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PRINCIPLES, GUIDELINES AND GUARANTEES FOR THE PROTECTION OF PERSONS DETAINED ON GROUNDS OF MENTAL ILL-HEALTH OR SUFFERING FROM MENTAL DISORDER

A CONTRIBUTION TO (a) *THE PROTECTION OF THE FUNDAMENTAL FREEDOMS, HUMAN AND LEGAL RIGHTS OF PERSONS WHO ARE MENTALLY ILL OR SUFFERING FROM MENTAL DISORDER;* (b) *THE ABOLITION OF PSYCHIATRIC ABUSES;* (c) *THE PROMOTION OF MENTAL HEALTH LAW AND MEDICAL PRACTICE AND* (d) *THE IMPROVEMENT OF MENTAL HEALTH CARE AND MENTAL INSTITUTIONS*

Report prepared by Erica-Irene A. Daes

Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities

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UNITED NATIONS
New York, 1986

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Preface

In contemporary society, scientific and technological development and progress in the fields of medicine, biology and biochemistry have brought many benefits to human beings through improved health and medical care, the extension of life expectancy, the reduction of infant mortality, the combating of many chronic diseases and the alleviation of some of man's personal physical afflictions.

Nevertheless, it has become increasingly evident that some technological and scientific advances have adverse effects and in certain cases pose threats to the physical and intellectual integrity of human beings. Consequently, in such cases human beings are in pressing need of the community's effective protection. There have, for instance, been abuses of modern technological and scientific advances which are not in accord with traditional medical therapy or are inconsistent with basic human rights. In this connection, reports have been issued by the competent organs and bodies of the United Nations with the main objective of protecting human beings from certain scientific and technological advances or their misuse.[1]

Furthermore, disturbing statements have been delivered by delegations of a number of States, mainly in the General Assembly of the United Nations and in the Commission on Human Rights, which provide a gloomy picture of the hundreds of innocent and sane persons kept in various types of psychiatric hospitals and prisons and subjected to the abuse of psychiatric treatment, including the administration of drugs, in grave violation of their human rights and to the serious detriment of their health.[2]

Furthermore, reports, studies, judgements and articles have been published by the specialized agencies, in particular the World Health Organization, regional intergovernmental organizations, regional and national courts and competent non-governmental organizations, which clearly reflect major violations of human rights of persons diagnosed as "mentally ill" and express the conviction of their authors that involuntary hospitalization and detention of persons in mental institutions on account of their political views and on other non-medical grounds is a grave violation of their human rights.[3]

In addition to the above-mentioned documents, the international press[4] has frequently, over the last ten years, drawn the attention of world public opinion to the fact that individuals have been subjected to deprivation of their liberty, involuntary admission and detention in mental institutions, horrible misuse of psychiatry, psychiatric mistreatment and torture by drugs, in contravention of medical ethics and in violation of the relevant humanitarian international instruments.[5] For these reasons, the law and practice relating to: (*a*) procedures for determining whether adequate grounds exist for detaining persons as mentally ill or as suffering from mental disorder, and (*b*) the effective protection of the civil, political, social, cultural, economic and legal rights of the mentally ill, as well as their rights to proper human and medical treatment, have been the subjects of long debates, criticisms and research in many countries and in the forums of the competent organs and bodies of the United Nations, the specialized agencies, in particular WHO, as well as intergovernmental and non-governmental organizations.

It is contended, *inter alia*, that: (*a*) involuntary admission to and detention in mental hospitals is unjustifiable and should be abolished; (*b*) abuses of involuntary admission and detention in psychiatric hospitals are taking place in several parts of the world, especially against persons who defend fundamental freedoms and exercise their human rights; (*c*) psychiatric mistreatment is a sinister abuse of scientific and medical technology; (*d*) drugs are used for torturing persons diagnosed as mentally ill; (*e*) high rates of social disorders, such as narcotic addiction, alcoholism, child exploitation, violence and deviance, are in certain cases related to the presence of certain types of mental illness; (*f*) in a period of rapid economic and social change many communities, in particular those of the least developed world, are exposed to severe psycho-social stresses; (*g*) in a number of countries, particularly less developed countries, while industrializ-

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[1] See the following reports of the Secretary-General on the subject of human rights and scientific and technological development: (*a*) "Respect for the privacy of individuals and the integrity and sovereignty of nations in the light of advances in recording and other techniques" (E/CN.4/1116 and Corr.1 and Add.1, Add.2, Add.3 and Corr.1 and Add.4); (*b*) "Protection of the human personality and its physical and intellectual integrity, in the light of advances in biology, medicine and biochemistry" (E/CN.4/1172 and Corr.1 and Add.1-3).

[2] See, in particular, *Official Records of the General Assembly, Thirty-sixth Session, Third Committee,* 27th meeting, paras. 6-9, 28th meeting, para. 13, 31st meeting, para. 16, 32nd meeting, paras. 29-31 and 47, 34th meeting, paras. 2 and 7-20, 35th meeting, para. 104 and 37th meeting, paras. 4-9. See also E/CN.4/1982/SR.12, paras. 6, 17, 18, 21 and 24, E/CN.4/1982/SR.13, paras. 7, 8, 18-21, E/CN.4/1982/SR.14, paras. 2, 6, 8, 19 and 40, and E/CN.4/1982/SR.30, paras. 15 and 16.

[3] This conviction was also expressed by the General Assembly and the Commission on Human Rights. See *Official Records of the General Assembly, Thirty-sixth Session, Third Committee,* 38th meeting, para. 57; see also General Assembly resolution 36/56B of 25 November 1981, and Commission on Human Rights resolution 1982/6 of 19 February 1982.

[4] See paras. 145-147 below.

[5] The Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Standard Minimum Rules for the Treatment of Prisoners. For the texts of these instruments see United Nations, *Human Rights: A Compilation of International Instruments* (United Nations publication, Sales No. E.83.XIV.1), pp.1, 3, 82 and 75, respectively.

ation and rural development remain key objectives, medical programmes and treatment have low priority and, even within these programmes, very little attention or financial resources are accorded to the mentally ill; (*h*) it is true that in certain circumstances involuntary admission, detention and treatment of persons on grounds of mental illness is justifiable and that some humanitarian, social, medical and legal procedures and safeguards have been established in a few countries[6] in recent years. In the light, however, of the growing challenge of the complexity and the variety of the mental health problems posed to the State, the local community, the family, medical practitioners and the individual and in the light of modern humanitarian and legal thinking and mental health policy and practice, such measures and procedures are often no longer adequate and certainly not universally applied; and (*i*) therefore, keeping in mind that mental health problems are world-wide and very complex in their nature, new or additional principles, guidelines, procedures, approaches and legal guarantees should be adopted at international, regional, national and local community levels.

It is within this framework that the Sub-Commission on Prevention of Discrimination and Protection of Minorities, as well as its parent body, the Commission on Human Rights, the Economic and Social Council and the General Assembly have been directly involved in some of the problems referred to in the preceding paragraphs.[7]

The basic objectives of the above-mentioned United Nations organs and bodies are to contribute to an effective protection of the fundamental freedoms and human, legal and economic rights of large numbers of persons diagnosed as "mentally ill", who are to be found in many parts of the world and who are not in a position either to request aid or to testify,[8] and to educate world public opinion on these complex issues.

To this end, and within the framework of her mandate,[9] the Special Rapporteur will briefly examine and discuss, *inter alia*, the following important issues relevant to the topic of the study:[10]

(*a*) Procedures and legal guarantees ensuring respect for the inherent dignity and protection of the fundamental freedoms and civil, political, socio-economic, cultural, medical and legal rights of persons diagnosed as "mentally ill" or as "suffering from mental disorder";

(*b*) Questions relating to arbitrary deprivation of the freedoms and human rights of an individual on grounds of his mental condition;[11]

(*c*) Reasons for voluntary and involuntary hospitalization of persons diagnosed as "mentally ill" or "suffering from mental disorder";

(*d*) Right to treatment of the mentally ill;

(*e*) Types of psychiatric institutions;

(*f*) Recommendations for the adoption of legislative and administrative measures or of new or additional procedures and approaches concerning, in particular, the protection of persons detained on grounds of mental ill-health or suffering from mental disorder;

(*g*) Recommendations for reform of existing mental health laws where inadequate or obsolete, and for medical, socio-economic and administrative measures concerning the improvement and modernization of mental health services and mental institutions.

The analysis of these and other important and complex interrelated issues and a comparative study of the replies of Governments, specialized agencies and non-governmental organizations form the basis of the conclusions of this report and the proposals and recommendations for the adoption of principles, guidelines and minimum legal guarantees to be afforded to the mentally ill.

The Special Rapporteur also wishes to emphasize that the basic principles on which she has founded the present study and the proposed "Draft body of principles, guidelines and guarantees for the protection of the mentally ill or persons suffering from mental disorder" are as follows:

(*a*) The inherent dignity and the inalienable human rights of every patient[12] shall always be recognized and respected;[13]

(*b*) The human personality and its physical and intellectual integrity, in the face of scientific and technological developments and advances, in particular in medicine, biology and biochemistry, shall be effectively protected;

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[6] See for instance the replies of the Governments of Australia, Canada, Italy, Mexico, New Zealand, Sweden and the United Kingdom of Great Britain and Northern Ireland in document E/CN.4/Sub.2/1983/17/Add.1, chap. 3. See also J. Bland, "A pressure group for Africa", in *World Health*, October 1982, pp. 8-11.

[7] In connection with the background to the present study, see paras. 1-20 below.

[8] See the summary records of the 916th and 917th meetings of the thirty-fourth session of the Sub-Commission (E/CN.4/Sub.2/SR.916 and SR.917, paras. 1-32).

[9] See the report of the Sub-Commission on its thirty-third session (E/CN.4/1413-E/CN.4/Sub.2/459 and Corr.1), p. 69, resolution II (XXXIII).

[10] Unfortunately, for reasons related mainly to regulations on the limitation of documentation, it has been impossible for the Rapporteur to examine in detail all aspects of the subject of mental illness and the interrelated humanitarian, political, socio-economic, medical and legal problems and to cite extensive information and comparative data on these matters. However, information and data concerning, in particular, mentally ill persons, their involuntary admission and detention, types of mental institutions, relevant legal procedures, etc., are contained in the replies to the Special Rapporteur's questionnaire submitted by Governments, specialized agencies and regional organizations (E/CN.4/Sub.2/1983/17/Add.1). Also, on grounds based on her mandate, the Special Rapporteur has considered it impossible to include in her report specific communications relating to violations of human rights of isolated individuals who have been defined as "mentally ill" as a consequence of the exercise of their human rights or of their opposition to a political régime. The Rapporteur wishes to state, however, that she condemns all such policies and practices, regardless of the State in which they take place.

[11] In violation of articles 2, 5, 6, 8, 9, 10, 11, 12, 17, 19, 20, 22, 23, 25, 27, 29 and 30 of the Universal Declaration of Human Rights, articles 7 (*b*) and 8 of the International Covenant on Economic, Social and Cultural Rights and articles 6, 7, 9, 10, 14, 15, 16, 17, 18, 19, 21, 22, 25 and 26 of the International Covenant on Civil and Political Rights.

[12] For the purposes of the present study, the term "patient" will be used to designate persons who are "mentally ill" and persons "suffering from mental disorder".

[13] Based on the preamble to the Universal Declaration of Human Rights and the International Covenants on Human Rights.

(*c*) Both law and medical practice shall be, wherever possible, the individual's right to self-determination and freedom from coercion in treatment;

(*d*) Every patient has the right to enjoy the highest attainable standards of physical and mental health;[14]

(*e*) Psychiatry shall never be used for the purpose of violating human rights and for the subversion of the political and legal guarantees of a patient's freedom; in particular, it shall never serve as an instrument for enforcing political conformity;

(*f*) Medical practitioners, and specifically psychiatrists, shall respect the Hippocratic Oath, which for centuries has embodied the high ethical standards of a great physician;[15] moreover, they shall observe the principles of contemporary medical ethics.[16]

It is the sincere hope of the Special Rapporteur that the present study will contribute to providing a clear source of guidance for all those interested in the tragic problems of the patient, the protection of his fundamental freedoms and human rights and the abolition of psychiatric and psychological abuses, and will lead to the adoption and implementation of United Nations standards for the care and effective protection of every person detained on grounds of mental ill-health or diagnosed as mentally ill or suffering from mental disorder.

