (or, if not possible, in other alternative place).

**Annex 1**

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**UNITED  
NATIONS**

**A**



**General Assembly**

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18 February 1992

Forty-sixth session  
Agenda item 98

**RESOLUTION ADOPTED BY THE GENERAL ASSEMBLY**

[on the report of the Third Committee (A/46/721)]

46/119. The protection of persons with mental illness  
and the improvement of mental health care

The General Assembly,

Mindful of the provisions of the Universal Declaration of Human Rights, 1/ the International Covenant on Civil and Political Rights, 2/ the International Covenant on Economic, Social and Cultural Rights 2/ and other relevant instruments, such as the Declaration on the Rights of Disabled Persons 3/ and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, 4/

Recalling its resolution 33/53 of 14 December 1978, in which it requested the Commission on Human Rights to urge the Subcommittee on Prevention of Discrimination and Protection of Minorities to undertake, as a matter of priority, a study of the question of the protection of those detained on the grounds of mental ill-health, with a view to formulating guidelines,

- 1/ Resolution 217 A (III).
- 2/ See resolution 2200 A (XXI), annex.
- 3/ Resolution 3447 (XXX).
- 4/ Resolution 43/173, annex.

/...

Recalling also its resolution 45/92 of 14 December 1990, in which it welcomed the progress made by the working group of the Commission on Human Rights in elaborating a draft body of principles for the protection of persons with mental illness and for the improvement of mental health care on the basis of a draft submitted to the Commission by the Subcommission on Prevention of Discrimination and Protection of Minorities,

Taking note of Commission on Human Rights resolution 1991/46 of 5 March 1991, 5/ in which the Commission endorsed the draft body of principles that had been submitted to it by the working group and decided to transmit it, as well as the report of the working group, to the General Assembly, through the Economic and Social Council,

Taking note also of Economic and Social Council resolution 1991/29 of 31 May 1991, in which the Council decided to submit the draft body of principles and the report of the working group to the General Assembly,

Taking note further of the recommendations of the Commission on Human Rights in its resolution 1991/46 and of the Economic and Social Council in its resolution 1991/29 that, on the adoption by the General Assembly of the draft body of principles, the full text thereof should be given the widest possible dissemination and that the introduction to the body of principles should at the same time be published as an accompanying document for the benefit of Governments and the public at large,

Taking note of the note by the Secretary-General, 6/ the annex to which contains the draft body of principles and the introduction to the body of principles,

1. Adopts the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, the text of which is contained in the annex to the present resolution;
2. Requests the Secretary-General to include the text of the Principles, together with the introduction, in the next edition of the publication entitled "Human Rights: A Compilation of International Instruments";
3. Requests the Secretary-General to give the Principles the widest possible dissemination and to ensure that the introduction is published at the same time as an accompanying document for the benefit of Governments and the public at large.

75th plenary meeting  
17 December 1991

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5/ See Official Records of the Economic and Social Council, 1991, Supplement No. 2 (E/1991/22), chap. II, sect. A.

6/ A/46/421.

ANNEX

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

Application

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 psychologist, 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 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, 1/ the International Covenant on Economic, Social and Cultural Rights, 2/ the International Covenant on Civil and Political Rights 2/ and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons 3/ and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. 4/
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.

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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. 2/ Mental health knowledge and skills shall never be abused.
4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

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2/ Resolution 37/194, annex.

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.
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;

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(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.