ERICA-IRENE A. DAES
Athens, 30 June 1983

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[14] Article 12 of the International Covenant on Economic, Social and Cultural Rights and article 10 (*d*) of the Declaration on Social Progress and Development (for the text of the Declaration, see United Nations, *Human Rights...*, p. 133).

[15] For the text of the Hippocratic Oath see W.H.S. Jones , transl., *Hippocrates* (Cambridge, Mass., Harvard University Press, 1962).

[16] In this connection, see in particular the Declaration of Tokyo, entitled "Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment" (A/34/273, annex, p. 8), adopted by the twenty-ninth World Medical Assembly, held at Tokyo in October 1975, and the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment (A/34/273/annex, pp. 9 and 10), adopted by the General Assembly in its resolution 3452 (XXX) of 9 December 1975. With regard to codes of medical ethics, see also the note by the Secretary-General of the United Nations (A/34/273), the report by the Director-General of the World Health Organization on the development of codes of medical ethics (A/34/273, annex, pp. 2 and 3), and the relevant document of the Council for International Organizations of Medical Sciences, entitled "Principles of medical ethics relevant to the role of health personnel in the protection of persons against torture and other cruel, inhuman or degrading treatment or punishment" (A/34/273, annex, pp. 4-7). See also the report by the Secretary-General submitted with regard to the question of torture and other cruel, inhuman or degrading treatment or punishment, entitled "Draft code of medical ethics" (A/37/264 and Add. 1 and 2), and General Assembly resolutions 36/61 of 25 November 1981 and 37/194 of 18 December 1982.

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Note concerning annex III

In its decision 1984/142 of 24 May 1984, the Economic and Social Council, noting Commission on Human Rights decision 1984/108 of 13 March 1984, decided that the report entitled "Principles, guidelines and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder" should be published, without annex III. The replies of governments, specialized agencies and intergovernmental organizations to the Special Rapporteur's questionnaire on the subject matter of the study will therefore be found in the mimeographed document E/CN.4/Sub.2/1983/17/Add.1 [annex III], which is not reproduced in the present publication.

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ABBREVIATIONS

ADUPSY	Association for the Rights of Users of Psychiatry
APA	American Psychological Association
CCHR	Citizens' Commission on Human Rights
ILO	International Labour Organisation
OAS	Organization of American States
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXPLANATORY NOTE

The resolutions of the Commission on Human Rights mentioned in the present study are to be found in the relevant annual reports of the Commission to the Economic and Social Council, published in the series *Official Records of the Economic and Social Council.*

INTRODUCTION

1. In its resolution XI of 12 May 1968, entitled "Human rights and scientific and technological developments",[1] the International Conference on Human Rights recommended that the organizations of the United Nations family should undertake a study of the problems relating to human rights arising from developments in science and technology.

2. By its resolution 10 A (XXXIII) of 11 March 1977 on human rights and scientific and technological developments, the Commission on Human Rights requested the Sub-Commission on Prevention of Discrimination and Protection of Minorities (hereinafter referred to as the Sub-Commission) to study, with a view to formulating guidelines, if possible, the question of the protection of those detained on the grounds of mental ill-health against treatment that may adversely affect the human personality and its physical and intellectual integrity. In 1979, the Sub-Commission requested the Secretary-General to prepare a report on the subject with a view to the formulation of guidelines relating to the medical measures that may properly be employed in the treatment of persons detained on the grounds of mental ill-health and procedures for determining whether adequate grounds exist for detaining such persons and applying such medical measures (resolution 6 (XXXII) of 5 September 1979).

3. The General Assembly, by its resolution 33/53 of 14 December 1978, requested the Commission on Human Rights to urge that the study of the question of the protection of those detained on the grounds of mental ill-health be undertaken as a matter of priority by the Sub-Commission.

4. At its thirty-third session, in 1980, the Sub-Commission, by its resolution 11 (XXXIII) of 10 September 1980, having considered the report submitted by the Secretary-General pursuant to Sub-Commission resolution 6 (XXXII) (E/CN.4/Sub.2/446), entrusted the Rapporteur, Mrs. Erica-Irene A. Daes, with the task of preparing "guidelines related to procedures for determining whether adequate grounds exist for detaining persons on the grounds of mental ill-health, and principles for the protection, in general, of persons suffering from mental disorder". By its resolution 35/130 B of 11 December 1980, the General Assembly at its thirty-fifth session welcomed the action taken by the Sub-Commission to implement General Assembly resolution 33/53.

5. At its thirty-fourth session, in 1981, the Sub-Commission had before it a preliminary report by the Rapporteur (E/CN.4/Sub.2/474), which, pursuant to Sub-Commission resolution 11 (XXXIII), contained a questionnaire in an annex. At the Rapporteur's request, the questionnaire was transmitted by the Secretary-General for comments to Governments and to the specialized agencies, regional intergovernmental organizations and non-governmental organizations concerned. As of 27 July 1981, as stated in the Rapporteur's preliminary report (E/CN.4/Sub.2/474), comments had been received from a number of Governments, specialized agencies, regional intergovernmental organizations and non-governmental organizations.

6. A written statement was also submitted to the Sub-Commission at its thirty-fourth session by the International Association of Penal Law and the International Commission of Jurists (E/CN.4/Sub.2/NGO/85).

7. By its resolution 20 (XXXIV) of 10 September 1981, the Sub-Commission, having considered and approved the preliminary report, requested the Rapporteur to submit her final report at its thirty-fifth session, including a draft body of (*a*) guidelines related to procedures for determining whether adequate reasons exist for detaining persons on the grounds of mental ill-health or mental disorder, (*b*) principles for the treatment and protection, in general, of persons suffering from mental disorder, and (*c*) guarantees for the protection of the human rights of persons suffering from mental disorder. By the same resolution, the Sub-Commission also decided to establish at its thirty-fifth session a sessional working group to consider the body of guidelines, principles and guarantees with a view to adopting it at its thirty-fifth session.

8. At its thirty-sixth session, in 1981, the General Assembly, by its resolution 36/56 B, noted with satisfaction the work undertaken by the Sub-Commission on the question of the protection of those detained on grounds of mental ill-health and requested the Commission to continue its consideration of this question in the light of the action taken by the Sub-Commission, with a view to submitting a report to the General Assembly at its thirty-eighth session through the Economic and Social Council.

9. The Commission on Human Rights at its thirty-eighth session, in 1982, noted with appreciation the preliminary report by Mrs. Erica-Irene A. Daes and decided to consider the final report at its thirty-ninth session resolution 1982/6 of 19 February 1982). By the same resolution, the Commission expressed its conviction that "detention of persons in mental institutions on account of their political views or on other non-medical grounds is a violation of their human rights".

10. In accordance with Sub-Commission resolution 20 (XXXIV), the questionnaire prepared pursuant to resolution 11 (XXXIII) of the Sub-Commission was transmitted by note verbale of 14 November 1981 to all Governments to which it had not yet been transmitted, and a reminder was also sent to those Governments,

[1] See *Final Act of the International Conference on Human Rights, Teheran, 22 April-13 May 1968* (United Nations publication, Sales No. E.68.XIV.2), chap. III.

specialized agencies and non-governmental organizations concerned which had not yet complied with the previous request addressed to them.

11. As of 15 June 1983, substantive comments have been received from the Governments of 49 States.[2]

12. Comments were also received from the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the United Nations Children's Fund, the World Health Organization,[3] as well as from the United Nations Centre for Social Development and Humanitarian Affairs (Social Affairs Officer, Crime Prevention and Criminal Justice Branch).

13. Replies to the questionnaire were further received from the Council of Europe and the Organization of American States.

14. Twenty non-governmental organizations also sent substantive information.[4] Replies were also received from the National Association for Mental Health (MIND), the Comité National Suisse de la Santé Mentale and the Citizen's Commission on Human Rights.

15. The Sub-Commission at its thirty-fifth session had considered: (*a*) a progress report (E/CN.4/Sub.2/1982/16 entitled: "Guidelines, principles and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder", prepared by Special Rapporteur Mrs. Erica-Irene A. Daes and (*b*) the report of the sessional Working Group on "The question of persons detained on the grounds of mental ill-health" (E/CN.4/Sub.2/1982/17). The Sub-Commission, after full consideration of the above-mentioned report,[5] adopted, without a vote, resolution 1982/34.

16. On 18 December 1982 the General Assembly adopted, without a vote, resolution 37/188, entitled: "Implications of scientific and technological developments for human rights", by which, having reaffirmed its conviction that detention of persons in mental institutions on account of their political views or on other non-medical grounds is a violation of their human rights and noted with satisfaction the progress made by the Sub-Commission in its consideration of the draft body of guidelines, principles and guarantees, it urged the Commission on Human Rights and through it the Sub-Commission, to continue and to expedite their consideration of this question with a view to the Commission submitting its views and recommendations to the General Assembly at its thirty-ninth session through the Economic and Social Council.

17. On 9 March 1983 the Commission on Human Rights at its thirty-ninth session adopted, without a vote, resolution 1983/44, entitled "Human Rights and Scientific and Technological Developments—Guidelines, principles and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder", and recommended to the Economic and Social Council the adoption of draft resolution VII, in regard to which the Council expressed its deep appreciation to the Special Rapporteur, Mrs. Erica-Irene A. Daes, for her work in preparing her report, noted with appreciation the report of the Sub-Commission's sessional working group on the question of persons detained on grounds of mental ill-health, and requested the Special Rapporteur to supplement her final report. It further requested "The Sub-Commission to establish a sessional working group and to allocate to it appropriate time and facilities for a proper examination, as a matter of the highest priority, of the above-mentioned body of principles, guidelines and guarantees and to submit the revised final report of the Special Rapporteur, including the documentation in paragraph 1 above, to the Commission on Human Rights at its fortieth session".[6]

18. In accordance with the mandate given to her by resolution 11 (XXXIII) of the Sub-Commission, the Special Rapporteur has taken into account in preparing the present study, as in the elaboration of her previous relevant reports, not only comments by Governments and the specialized agencies, regional intergovernmental organizations and non-governmental organizations concerned, but also other material, including judgements of regional and national courts and writings of recognized scholars and scientists.[7] She was therefore confronted with the difficult task of studying an enormous amount of documentation which, on account of United Nations regulations on the limitation of these publications, has had to be severely restricted and reduced. For this basic reason, it has been impossible for the Special Rapporteur to discuss and analyse all aspects of the topic of mental illness and its related problems and to reflect in the following pages of the study extensive information and data available on these matters.

19. As suggested in her preliminary report, in a subsequent report[8] and in her relevant introductory statements before the Sub-Commission,[9] the Special Rapporteur submits the present final report, which, *inter alia*, contains a preface, an introduction and five chapters. Chapter I contains a summary of the history

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[2] For a list of these States see annex I of the present study.

[3] A summary of the comments made by the WHO staff on the progress report prepared by the Rapporteur (E/CN.4/Sub.2/1982/16) will be found on pages 16 to 18 of document E/CN.4/Sub.2/1983/17/Add.1.

[4] For the list of these organizations, see also annex I of the present study.

[5] A summary of the discussion appears in documents E/CN.4/Sub.2/1982/SR.31/Add.1 and SR.36, paras. 15-17 and 71-74, respectively. See also the report of the Sub-Commission on the work of its thirty-fifth session (E/CN.4/Sub.2/1982/43 and E/CN.4/1983/4), chap. XI.

[6] See the report of the Commission on Human Rights on its thirty-ninth session, *Official Records of the Economic and Social Council, 1983, Supplement No. 3* (E/1983/13 and E/CN.4/1983/60), chap. I, sect. A and chap. XXVII, sect. A. A summary of the comments made on this subject is contained in the summary records of the 50th, 51st and 54th meetings of the Commission on Human Rights (E/CN.4/1983/SR.50/Add.1, pp. 6 and ff., E/CN.4/1983/SR.51, para. 22, and E/CN.4/1983/SR.54, para. 10).

[7] See resolution II, adopted at the twelfth session of the Commission on Human Rights, *Official Records of the Economic and Social Council, Twenty-second Session, Supplement No. 3* (E/2844—E/CN.4/731, para. 49).

[8] Documents E/CN.4/Sub.2/474 and E/CN.4/Sub.2/1982/16.

[9] A summary of these introductory statements appear in the summary records of the 916th and 931st meetings of the Sub-Commission (E/CN.4/Sub.2/SR.916, paras. 1-4, and E/CN.4/Sub.2/SR.931, paras. 26-32).

of mental illness, the treatment and care of the mentally ill and of mental institutions. Chapter II refers to the basic contribution made to the protection of the human and legal rights of the patient by the United Nations, specialized agencies, regional organizations, courts, and non-governmental organizations. Chapter III reflects the views and considerations of the Special Rapporteur concerning the main problem of mental illness and the relevant issues: procedures for admission to mental institutions, involuntary detention, treatment and consent of the patient. Chapter IV is devoted to the basic conclusions and chapter V to recommendations. The select bibliography includes only those main works published before June 1983 which are of specific relevance to the present study.

20. Finally, the reader's attention is drawn to a draft body of principles, guidelines and guarantees, set out in annex II, for the protection of the mentally ill or persons suffering from mental disorder.

Chapter I

SUMMARY OF THE HISTORY OF MENTAL ILLNESS, OF THE TREATMENT AND CARE OF THE MENTALLY ILL AND OF MENTAL INSTITUTIONS

21. The history of diseases and especially of mental illness is valuable because it can contribute to an understanding of relevant contemporary problems.

22. Man has always feared illness and has always recognized healers. However, the picture of the historical evolution of mental illness is of a peculiar nature, mainly because a person afflicted with a mental illness often does not know that he is ailing and violently protests against being called sick.

23. Many centuries passed before humanity made some headway along the road to a more enlightened comprehension of the mentally ill and the defenceless and fearful "wild people".[1]

24. Across the wide range of cultures and irrespective of local beliefs and traditional practices, religion has played a great role in the promotion of mental well-being and in the alleviation of mental disorders. For example, reference is made to the therapeutic institution in ancient Egypt called the "temple sleep".[2] Treatment was influenced by the psycho-religious climate of the temples, by the confidence people had in the supernatural powers of the deity, and by techniques of suggestion used by the healers.

25. Greek science made the first serious attempt to place the consideration of mental diseases on a scientific medical basis.[3]

26. The medical centres of pre-Hippocratic days were the Aesculapian temples and the oracles, the source of a great deal of medical and, in particular, medicopsychological advice.

27. Hippocrates introduced psychiatric problems into medicine. Among his earliest writings were the *Praenotiones* and the *Prophetica*, which were probably a kind of compilation of records of the symptoms of depression, also known in contemporary societies as "melancholia".[4] He formulated the view that a disease or injury to the brain was the sole cause of mental illness and offered a rational classification of mental diseases. That classification included epilepsy, mania (states of abnormal excitement), melancholia (depression) and paranoia (mental derangement).

28. Aristotle laid the foundations of the science of psychology. He thought that every mental illness was a physical, organic illness and stated that there were those who were reduced to this state by an illness.[5]

29. Later the Romans, and especially Celsus and Cicero, dealt with the subject of mental illness. Celsus favoured the view that madness belonged to the affections of *totius corporis*. The significance of this view resides in the idea that in a mental disease the whole personality and not some single bodily organ is affected.

30. Cicero distinguished *insania* from *furor* and explained that *insania* is an absence of calm and poise but *furor* denotes a complete breakdown of intellectual capacity, which makes the afflicted individual legally irresponsible. This should be considered as one of the earliest references to the problem of legal responsibility of the mentally ill.[6]

31. In August 1793, Philippe Pinel removed the chains from one of the most feared patients at the Bicêtre, the Paris asylum for male lunatics. This historical gesture of psychiatric treatment consisted neither in prescribing medicines nor in performing operations, but in giving an imprisoned human being a measure of freedom.

32. In the nineteenth century the tendency to build large, rurally or semi-rurally located institutions developed further. These institutions were used for the care and treatment of mentally ill persons and became known as "asylums". Their establishment and development was a kind of response to the conditions of disorder in great cities caused mainly by industrialization.

33. The basic common characteristics of asylums of that period were the inhuman living conditions and the cruel, even brutal, treatment of the patients.[7]

34. At that time, procedures for the admission of patients to asylums were easier than those for their discharge.

35. The length of stay in asylums, and in the more modern mental hospitals which were subsequently established, was reduced between 1919 and 1940, although an increase in readmissions was observed in certain cases.

36. Furthermore, between these years and in particular after the Second World War, certain countries introduced significant reforms in mental health care by

[1] G. Zilboorg, *A History of Medical Psychology* (New York, Norton, 1941), p. 29.

[2] This temple was associated with the name of I-em-hotep (2980-2900 B.C.), who was regarded as the patron saint and god of medicine. For more details, see Taha Baasher, "The healing power of faith", *World Health*, October 1982, pp. 5-7.

[3] Zilboorg, *op. cit.*, p. 35.

[4] E. Isensee, *Geschichte der Medizin*, Berlin, 1845, part II, book 6, pp. 1216 and 1217.

[5] Zilboorg, *op. cit.*, p. 55.

[6] *Ibid.*, pp. 64-66.

[7] *Ibid.*, pp. 341 and ff. See also W. Sargant, *The Unquiet Mind* (London, Heinemann, 1967).

creating networks of community mental health centres (psychiatric dispensaries) which made psychiatric care more easily available to those who needed it and reduced the requirements for prolonged hospitalization.

37. In many developing countries, the religious healer[8] has an important role to play. As a community leader, he is concerned with the person as a whole—physically, psycho-socially and spiritually—and he applies his knowledge and skills within the socio-cultural context and in harmony with the patient's and the community's relations.

38. A number of villages in the Sudan have long been known for their traditional and religious healing facilities. These occupy a central place in the villages and play a central role in the life of the community. Some of these institutions have been established for more than two centuries and were founded before the development of modern psychiatric services in the country.

39. In a number of countries of the least developed world, efforts are being made to involve traditional healers in modern psychiatric services.[9]

40. In the year 1950 the so-called "drug revolution" took place. New and powerful tranquillizing drugs were introduced and offered far more effective and active therapy for various psychotic illnesses than had been previously available.[10] Also, certain forms of "minor" tranquillizers were developed.

41. Fundamental changes in the fields of political history, socio-economic progress and development, protection of fundamental freedoms and human rights and advances in the treatment, hospitalization and rehabilitation of the patient have taken place during the last 30 years. One of the most striking developments from the political, economic, social, cultural, legal and medical standpoints was the wave of independence of a great number of nations.

42. At the beginning of their independence many of these nations continued to use the legal structures set up in the years of colonialism. In a great number of cases mental health legislation, medical and psychiatric practice, the treatment of the patient and the establishment of large mental hospitals were based mainly on the patterns of colonial times.

43. Nevertheless, some of these new independent States as well as other States from the least developed world introduced community-based care, in particular in mental health. Botswana is one of these developing countries that has given particular attention to a pilot community care project that began in 1977.[11]

44. During 1978-1979 the staffs of the medical colleges were brought together and the medical curricula were re-established, as far as possible, in the People's Republic of China. This new process of regrouping and planning has included the recognition by the Chinese authorities of the need to give some priority to the development of psychiatry and modern health care. Of great help in implementing the objective of better mental health services for the patient were the seminars held in China, organized jointly by the Chinese authorities and WHO.[12]

45. Another important project, using mental health expertise at community level, has been carried out in another part of the least developed world, namely in Honduras. Thus, health and mental health education were constantly stressed, *inter alia*, in lectures and discussion groups. Among mental health activities the focus was on the establishment of a sense of community and the creation of organizations for co-operative activities. This project has proved that in a small country with only a limited number of mental health personnel, mental health services have been improved and the patient has been helped by the training of local leaders to carry on the work of the mental health specialists.[13]

46. In general, it should be mentioned that very little has been done over the last decade as regards the improvement of conditions in mental institutions, which in most countries of the international community are not adequately funded by the State. Some of these institutions have gross deficiencies, especially in medical and nursing personnel, offer poor food, and relationships between the medical personnel and the patient are usually unsatisfactory.

47. The main explanation of these unsatisfactory conditions in mental hospitals is that the maintenance of high standards in public mental health institutions is not always among the high priorities of Governments. Government reluctance in a great number of developed countries—or inability in certain least developed countries—to provide adequate funding for mental hospitals has often brought the care, treatment and accommodation of patients below acceptable civilized standards.

48. In many cases the failure of the State to establish proper community facilities pushes former patients into non-psychiatrically oriented institutions, mainly nursing homes.

49. This fact and existing conditions have made "deinstitutionalization" an issue as a means of ensuring better and more human standards of care and treatment for patients.[14]

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[8] For example, the "pir" or "fakir" in Afghanistan, Pakistan and India, the "mutawee" in the United Arab Emirates. See Baasher, *loc. cit.*, p. 6.

[9] Examples of this are the village system in Aro, Nigeria, and that in Om Dawan Ban village in the Sudan. See Baasher, *loc. cit.*, p. 7.

[10] For further details, see W. J. Curran and T. W. Harding, *The Law and Mental Health: Harmonizing Objectives* (Geneva, World Health Organization, 1978), p. 15.

[11] See D. I. Ben-Tovim, "Community-based care", *World Health,* October 1982, pp. 12-15.

[12] See J. E. Cooper, "Seminars in China", *World Health,* October 1982, pp. 23-25.

[13] See C. Eisenberg, "Portrait of a Central American slum," *World Health,* October 1982, pp. 26-29.

[14] With regard to the issue of hospital care versus community care, see C. A. Butterworth and D. Skidmore, *Caring for the Mentally Ill in the Community* (London, Croom Helm, 1981), pp. 22-32.

Chapter II

THE BASIC CONTRIBUTION TO THE PROTECTION OF THE HUMAN AND LEGAL RIGHTS OF THE PATIENT BY THE UNITED NATIONS, SPECIALIZED AGENCIES, REGIONAL ORGANIZATIONS, COURTS AND NON-GOVERNMENTAL ORGANIZATIONS

A. The protection of the human and legal rights of the patient by the Charter of the United Nations and other international instruments

50. The Charter of the United Nations, in its Articles 13 and 62, provides that the General Assembly, the Economic and Social Council and the specialized agencies concerned may make or initiate studies and reports with respect to international economic, social, cultural, educational, health and related matters, and may make recommendations with respect to any such matters to the General Assembly, to the Members of the United Nations, and to the specialized agencies concerned. In particular, the Economic and Social Council and its subsidiary bodies may also "make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all".

51. The Universal Declaration of Human Rights, in which the people of the United Nations reaffirm their faith in fundamental human rights, in the dignity and worth of the human person and in equal rights for men and women, contains in its articles 3, 5, 6, 7, 8, 9, 10, 12, 25 and 26 basic provisions related to the protection of the human rights of the patient.

52. The Constitution of the World Health Organization[1] and the Declaration of Alma-Ata,[2] *inter alia*, provide that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

53. The International Covenant on Civil and Political Rights, in its article 7, prohibits torture and cruel, inhuman or degrading treatment or punishment, and states "in particular, no one shall be subjected without his free consent to medical or scientific experimentation".[3]

54. Despite the above-mentioned basic provisions, and other clauses and recommendations contained in other international instruments which are relevant to some aspects of the effect of scientific and technological development upon the enjoyment of human rights and fundamental freedoms, this question was not considered in detail until it was discussed by the International Conference on Human Rights, held at Teheran in 1968.

55. Paragraph 18 of the Proclamation of Teheran provides: "While recent scientific discoveries and technological advances have opened vast prospects for economic, social and cultural progress, such developments may nevertheless endanger the rights and freedoms of individuals and will require continuing attention".[4]

56. The International Conference on Human Rights dealt with the question of human rights and scientific and technological developments at greater length in its resolution XI, by which it recommended that the organizations of the United Nations family should undertake a study of the problems with respect to human rights arising from developments in science and technology.[5]

57. Since then the General Assembly and the Commission on Human Rights have adopted a great number of resolutions[6] on the question of human rights and scientific and technological developments and, in recent years, on the protection of the human rights of patients.[7]

58. The Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind[8] also contains basic provisions which expressly state: (*a*) that scientific and technological achievements can entail dangers for the civil and political rights of the individual or groups and for human dignity; (*b*) that all States shall take appropriate measures to prevent the use of scientific and technological developments, particularly by the State organs, to limit or interfere with the enjoyment of the human rights and fundamental freedoms of the individual as enshrined in the Universal Declaration of Human Rights, the International Human Rights

[1] United Nations, *Treaty Series*, vol. 14, No. 221, p. 185.

[2] The Declaration of Alma-Ata was adopted on 12 September 1978 by the International Conference on Primary Health Care, held at Alma-Ata (USSR) from 6 to 12 September 1978 (see the joint report of WHO and UNICEF, *Alma-Ata 1978: Primary health care*, Geneva, World Health Organization, 1978, pp. 2-6.

[3] United Nations, *Human Rights—A Compilation of International Instruments* (United Nations publication, Sales No. E.83.XIV.1), p. 9.

[4] *Final Act of the International Conference on Human Rights*, Teheran, 22 April-13 May 1968 (United Nations publication, Sales No. E.68.XIV.2), p. 5.

[5] *Ibid.*, p. 12.

[6] See the introduction to the present report, paras. 1-10 above.

[7] See the preliminary report by the Special Rapporteur, Mrs. E.-I. A. Daes (E/CN.4/Sub.2/474), pp. 1-3.

[8] Proclaimed by the General Assembly of the United Nations on 10 November 1975 (resolution 3384 (XXX)). For the text of the Declaration, see United Nations, *Human Rights...*, p. 140.

Covenants and other relevant international instruments.[9]

59. The impact of recent scientific and technological developments on the right to health, and in particular on problems related to mental disorders caused by the urban environment and experiments on human subjects, and the meaning of "informed consent" for the purpose of such experiments, were discussed in detail at the Seminar on human rights and scientific and technological developments.[10]

B. Specialized agencies

1. World Health Organization (WHO)

60. WHO has made a great contribution, in particular through its studies and publications, to the protection of the human rights of persons suffering from mental disorder, and to informing the world community of the health aspects of avoidable maltreatment of prisoners and detainees and of the effects of pyschiatric treatment on prisoners.[11]

61. The above-mentioned organization also elaborated an important document, "*Apartheid* and Mental Health Care",[12] which was prepared on the basis of information published[13] at the request of the United Nations Special Committee Against *Apartheid* and in conformity with resolutions of the World Health Assembly and decisions of the Committee of the American Association, which visited the country concerned (South Africa) and was able to confirm most of the conclusions of the WHO review, as well as to add new facts and details.

62. In response to the above-mentioned request of the United Nations Special Committee Against *Apartheid*, and in view of the serious implications of the Mental Health Amendment Act of 1976 for the feasibility of an open and free discussion *in situ*, the Director-General of WHO decided to undertake a preliminary inquiry into the mental health situation in the Republic of South Africa, and, in particular, into the allegations about discrimination, inhuman treatment and exploitation of black mental patients. The inquiry was based mainly on official South African documents, scientific publications and consultations with experts.

63. The information and comments of the author of the preliminary review prepared by the World Health Organization are the following:

Between 8,000 and 9,000 Africans suffering from mental disorders are detained against their will in privately owned institutions in the Republic of South Africa. These Africans are the object of a business deal between the State and profit-making white-owned companies which receive a Government subsidy on a *per capita* basis against the provision of custodial care for mental patients, who are referred to in Government publications as the "sediment of mentally maladjusted persons and deviates". There is not a single black psychiatrist in South Africa and vital decisions about thousands of African mental patients are made by part-time physicians who do not even speak the language of the patients. While the majority of the white mental patients are receiving care in services provided by the State (the provision of psychiatric beds per 1,000 of the white population is 3.3 times greater than for Africans), the majority of the African mental patients are certified as mentally ill by the State and transferred involuntarily to profit-making private "sanatoria". About one-third of the whole mental health budget of the Republic of South Africa subsidizes this operation. The rapidly rising "demand" for institutional care of mentally ill Africans, which is given as an explanation of these anomalies and discriminatory practices, is understandable in the context of overall *apartheid* policies which have resulted in the uprooting of over 3 million people, the disintegration on a mass scale of the African family and the breakdown of community support for the mentally ill. Recent legislative measures of the Government concerning the "rehabilitation" of African pass offenders equate in a dangerous way the non-observance of the *apartheid* laws with mental disorder. The Mental Health Amendment Act of 1976 virtually imposes a ban on information and free discussion of the conditions and policies prevailing in the mental health services. These conditions and policies, being a direct effect of *apartheid* in the health field, are inimical to the letter and spirit of the Constitution of the World Health Organization which proclaims that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[14]

64. The World Health Organization has already examined the implications of the doctrines of *apartheid* in South Africa, with the basic conclusion that "the prevailing situation stemming from the policy of *apartheid* presents an obstacle to the achievement of the highest level of health for all individuals".[15]

65. It is evident that the implications of *apartheid* for the mental health of the population and for mental health care cannot be understood if taken out of the context of the psychosocial stress and deprivations which are inherent by design in contemporary South African society.

66. "*Apartheid* is a crime against humanity" and inhuman acts resulting from the policies and practices of *apartheid* and similar policies and practices of racial segregation and discrimination, as defined in article II of the International Convention on the Suppression and Punishment of the Crime of *Apartheid*, are crimes violating the principles of international law, in particular the purposes and principles of the Charter of the United Nations, and constitute a serious threat to international peace and security.[16]

67. The Special Rapporteur on another occasion has written that the Government of South Africa set out on the path to *apartheid* as the frightened response of a

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[9] Preambular paragraph 4 and paragraph 2 of the Declaration, *ibid.*

[10] See *Seminar on Human Rights and Scientific and Technological Developments,* Vienna, Austria, 19 June-1 July 1972 (ST/TAO/HR/45), paras. 43 and 44.

[11] See, among others, L. Bovet, *Psychiatric Aspects of Juvenile Delinquency* (Geneva, World Health Organization, 1951), pp. 7-90.

[12] See World Health Organization, "*Apartheid* and mental health care", *Objective: Justice* (journal published by the United Nations Office of Public Information), vol. 9, No. 1 (Spring 1977), pp. 37-45.

[13] In 1974-1975, reports in the South African press exposed the existence of a chain of privately owned institutions in which many thousands of mentally ill black Africans were detained against their will.

[14] See World Health Organization, *loc. cit.*, p. 37.

[15] See H. T. Mahler, "Health implications of *apartheid*", *Objective: Justice* (journal published by the United Nations Office of Public Information), vol. 7, No. 2 (April-June 1975), p. 37.

[16] Articles I and II of the International Convention on the Suppression and Punishment of the Crime of *Apartheid*, United Nations, *Human Rights...*, p. 29. See also E.-I. A. Daes, *The Duties of the Individual to the Community and the Limitations on Human Rights and Freedoms under article 29 of the Universal Declaration of Human Rights* (United Nations publication, Sales No. E.82.XIV.1), introduction, paras. 74-85.

white minority to the challenge of democracy in a multiracial State with an overwhelming black majority.[17] Thus, one of the main consequences of this abhorrent system is the almost total control over the lives of men and women through legislation that is based on racial distinctions.

68. Consequently, millions of people in South Africa are being exposed to stress which strikes at the roots of their experience of dignity, security and purpose in life. Typical stresses affecting all these millions of people and creating for the African an environment characterized by unpredictability, hostility and inhuman acts include the following:

(*a*) *Forced mass uprooting*. This takes place under the legislation aiming to achieve a "bantustanization" in certain desert places of the country by forcing against their will millions of black people into the so-called "homelands".

(*b*) *Forced splitting of families*. The overriding purpose of the "homelands" programme is to perpetuate white economic and political supremacy by creating a mobile pool of destitute migratory labour. Africans are thereby declared aliens in their own country and compelled to spend most of their active lives as migrant workers in white-controlled areas. African men return to their families, who are confined in the "homelands", only once or twice a year. Family life is severely disrupted or non-existent.

(*c*) *Enforced economic deprivation and unfavourable discrimination with regard to salaries and wages*

(*d*) *Enforced inferior status and de-individuation*. This is the result of a series of laws and practices: e.g., the Population Registration Act of 1950, which set up a racial register of the population and whose implementation required a "reclassification" of about 1 per cent of the total population of the country; the Bantu Education Act of 1953, the basic objective of which was to eliminate "the vain hope that was created among the natives that they could occupy posts within the European community".[18]

(*e*) *Harassment and basic insecurity*. The great number of unfair and discriminatory laws to which the black Africans are subjected creates for them serious problems and threatens their freedom and security. For example, section 29 of the Bantu Urban Areas Act contains detailed definitions of "idle" and "undesirable" Africans.

(*f*) *A cultural "double-bind" situation*. The cultural heritage of the African people is defamed as "ignorance, traditional taboos and superstition" by the white minority.

(*g*) *Denial of the means of self-expression and of coping with stress*. Black Africans are deprived of most of the mechanisms which human groups enjoy to cope with situations of frustration, tension and stress.

69. Mental health care for black Africans is a seriously neglected area in the Republic of South Africa, despite the vast economic resources of the country.

70. It should be also noted that in the reply of the Government of the Republic of South Africa to the questionnaire sent out in connection with the present study, not one of the above-mentioned elements is mentioned.[19] This reply provides general information concerning the definition of "mental illness" and "psychopathic disorder", etc.; statistics which indicate that the number of in-patients decreased between the years 1975 and 1980; types of mental institutions and clinics; procedures for determining whether adequate grounds exist for detaining persons on the grounds of mental disorder; treatment of minors; safeguards; principles for protecting persons suffering from mental disorder; protection of legal rights/status; procedures in criminal proceedings; medical treatment; and rehabilitation.

2. International Labour Organisation (ILO)

71. ILO is not normally concerned with matters relating to the protection of persons suffering from mental disorder. However, the Committee of Association of the Governing Body of ILO has considered a case in which allegations were made of anti-union action by means, *inter alia*, of internment of trade unionists in psychiatric institutions. In this connection, the aforesaid Committee notes *inter alia* that a large number of the founders of the Free Inter-occupational Union of Workers (SMOT)—as was also the case of the "USSR Workers' Free Trade Union Association"—have been admitted to, or remain in psychiatric hospitals or clinics. The Committee's recommendations are the following:

> In these circumstances the Committee recommends the Governing Body to approve the following conclusions: as regards the case as a whole, the Committee points out that the right of workers to establish organizations of their own choosing, guaranteed by Article 2 of Convention No. 87, implies in particular the real possibility of forming, in a climate of full security, workers' organizations independent both of those which exist already and of any political party. Regarding the specific legislative question, the Committee recalls that the Committee of Experts on the Application of Conventions and Recommendations considered it desirable that the legislation be amended in order to recognize clearly the right of workers to establish, should they so wish, an organization outside the factory, works and local trade union committees which exist. As for the measures of repression taken against the founders or members of SMOT, the Committee points out on the one hand, that the granting of freedom to a trade unionist on the condition that he leaves the country cannot be considered to be ible with the exercise of trade union rights. The Committee also points out that all the necessary safeguards should be provided to prevent measures of commitment to psychiatric hospitals from being taken as sanctions or as means of pressure against persons who wish to establish a new organization independent of the existing trade union structure, and it invites the Government to re-examine the situation from this point of view.[20]

The Committee's recommendations were approved by the Governing Body. The Government of the USSR in its relevant reply to the above-mentioned Committee stated, *inter alia*, that

> it has been repeatedly shown that Convention No. 87 on Freedom of Association is fully applied in the USSR. Soviet legislation, as regards the activities of trade unions, contains no provision which conflicts

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[17] See Daes, "Protection of minorities under the International Bill of Human Rights and the Genocide Convention", *Xenion: Festschrift für Pan. J. Zepos* (Athens, C. Katsikalis, 1973), vol. II, pp. 35-86.

[18] See World Health Organization, *loc. cit.*, p. 38.

[19] See the summary of the reply of the Government of the Republic of South Africa in document E/CN.4/Sub.2/1983/17/Add.1.

[20] See the summary of the reply of ILO in document E/CN.4/Sub.2/1983/17/Add.1, p. 13. See also International Labour Office, Report of the Committee on Freedom of Association (207th report), *Official Bulletin*, vol. LXIV, 1981, series B, No. 1, para. 130.

with international labour standards; on the contrary, it guarantees more favourable conditions to workers within the meaning of article 19, paragraph 8, of the ILO Constitution.[21]

With regard to the reply of the Government of the USSR,

There are a number of mental patients among the persons allegedly being prosecuted for their membership of the organization known as SMOT. This is the case of Anatoly Pozdniakov, on whom information has been requested. This person has been kept under observation for over 15 years in a neuro-psychiatric clinic. In 1979, A. Pozdniakov was prosecuted for having hit the foreman of the workshop where he was working in front of witnesses. While recognizing the dangerous nature of his act for society, the court took account of the condition of the accused, who had been examined by the Forensic Psychiatric Commission, and decided to clear him of responsibility and refer him to a psychiatric hospital for treatment. Valeriya Novodvorskaya and Vladimir Gershuni are also mental patients. V. Novodvorskaya lives in Moscow and does not work. She has been hospitalized on a number of occasions and is at present under observation at the district neuro-psychiatric clinic. Because of the aggravation of his mental illness V. Gershuni received treatment in a psychiatric hospital from June to August 1980. During this period he was transferred for a time to a general clinic for an appendectomy. Vsevolod Kouvakin is living is Moscow, where he is working as legal adviser to a hospital. He has not been sentenced for his so-called participation in the organization known as SMOT. Albina Yakoreva is a vagrant and is not working anywhere despite repeated offers of employment. If only for this reason, she cannot be a member of a trade union, still less act as a representative of the occupational interests of the workers. A number of the persons on whom information was requested, such as M. Morozov, A. Pozdniakov and M. Kukobako, do not in any way regard themselves as members of SMOT.[22]

3. United Nations Children's Fund (UNICEF)

72. UNICEF attaches considerable importance to the elaboration of principles and guidelines affecting persons suffering from mental disorder, particularly with reference to children or "persons under age" or "minors as referred to in the questionnaire of the present study".[23]

73. In this connection, UNICEF proposed the following issues for consideration:

(*a*) *Prevention of mental illness*, particularly with regard to children, as it is in childhood that prevention must start if it is to be effective. This calls for sound community-based mental health programmes with emphasis on prevention, and with the active participation of local residents in the planning, implementation and monitoring of preventive programmes;

(*b*) *Promotion of health education*, which needs to include mental health education and recognize at the same time that the subject of mental health is taboo in many countries because of ignorance, prejudice and fear. Hence the added importance of incorporating mental health aspects in all health education programmes;

(*c*) *Development of services*, which include the whole gamut of prevention, rehabilitation and treatment of the mentally ill. Legislation is often needed for the establishment as well as the funding of these services. Children have special needs which call for special services. These too have to be mandated by law;

(*d*) *Due process of law* to ensure that no one is committed to a mental health institution who does not need that type of placement;

(*e*) *Education* in keeping with the abilities of the child and worked out with parental participation;

(*f*) *Attention to social factors* and recognition that emotional and behavioural disturbances stem from social and economic deprivation and social stress—much of it the result of modernization—all of which tend to erode the social fabric, the family system and the traditionally valued ways of life. The establishment of supports within the family and the community are essential elements in preventing the onset of emotional illness;

(*g*) *Emergencies*. UNICEF involvement in emergencies in Africa and in Kampuchea has taught us how the vulnerability of certain population segments such as the mentally ill, and in particular the mentally ill child or the child at risk, tends to make for greater disorientation during periods of crisis than would be the case in "normal" circumstances. It is therefore all the more important to ensure that the rights of the mentally ill are protected not only in day-to-day life but also in times of emergency (natural disasters, war, refugee upheavals).

74. Consequently, the main point which UNICEF brings out refers to the rights of the child or the adult before he or she becomes a patient. Hence the importance of the preventive aspects and the need to incorporate them in the legislation, together with appropriate funding allocations. This is in addition to the full range of services available for mentally ill persons, which are provided not only through medical and psychiatric auspices but also through community-based programmes, trained social workers and psychologists. The involvement of close family members is crucial in any decision which affects treatment and placement of a mentally ill person. The voice of advocacy on these issues needs to be raised loud and clear.

75. Basically, what seems indicated is that the mentally ill child (or adult) should benefit from the same services provided to the handicapped child (or adult) in terms of prevention, early identification, treatment and rehabilitation that is individually tailored and undertaken in the least restrictive setting, with periodic reviews of the treatment plan and the applicability of the setting.

C. Regional organizations

1. Council of Europe

76. The Council of Europe have paid particular attention to the legal protection of mentally ill persons.[24] Thus, on 8 October 1977, the Parliamentary Assembly of the Council of Europe adopted recommendation 818 (1977) on the situation of the mentally ill.[25] In this rec-

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[21] International Labour Office, Report of the Committee on Freedom of Association (207th report), *Official Bulletin*, vol. LXIV, 1981, series B, No. 1, para. 117.

[22] *Ibid.*, paras. 120 and 121. See also the summary of the reply of the Government of the USSR, which constitutes a general reply to the questionnaire in document E/CN.4/Sub.2/1983/17/Add.1.

[23] See the summary of the reply of UNICEF in document E/CN.4/Sub.2/1983/17/Add.1, pp. 14-16.

[24] A summary of the reply of the Council of Europe is given in document E/CN.4/Sub.2/1983/17/Add.1, p. 18.

[25] For the text of the recommendation, see the Parliamentary Assembly of the Council of Europe, Report of the Committee on Social and Health Questions (doc. 4014).

ommendation several problems of internment and civil incapacity of mentally ill persons were raised and a number of points were recommended to improve the situation of these sick persons and curb abuses of such internments, which are condemned in all democratic societies.

77. The Committee of Ministers submitted this recommendation to the European Committee on Legal Co-operation for opinion. At its 30th meeting (4th as a Steering Committee), the European Committee on Legal Co-operation proposed to the Committee of Ministers that it charge the future committee of experts on legal problems in the medical field with the task of studying, *inter alia*, the legal situation of the mentally ill from the point of view of private law in the light of recommendation 818 (1977) of the Assembly.

78. At its 301st meeting, the Committee of Ministers decided to create the proposed Committee of Experts and asked it to study the problems of:

(*a*) The legal situation of the mentally ill from the point of view of private law, in the light of recommendation 818 (1977) of the Assembly;

(*b*) The protection of patients' rights;

(*c*) Compensation for damages caused by medical acts, with a view to identification of specific issues lending themselves to legislative agreement throughout Europe.

79. The Secretariat of the Council of Europe also prepared an important document (CJ/ME (79) 1) which referred to the following main issues of the subject under study:

(*a*) The definition of the term "mental illness";

(*b*) The legal situation of the mentally ill;

(*c*) The question of the right period of internment of a mentally ill person;

(*d*) The procedural guarantees for the mentally ill person.

80. Further, the Committee of Ministers of the Council of Europe adopted recommendation No. R(83)2 (1) concerning the "Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients". By this recommendation the above-mentioned Committee of Ministers urged the Governments of the Member States to adapt their laws to the rules annexed to it or adopt provisions in accordance with those rules when introducing new legislation.[26]

2. European Court of Human Rights

81. The following two cases constitute a valuable contribution to the protection of the human rights of the patient:

82. The first case originated in an application against the Netherlands lodged with the European Commission of Human Rights in December 1972 by Mr. Frits Winterwerp, a Netherlands national. In 1968, at the request of his wife, Mr. Winterwerp was committed to a mental hospital under a provisional order made by the local District Court. Subsequently, the detention order was renewed periodically by decision of the regional court on the basis of medical reports from the doctor in charge of his case.

83. Mr. Winterwerp complained that he was never heard by the various courts, that he was never notified of the orders concerning his detention, that he did not received any legal assistance and that he had no opportunity of challenging the medical reports. In his view, his deprivation of liberty could not be considered "lawful" within the meaning of article 5, para. 1, of the European Convention on Human Rights.[27] He further claimed that he was unable to take court proceedings in accordance with article 5, para. 4, of the above Convention to test the lawfulness of his detention. Finally, he alleged a breach of article 6, para. 1, in that his detention deprived him, automatically and without a proper judicial procedure, of the capacity to administer his property.[28]

84. In March 1980, Mr. D. Evrigenis, the President of the Chamber, suspended the time-limit granted to the European Commission of Human Rights for the filing of its observations until further order, pending the outcome of settlement negotiations which had begun in February between the Government of the Netherlands and the applicant's lawyer. From the outset, the principal claim of the applicant's lawyer was that his client should be placed in a "gezinsvervangend tehuis" (hostel) which is a private institution where persons formerly in need of psychiatric treatment in a hospital live together in small groups and where Mr. Winterwerp could, as a person at liberty, feel at home in family-like surroundings, with some guidance and care from social and medical experts.

85. In answer to enquiries made by the Registrar, the Court was informed in March and April 1981 that the Commission, the Government and the applicant's lawyer wished the President's Order of 11 March 1980 to be maintained for some while longer, as settlement negotiations were still in progress. The Chamber held a meeting on 28 May 1981 to consider the state of the proceedings. In a letter received on 5 October 1981, the agent of the Government announced that a settlement had been reached. The main points of the material parts read as follows:

> ...
>
> (*d*) that in the opinion of the State [of the Netherlands ("the State)], the State could not be considered under Article 50 of the Convention[29] to be obliged to perform the provisions of the operative

[26] This recommendation and the relevant rules annexed to it can be consulted at the secretariat of the Centre for Human Rights.

[27] For the text of the Convention for the Protection of Human Rights and Fundamental Freedoms (known as the "European Convention on Human Rights"), see United Nations, *Treaty Series*, vol. 213, No. 2889, p. 221.

[28] European Court of Human Rights, *"Winterwerp Case" (Publications of the European Court of Human Rights, Series B, Pleadings, Oral Arguments and Documents, vol. 31, 1978-1981).*

[29] Article 50 of the European Convention on Human Rights provides as follows:

> "If the Court finds that a decision or a measure taken by a legal authority or any other authority of a High Contracting Party is completely or partially in conflict with the obligations arising from the present Convention, and if the internal law of the said Party allows only partial reparation to be made for the consequences of this decision or measure, the decision of the Court shall, if necessary, afford just satisfaction to the injured party."

paragraphs 1 and 2 of this agreement, and that therefore the State voluntarily accepts to perform those provisions;

(*e*) that Mr. Winterwerp does not share the view stated under (*d*), and is of the opinion that on account of the violation of the Convention established by the European Court the State is definitely bound to pay him compensation, a compensation at least equal to the performance which the State has (voluntarily) agreed to under (1) and (2) below;

(*f*) That the State and Mr. Winterwerp wish, however, to avoid further proceedings;

(*g*) that the parties, therefore, enter into the following agreement:

(1) the State shall promote that Mr. Winterwerp be placed as soon as possible in a hostel. The State Psychiatric Establishment at Eindhoven is and will remain prepared to give Mr. Winterwerp medical treatment whenever this might be necessary;

(2) the State shall transfer a lump sum of fl. 10,000 (ten thousand guilders) to (Mr. Winterwerp's new guardian) to be used for the resocialization of Mr. Winterwerp.

Parties hereby declare that they have reached an amicable settlement and have no further claims against each other.

The Agent of the Government explained that the sum of 10,000 guilders was intended to be used as financial assistance in connection with additional costs, not covered by social security legislation, likely to confront Mr. Winterwerp once he was admitted to a hostel.

86. Since 24 October 1979, the date on which it had rendered its judgement,[30] the Court had been informed of the terms of the friendly settlement reached between the Government and the applicant in respect of the latter's claims under article 50. The Court noted that on the applicant's side the agreement was signed both by Mr. Winterwerp himself, who thereby confirmed his personal approval, and by the guardian appointed for him in accordance with the relevant domestic law.

87. Having regard to the measures agreed upon and to the absence of objection on the part of the Commission's delegate, the Court found that the settlement reached was of an "equitable nature" within the meaning of Rule 50, section 5, of the Convention.[31] Accordingly, the Court took formal note of the settlement and concluded that it would be appropriate to strike the case from its list (see, *mutatis mutandis*, Rule 47 of the Rules of Court). For these reasons the Court decided unanimously to strike the case from its list.[32]

88. The second case, that of *X* v. *the United Kingdom*, was referred to the Court by the European Commission of Human Rights. The case originated in an application against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission on 14 July 1974 under article 25 of the Convention by a citizen of the United Kingdom referred to as X in this judgement. Contrary to the usual practice, the identity of the applicant, who died in 1979, has not been made public in view of the wish expressed by his next of kin.[33]

As to the facts

89. The applicant, a citizen of the United Kingdom born in 1934, died in 1979. At the time of lodging his application with the Commission he was detained in Broadmoor Hospital, a special secure mental hospital for the criminally insane. His complaints were directed against his recall to Broadmoor Hospital in April 1974, following a three-year period of conditional discharge. He claimed that his recall was unjustified, that he was not promptly given sufficient reasons for his re-detention, and that he had no effective way of challenging the authorities' action.

Proceedings before the European Commission of Human Rights

90. On 14 July 1974, the applicant lodged his application with the Commission. He complained that he had been recalled to Broadmoor Hospital after three years of normal life, without first going before any legal authority and without any doctors having certified first that he was of unsound mind. He further complained that the *habeas corpus* proceedings did not fully investigate the merits of the decision to recall him, but merely examined if the recall had been ordered in accordance with the relevant provisions of the 1959 Act. He relied on article 3 and article 5, paras. 1, 2 and 4 of the Convention. On 11 March 1976, the Commission declared the application inadmissible in so far as the applicant alleged inhuman or degrading treatment in breach of article 3. By a decision of 14 May 1977, it accepted the remainder of the application.

91. On 23 January 1979, the applicant's legal representative notified the Commission of his client's death, but added that the deceased's sister had informed him on behalf of herself and other members of the family, including X's parents, that they wished the case to proceed. In view of these wishes and the issues of general interest raised, the Commission decided on 1 March 1979 to retain the application. Although the next of kin are today to be regarded as having the status of "applicants" (see the Deweer judgement of 27 February 1980, Series A, No. 35, pp. 19-20, para. 37), for the sake of convenience the present judgement will continue to refer to X as the "applicant".

92. In its report of 16 July 1980 (article 31 of the Convention), the Commission expressed the opinion:

By 14 votes to 2, that X's recall to Broadmoor Hospital and further detention there had not violated his rights under article 5, paragraph 1;

Unanimously, that there had been a breach of article 5, paragraph 2, in that X was not given prompt and sufficient reasons for his arrest and readmission to Broadmoor;

Unanimously, that article 5, paragraph 4 had been violated, since X had not been entitled to take proceedings by which the lawfulness of his detention consequent upon his recall to hospital could be decided speedily by a court.

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[30] European Court of Human Rights, *"Winterwerp Case", judgement of 24 October 1979 (Publications of the European Court of Human Rights, Series A, Judgements and Decisions, vol. 33).*

[31] For the text of the ruling of the European Court of Human Rights, see *European Convention of Human Rights, Texts and documents*, vol. I, published by H. Miesler and H. Petzold, Cologne, C. Heymanns, 1982, p. 1.

[32] Regarding the application of article 50 of the *European Convention of Human Rights*, see *European Court of Human Rights, "Winterwerp Case", judgement of 27 November 1981 (Publications of the European Court of Human Rights, Series A, Judgements and Decisions, vol. 47)*. In connection with the present study in general, see also the very constructive contribution made by Mr. Kooijmans, delegate of the Netherlands to the 39th session of the Commission on Human Rights (E/CN.4/1983/SR.50/Add.1), pp. 3 and 4.

[33] *European Court of Human Rights, Case of X.* v. *the United Kingdom, judgement of 5 November 1981 (Publications of the European Court of Human Rights, Series A, Judgements and Decisions, vol. 46).*

Final submissions to the European Court of Human Rights

93. At the hearing on 22 June 1981, the Government of the United Kingdom maintained the submissions set out in their statement. At the hearing, the Commission's delegate requested the Court

to determine the questions that have been put before [it]—that is to say whether the applicant was a victim of a violation of article 5, paragraphs 1 and 2 of the Convention when he was recalled to Broadmoor Hospital on 5 April 1974 and whether thereafter the applicant was entitled to and received an adequate judicial determination of the lawfulness of his renewed detention in accordance with article 5, paragraph 4 of the Convention.

As to the law

The alleged breach of article 5, paragraph 1

94. The applicant claimed that his recall to Broadmoor Hospital gave rise to a deprivation of liberty contrary to article 5, paragraph 1 of the European Convention on Human Rights".[34]

95. The relevant facts were not disputed. On 7 November 1968, following X's conviction for an offence of wounding with intent to cause grievous bodily harm, the Sheffield Assizes made an order committing him for an indefinite period to Broadmoor Hospital, a secure mental hospital for the criminally insane; on 19 May 1971, the Home Secretary ordered his conditional discharge; on 5 April 1974, he was recalled to Broadmoor Hospital by warrant of the Home Secretary; he remained confined there until February 1976, when he was allowed out of hospital on leave; he was conditionally discharged a second time on 28 July 1976 and died on 17 January 1979.

Whether paragraph 1 (a) *and paragraph 1* (e) *were applicable*

96. Before the Commission, the Government argued that at all times throughout his detention the applicant was lawfully detained after conviction by a competent court within the meaning of paragraph 1 (*a*) of article 5. In the Commission's opinion, on the contrary, paragraph 1 (*c*) applied to the exclusion of paragraph 1 (*a*) in the case of an accused person of unsound mind dealt with by committal to a mental hospital for treatment rather than by imposition of a penal sanction.

97. In the Court's view, there was, in the full sense of the term, a "conviction"—that is to say, a finding of guilt (see the Guzzardi judgement of 6 November 1980, Series A, No. 39, p. 37, para. 100)—"by a competent court" and, following and dependent upon that conviction, a "lawful detention" ordered by the same court. Subparagraph (*a*) therefore applied. However, the court did not deal with X by way of punishment but, being satisfied that he was suffering from a mental disorder warranting his confinement in a mental hospital for treatment, committed him to Broadmoor. Consequently, subparagraph (*e*), in so far as it related to the detention of "persons of unsound mind", also applied. It accordingly followed that, initially at least, the applicant's deprivation of liberty fell within the ambit of both subparagraphs.

98. Having regard to the reasons for X's recall to hospital in 1974 and subsequent detention there until 1976, subparagraph (*e*) likewise covered the second stage of his deprivation of liberty. The particular circumstances of this case, and notably the fact that X was conditionally released and enjoyed a lengthy period of liberty before being re-detained, may have given rise to some doubts as to the continued applicability of subparagraph (*a*). The Court did not judge it necessary to decide the point, however, since it had in any event to verify whether the requirements of subparagraph (*e*) were fulfilled and no problem arose in the present case with regard to compliance with the requirements of subparagraph (*a*).

99. In conclusion, there was no breach of article 5, paragraph 1.

The alleged breach of article 5, paragraph 4

100. It was argued on behalf of the applicant that he had had no possibility of having the lawfulness of his readmission to Broadmoor judicially determined, as required by article 5, paragraph 4.[35]

101. The Court recalled that by virtue of the two orders made against him in November 1968 by the Sheffield Assizes following his conviction for a criminal offence, X was transferred from the authority of the courts to the authority of the Home Secretary and committed to a psychiatric hospital for an indefinite period. After releasing him in May 1971, the Home Secretary ordered his return to hospital in April 1974. This was an administrative decision based, in part, on circumstances distinct from those promoting the initial court orders. Furthermore, although the conditions specified under section 60, paragraph 1 and section 65, paragraph 1 of the 1959 Act for the making of such orders depended upon matters, notably medical, which of their nature might change with the passage of time, there was no system of periodic judicial review to verify that these conditions remained satisfied throughout the contested detention.

102. Therefore, without underestimating the undoubted value of the safeguards thereby provided, the Court did not find that the other machinery referred to by the Government served to remedy the inadequacy, for the purposes of article 5, paragraph 4, of the *habeas corpus* proceedings.

103. In conclusion, there has been a breach of article 5, paragraph 4.

[34] Article 5, para. 1, of the European Convention on Human Rights, which, in so far as it is relevant to the present case, reads as follows:

"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

"(*a*) the lawful detention of a person after conviction by a competent court;

"...

(*e*) the lawful detention ... of persons of unsound mind ...;

"...".

[35] Article 5, paragraph 4 of the European Convention on Human Rights provides:

"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

The alleged breach of article 5, paragraph 2

104. The applicant complained that he had not been adequately and promptly informed of the reasons for his recall to hospital, either by the police when he was taken into custody or, subsequently, by the responsible medical staff at Broadmoor. He claimed to be a victim of a breach of article 5, paragraph 2[36] of the European Convention on Human Rights.

105. The Government invited the Court to have regard to the revised procedure in the matter presently in operation and to conclude that it was no longer necessary to pursue the question whether the superseded procedure did or did not comply with article 5, paragraph 2.

106. The changes relied on by the Government were introduced expressly "in order to meet criticisms made by the European Commission of Human Rights" on the basis, precisely, of article 5, paragraph 2. Nevertheless, they dated from the end of 1980, and are valid only for the future and clearly could not have restored the right claimed by X under article 5, paragraph 2, whose requirements, moreover, the Government continued to deny having contravened (see the above-mentioned Deweer judgement, and the Luedicke, Belkacem and Koç judgement of 28 November 1978, Series A, No. 29, p. 15, para. 36). It was therefore not possible to speak of a "solution", even partial, "of the matter" (see, *mutatis mutandis,* rule 47, paragraph 2 of the Rules of Court and the above-mentioned Guzzardi judgement).

107. The Court did not consider that it had to settle this double conflict of opinion, especially since the facts of the case were not entirely clear on the point at issue. The Court pointed out in the first place that the need for the applicant to be apprised of the reasons for his recall necessarily followed in any event from article 5, paragraph 4; anyone entitled—as X was—to take proceedings to have the lawfulness of his detention speedily decided could not make effective use of that right unless he was promptly and adequately informed of the facts and legal authority relied on to deprive him of his liberty. The Court further noted that at the close of the first hearing before the Divisional Court, the application for a writ of *habeas corpus* was adjourned because the Divisional Court itself felt that more information was required before any decision could be arrived at. At the adjourned hearing on 21 June 1974, since the detention was apparently legal, the onus was effectively on X to show that the Home Secretary had acted unlawfully in exercising his statutory discretion. However, it was clear from the evidence that lack of information as to the specific reasons for the recall, a matter almost exclusively within the knowledge of the Home Secretary, prevented X's counsel, and thus the Divisional Court, from going deeper into the question. Consequently, the complaint under paragraph 2 amounted, in the particular circumstances, to no more than one aspect of the complaint that the Court had already considered in relation to paragraph 4; there was no call to rule on the merits of a particular issue which was part of and absorbed by a wider issue (see, *mutatis mutandis*, the above-mentioned Deweer judgement and the Dudgeon judgement of 22 October 1981, Series A, No. 45, para. 69).

The application of article 50 of the European Convention on Human Rights[37]

108. Counsel on behalf of X stated that, should the Court find a violation of the Convention, they would be submitting a claim under article 50 for just satisfaction to obtain both compensation for damage suffered and reform of the law. The Government, for their part, reserved their position.

109. Accordingly, although it was raised under Rule 47 *bis* of the Rules of Court, the question was not yet ready for decision. The Court was therefore obliged to reserve the matter and to fix the further procedure, taking due account of the possibility of an agreement between the respondent State and the applicant's next of kin.

110. For these reasons, the Court, having decided as follows:

1. *Holds* unanimously that there has been no breach of article 5, paragraph 1 of the Convention;

2. *Holds* unanimously that there has been a breach of article 5, paragraph 4;

3. *Holds* by 6 votes to 1 that it is not necessary also to examine the case under article 5, paragraph 2;

4. *Holds* unanimously that the question of the application of article 50 is not ready for decision;

(*a*) accordingly reserves the whole of the said question;

(*b*) invites the Commission to submit to the Court, within two months from the delivery of the present judgement, the Commission's written observations on the said question and, in particular, to notify the Court of any friendly settlement at which the Government and the applicant's next of kin may have arrived;

(*c*) reserves the further procedure and delegates to the President of the Chamber power to fix the same if need be.

111. In this connection the following was the dissenting opinion of Judge Evrigenis:

To my great regret I have been unable to agree with the majority of the Chamber as regards point no. 3 of the operative provisions of the judgement. The right of an individual deprived of his liberty to be informed promptly, pursuant to paragraph 2 of article 5,[38] of the reasons for his being taken into custody constitutes a safeguard of personal liberty whose importance in any democratic system founded on the rule of law cannot be underestimated. Quite apart from enabling the person detained to make proper preparations for bringing legal proceedings in accordance with paragraph 4 of article 5, it is the embodiment of a kind of legitimate confidence in the relations between the individual and the public powers. In other words, what is guaranteed is a right that is autonomous and not auxiliary to the one provided for under paragraph 4 of article 5. The merits of the complaint under paragraph 2 of article 5 should therefore be examined.

112. With respect to the above-mentioned important judgement of the European Court of Human

[36] Article 5, paragraph 2 of the European Convention on Human Rights provides:

"Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him."

[37] For the text of article 50 of the European Convention on Human Rights, see footnote 29 above.

[38] For the text of article 5, paragraph 2 of the European Convention on Human Rights, see note 36 above. In connection with this case and in particular the limits of *habeas corpus,* see F. Wheen "Mental health and human rights—What the European Commission found about the limits of *habeas corpus*", *New Statesman* (London), 31 October 1980, p. 13.

Rights, the following interesting comments were submitted by the Government of the United Kingdom.

113. In November 1981 the European Court of Human Rights confirmed an earlier finding of the European Commission that the Government of the United Kingdom was in breach of article 5, paragraph 4 of the European Convention on Human Rights in that it failed to provide restricted patients (i.e. those whose discharge is at present at the discretion of the Home Secretary) with a periodic right of access to a court capable of reviewing the substantive grounds for their continued detention in hospital and of ordering their discharge if these were not satisfied. (The Court did not find it necessary to reach a decision on the Commission's finding that the United Kingdom was also in breach of article 5 (2) for failing to give the patient concerned adequate reasons for his recall).

114. In January 1982, in response to the European Court's judgement, the Government of the United Kingdom introduced amendments to the Mental Health (Amendment) Bill, which was then before Parliament, designed to empower mental health review tribunals to order the discharge of restricted patients. The amendments inserted into the Bill (now the Mental Health (Amendment) Act 1982) provided that from the coming into force of the Act, mental health review tribunals should be empowered to consider the substantive grounds for the continued detention of a restricted patient, and should be required to order discharge where appropriate. The Act provided that such patients should be entitled to apply directly to a mental health review tribunal once in the second six months of their detention and, thereafter, once in any further 12-month period. A mental health review tribunal considering the case of a restricted patient would be required to direct his *absolute* discharge if it was satisfied that:

(*a*) He was not then suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment, or from any of those forms of disorder of a nature or degree which made it appropriate for him to be liable to be detained in a hospital for medical treatment, *or* that

(*b*) It was not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment, *and* that

(*c*) It was not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

115. If the tribunal was satisfied as to (*a*) or (*b*) but not as to (*c*) (i.e. it believed that a continuing liability to recall to a hospital was appropriate) it was to be required to order his *conditional* discharge.

116. The Act provided that it shall be up to tribunals themselves to approve the conditions subject to which a conditionally discharged patient shall be discharged. Conditionally discharged patients would be able to apply to a tribunal to vary the conditions attached to a warrant of conditional discharge, or to discharge the order altogether; this right might be exercised once during the second 12 months from the date of conditional discharge, and once thereafter in every subsequent period of two years. The Act provided that the case of a conditionally discharged patient who was recalled to hospital by order of the Home Secretary shall be referred to a mental health review tribunal within one month of the date of his recall. There was also a provision to ensure the regular review of the cases of all detained patients whereby any case which had not been reviewed by a tribunal within the last three years shall be referred to a Tribunal.

117. Thus, under the provisions of the Act, mental health review tribunals, which were wholly independent of the executive, would be able to enquire into and determine all aspects of the question whether an applicant's detention as a person of unsound mind continued to be lawful. Moreover, the Government had given an undertaking to Parliament to provide legal representation at public expense for patients coming before mental health review tribunals whose own financial resources were insufficient. In the Government's view, the proposals contained in the legislation would remedy the deficiency in domestic law found by the Court to exist in the case of *X* v. *the United Kingdom*.[39]

3. Organization of American States (OAS)

118. The OAS commended the work of the Sub-Commission and the Rapporteur and made the following, *inter alia*, brief comments and suggestions:

(*a*) A suggestion not to use terms such as "suffering from", "afflicted with" or other such terms which reflect negative attitudes, but instead use the terms "persons diagnosed as having mental illness" or persons "with" or "having" mental illness as possible alternatives;

(*b*) A suggestion that adequate differentiation be made between persons diagnosed as having mental illness and persons diagnosed as having mental retardation or other related neurological disabilities, because there is often systematic confusion with mental disabilities, resulting in misapplication of services, treatment and resources.[40]

D. Activities and contributions by non-governmental organizations concerning the protection of human and legal rights of persons diagnosed as mentally ill or suffering from mental disorder

119. Twenty non-governmental organizations[41] and three national organizations, the National Association for Mental Health (MIND) of London, the Comité National Suisse de la Santé Mentale (Swiss National Committee for Mental Health), and the Citizen's Commission on Human Rights, based in Switzerland, have transmitted very useful information concerning their activities in the field of the protection of human rights of persons diagnosed as mentally ill or suffering from mental disorder, including their treatment in psychiatric hospitals, and the abolition of psychiatric abuse and terror. Likewise they have made important comments and suggestions related to the questionnaire of the present

[39] A summary of the reply of the Government of the United Kingdom is given in document E/CN.4/Sub.2/1983/17/Add.1.

[40] A summary of the reply of the Organization of American States is given in document E/CN.4/Sub.2/1983/17/Add.1.

[41] For the list of these non-governmental organizations, see annex I of the present study.

study and the draft body of principles, guidelines and guarantees prepared by the Special Rapporteur.

1. The International Association of Penal Law and the International Commission of Jurists

120. In particular, the contribution made by the International Association of Penal Law and the International Commission of Jurists, which provided the records of proceedings of two meetings of experts held at the International Institute of Higher Studies in Criminal Sciences at Syracuse in Sicily (Italy) under the auspices of the two above-mentioned non-governmental organizations was remarkable.[42]

121. In addition to this the International Commission of Jurists has provided the Special Rapporteur with very useful relevant material concerning the hospitalization and treatment of patients.[43]

2. Amnesty International

122. Amnesty International expressed its particular concern about one aspect of the main problem, that is, the forcible confinement as well as the treatment in psychiatric hospitals of people for exercising their human rights rather than for authentic medical reasons. Also, Amnesty International underlined the abuse of psychiatry for political purposes and presents concrete complaints concerning the treatment of prisoners of conscience and other persons inside psychiatric hospitals in the Soviet Union.[44] Further, "in another country in the same region persons have been detained in psychiatric hospitals because of the non-violent exercise of their human rights."[45] Furthermore, the same non-governmental organization, on the occasion of the VIIth World Congress of Psychiatry, presented a report in which it outlined the following areas relevant to the subject of this study: "the psychiatric sequels of torture; the psychological effects of long-term imprisonment; psychiatric aspects of long-term isolation; the use of psychological methods to de-stabilize prisoners; psychiatric problems associated with "disappearance"; psychiatry and the death penalty; psychiatric rehabilitation of former prisoners; abuse of psychiatry for political purposes; and the imprisonment of psychiatrists and members of closely related professions for political reasons".[46] These issues are of particular importance to the psychiatric profession.

3. The World Medical Association

123. The World Medical Association, among others, referred to the contemporary trends, myths and facts of mental illness.

> The philosophico-politico-mystical movements of the 1960s had an effect both on medicine and on psychiatry, which is more exposed than any other branch of medicine to the winds of social change... .

Youth in its enthusiasm

> being unaware of the specific problems of the psychiatric patient and the economic and social realities of rehabilitation, has gone so far as to deny the existence of mental illness in order to pursue the myth of the complete elimination of psychiatric hospitals. Beneath these watchwords and theories seem to lie the signs of a real power struggle which indicate that our society has not yet assimilated certain new branches of knowledge.

The World Medical Association further raised the problem of the confusion between treatment and

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[42] In this connection, see the "Preface" by C. Bassiouni and the "Introduction and commentary to the draft guidelines" by N. MacDermot and I. Khan, as well as the "Draft guidelines for the protection of persons suffering from mental disorder", prepared by a committee of experts assembled at Syracuse (Italy) from 1 to 4 December 1980, in Association Internationale de Droit Pénal, *The Protection of Persons Suffering from Mental Disorder* (Toulouse, Erès (Nouvelles Etudes Pénales), 1981), pp. 5 and 6, 21-28, 10-19. See also International Commission of Jurists, *Newsletter*, Geneva, No. 10 (July-Sept. 1981), pp. 33-53.

[43] See the letter by a Japanese lawyer, E. Totsuka, dated 31 July 1982, submitted to the secretariat of the Centre for Human Rights by the International Commission of Jurists (Ref. 5/204/2), which contains the following disturbing information about the number of patients, their compulsory detention and treatment in mental hospitals in one country in the Far East:

> "Did you know that 300,000 patients are hospitalized in mental hospitals and the number of beds are increasing by 5,000 every year?
>
> "Did you know that almost all of them are compulsorily detained into mental hospitals?
>
> "Did you know that many of them are deprived of freedom of communication, and that it is very difficult for them to ask lawyers to take the proceedings for their liberation?
>
> "Did you know that patients are deprived of their right to the proceedings that are guaranteed by section 4 of article 9 of the International Covenant on Civil and Political Rights?"

[44] The following complaints are common to the very many accounts of conditions in these psychiatric hospitals by former prisoners of conscience:

> "Most prisoners of conscience, and very many other inmates in such institutions have been mistreated with drugs. The drugs which have most often been applied are haloperidol, aminazin and triphtazine. These drugs, which are used commonly for treatment of certain types of mental illness in many countries, have been administered routinely in psychiatric hospitals in this country in excessive doses, without necessary precautions and without regard as to whether they were positively dangerous for the subject. Application of these drugs in many known cases caused much suffering to those receiving them.
>
> "The drugs have also frequently been administered in excessive doses as a form of punishment. Other psychiatric methods which have been used against inmates of psychiatric hospitals in this country as a form of punishment are the drugs sulfazin, insulin shock therapy and various methods of fixation or immobilization.
>
> "Many inmates have been beaten, often severely. This form of ill-treatment has been especially common in special psychiatric hospitals, where it has been common practice to employ convicted prisoners as orderlies.
>
> "Prisoners of conscience have been put under pressure to renounce their convictions and the public expression of their convictions as a pre-condition for release."

See in this regard the statement by the representative of Amnesty International at the thirty-second session of the Sub-Commission (doc. AI INDEX: POL 03/01/79, distr. NS/CO, p. 4. It should be noted that the above-mentioned drugs should be mentioned by their generic rather than their proprietary names, according to the suggestion made by the WHO staff—thus, "chlopromazine" for "aminazin" and "trifluoperazin" for "triphtazine".

[45] According to Amnesty International, all the information received by it "indicates that these individuals were neither mentally unfit at the time of confinement nor a danger to themselves or others". Also, "former prisoners of conscience interned in psychiatric hospitals in Romania have alleged that they were forcibly subjected to treatment with drugs, electro-shock treatment, beatings by medical assistants and reduced food rations" (doc. AI INDEX: POL 03/01/79, distr. NS/CO, p. 4.)

[46] In this regard, see the second reply, of 8 June 1983, by Amnesty International to the questionnaire (doc. AI INDEX: POL 03/01/83, distr. SC/PG, pp. 1-5.

punishment, doctor and judge; it noted the contemporary tendency to create what are in effect small courts of patients, before which doctors and patients are brought to confront one another and asked whether it was not simpler to let the doctor be responsible for the patient's treatment and, if necessary, call in for a second opinion another specialist, since only specialists had competence in the matter.[47]

4. The International Federation of Human Rights and the World Federation of Neurology

124. The above-mentioned non-governmental organizations have dealt, *inter alia,* with the protection of the rights of in-patients. In particular, the World Federation of Neurology has transmitted useful information related to admission and committal procedures for psychiatric patients in Norway.[48]

5. The Citizens' Commission on Human Rights (CCHR)

125. The main task of CCHR has been to achieve reform in the field of mental health and the preservation of the rights of individuals under the Universal Declaration of Human Rights. CCHR has been responsible for many great reforms. At least 30 bills throughout the world, which would otherwise have inhibited even more the rights of mental patients, or would have given psychiatry the power to commit minority groups and individuals against their will, have been defeated by CCHR actions. CCHR has been instrumental in securing the release from mental hospitals of patients who were held there against their will. It has brought about public awareness of the existence of the many abuses in the psychiatric field, including LSD (and other) experiments carried out on patients without their consent. It has exposed unsanitary conditions and illegal activities in mental hospitals, which were then corrected by health and hospital corporations. All over the world, branches of CCHR offered help to members of parliaments to increase their awareness of mental health situations, so that actual reform could occur. CCHR made the following basic suggestions in connection with the subject under study:

(*a*) Governments should start immediately to investigate psychiatry and the mental health field and get the real facts;

(*b*) The CCHR and others should provide Governments with workable methods to handle the mentally ill;

(*c*) An amnesty should be granted to all psychiatrists who admit to having engaged in abusive practices and human rights violations and who have ceased to do so;

(*d*) All community health centres and other mental care homes should be run by churches or other religious groups who have a real care for patients and a workable method;

(*e*) The use of all drugs, whether street drugs or psychopharmacological drugs, should be discontinued.

The conclusion of CCHR is that "There will be peace on earth when the mental health field has been reformed and is clean".[49] Further, CCHR has transmitted useful documentation reflecting the position of certain participants in the International Conference on Psychiatry and Human Rights held in Zurich—Oerlikon, on 27 and 28 June 1981. At that Conference, experts in the fields of institutionalizing, psychiatric practices and alternative healing methods expressed very constructive views.[50]

6. The New Life Psychiatric Rehabilitation Association (Hong Kong)

126. The New Life Psychiatric Rehabilitation Association of Hong Kong, among others, refers to the three major areas of rehabilitation of patients: occupational, residential and social. Voluntary agencies like the New Life Rehabilitation Association play a major role in the running of local rehabilitative services in the community, with the Government supplying most of the material resources.[51]

7. The World Federation for Mental Health

127. The World Federation for Mental Health, which has its Head Office in Canada, submitted useful information and abstracts from provincial mental health legislation and proposals from the President of the Canadian Mental Health Association regarding relevant amendments to the Canadian Human Rights Act which, when properly adopted by the competent legislative bodies, will, *inter alia,* clearly prohibit discrimination on the basis of "mental disorder".[52]

8. Commonwealth Medical Association (Asia Region)

128. This association, which constitutes a joint body of the British Commonwealth, submitted useful information concerning the Mental Health Law as applied in Singapore, Malaysia, Hong Kong and, very likely, Australia and New Zealand.[53]

9. American Psychological Association (APA)

129. APA furnished certain pertinent references, beginning with the policies and stances of its own association.

130. Reference was also made to an *amicus curiae* brief in the *United States* v. *Byers,* a case in the Federal Appeals court involving a mental patient's right to counsel and protection from self-incrimination in the context of a court-compelled evaluation.

131. APA provided further information and especially referred to the criminal justice mental health standards project set up by the American Bar Association. In this project seven specialized task forces will

[47] See the reply by the World Medical Association in the file at the secretariat of the Centre for Human Rights.

[48] See the replies by both non-governmental organizations in the file at the secretariat of the Centre for Human Rights.

[49] See the reply by CCHR in the file at the secretariat of the Centre for Human Rights.

[50] See the relevant unpublished lecture by Thomas S. Szasz, in the file at the secretariat of the Centre for Human Rights. See also paragraphs 136 and 137 below.

[51] See the reply of this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

[52] See the reply of this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

[53] See the reply of this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

develop official policy governing the treatment of the mentally ill within the criminal justice system.[54]

10. World Federation for Mental Health

132. This Federation submitted a very comprehensive reply to the questionnaire of the Special Rapporteur and underlined that the whole problem of the protection of the mentally ill in Switzerland is complicated by the fact that in Switzerland the Health Service is organized not on a state but on a cantonal level. However, some common principles prevail despite the differences between the cantons with respect to practice.[55]

11. The Association for the Rights of Users of Psychiatry (ADUPSY)

133. This association made some comments and very useful suggestions, including the one that the problem of the protection of mentally ill persons should be debated at the human rights level, so that the patients should not find that their rights or freedoms are restricted solely because they are ill. In connection with the present situation of the protection of the mentally ill, their treatment and detention in mental institutions in the Canton of Geneva, and the law of 14 March 1936 on the regulations relating to persons afflicted with mental ailments, the following basic comments were made: "In 1975, most mentally sick persons were still entering Bel-Air (clinic) against their will, committed by means of an emergency procedure ...".

134. "Although the 1936 Act abolished such pejorative words as 'lunatics', 'asylum' and 'locking up', and transferred the administration and supervision of the mentally sick from the Department of Justice and Police to the Department of Social Welfare and Public Health, it changed things only on the surface. In actual fact, the psychiatric hospital is still supervised by the Attorney General and 'asylum decay' (precisely what the 1936 Act was designed to combat) of confined patients, particularly old people, is constantly encountered."

Supervision of patients

135. The Board of Psychiatric Surveillance, which was set up to protect the patient against any abuses of medical authority, has been acting mainly along the lines of protecting society against certain persons that it stigmatizes. We have seen the cases of the ladies B and of the law student D, who were abusively confined (or threatened with confinement) by the Board. Instead of "verifying the legality of the admissions, ... and checking their validity", the Board almost routinely rubber-stamped the decisions of its fellow-doctors, on the basis of a single medical certificate which it received from the institution (in the case of voluntary admissions) and from the Department of Social Welfare and Public Health (in the case of committals). With regard to appeals, the Act provided that "any person concerned, including the patient himself, may appeal to the Administrative Tribunal against the decisions of the Board". In actual fact, this right of appeal is a purely theoretical one in that not only is the person confined not informed of it but also, in practice, he is not given the possibility of putting it into effect under lock and key, no contact with the outside world, hydrotherapy, shock treatment, etc. Moreover, the institution has ways of "soothing" any individual who is allegedly trying to be difficult.[56]

12. Commission suisse pour la protection des droits de l'homme contre les abus psychiatriques[57]

136. The above-mentioned Committee, commenting in particular on the issue "psychiatry versus human rights", points out that the International Conference on Psychiatry against Human Rights (held at Zurich on 27 and 28 June 1981 with the participation of 400 delegates, psychiatrists, medical doctors and politicians), expressed its "general agreement that there are abuses of human rights in today's psychiatry, both in the East and the West." The speakers concluded that the public mind should be stirred by the fact that there are not only some horrifying cases which one reads about in magazines from time to time. Today we have an extremely powerful psychiatric system, which—similar to the priest system of other cultures—decides about right and wrong, about treatment or no treatment, about being locked up in a clinic or not being locked up. In many cases patients are neither able to complain nor to return to society and thus become victims of psychiatry, paid by society.[58]

137. The same non-governmental organization attached to its reply the resolution on "Psychiatry *vs* Human Rights"[59] adopted by the International Conference organized by the Citizens' Commission on Human Rights, which reads as follows:

Resolution

1. We believe that the evolution of what is to be the science of mental healing toward a more human approach to the care of the mentally disturbed, including an increasing awareness and responsibility of the community about the problem, will see the disappearance of barbaric treatments such as electric and insulin shock treatments and psychosurgery. However, for the time being, we can only condemn and demand abolishment by legislation of such treatments of irreversible nature, as well as forced treatments in general.

2. We believe that the same evolution will see abolishment of involuntary commitments in psychiatric institutions through the development of alternatives preserving human integrity and restoring lost abilities, but in the light of today's countless abuses under arbitrary commitments, we demand an independent court, guaranteeing legal assistance to the patient, to hear and decide before any forced commitment can be set in motion.

3. Being aware of the total failure of psychiatry in its attempts to cure its self-created mental illness, we demand that studies, research projects and methods directed to the valorization of the social and human aspects of the mentally disturbed be promoted, supported and financed by all responsible governments.

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[54] See the reply of this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

[55] See the reply of this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

[56] See the reply by ADUPSY in the file at the secretariat of the Centre for Human Rights.

[57] The German name of this Commission is "Schweizerische Kommission zum Schutz vor Verstössen der Psychiatrie gegen Menschenrechte" and its seat is in Zürich.

[58] See the reply by this non-governmental organization in the file at the secretariat of the Centre for Human Rights.

[59] This resolution is cited as a whole, in view of its direct relevance to the subject of the study.

4. In order to promote the development of the sociocultural maturity which is essential to overcome the violation of rights of persons under psychiatric care, we demand an information campaign to be set up within the community, to enlighten the public about the brutal realities of today's psychiatry, the heroic efforts of a few for human alternatives, and the legal rights available to protect people from the aggressiveness and brutality committed in the name of the science of the mind.

5. As a conclusion, we shall alert all governments about the current deteriorating state of mental health care, as evidenced by the innumerable psychiatric atrocities exposed in the media internationally, such as a frightening number of criminals having been in psychiatric hands before committing their crimes, and the pleas and testimonies of numerous experts throughout the world who are seeking true reforms toward human rights. For these reasons and many unstated others we demand government investigations into mental health care with the purpose of restoring the spiritual and human character of such care, which got lost along the way of its erratic evolution."

Zurich 28.6.81

13. The International League for Human Rights

138. This non-governmental organization has submitted useful comments and suggestions related to the "Draft body of principles, guidelines and guarantees" prepared by the New York Civil Liberties Union.[60]

E. Position of other international forums which have dealt with the protection of the patient and the condemnation of psychiatric and psychological abuses

1. The Sixth World Congress of Psychiatry and the Declaration of Hawaii

139. The topic of the protection of the human and legal rights of the patient and especially the issues related to psychiatric ethics received considerable attention at the Sixth World Congress on Psychiatry.[61] The General Assembly of this Congress adopted a statement on ethical strandards in psychiatric practice called the "Declaration of Hawaii", proposed by one qualified non-governmental organization, the World Psychiatric Association. The main principles of this Declaration are presented below:

Ever since the dawn of culture ethics has been an essential part of the healing art. Conflicting loyalties for physicians in contemporary society, the delicate nature of the therapist-patient relationship, and the possibility of abuses of psychiatric concepts, knowledge and technology in actions contrary to the laws of humanity, all make high ethical standards more necessary than ever for those practising the art and science of psychiatry.

As a practitioner of medicine and a member of society, the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal duties of every man and woman.

1. The aim of psychiatry is to promote health and personal autonomy and growth. To the best of his or her ability, consistent with accepted scientific 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 the public.

2. Every patient must be offered the best therapy available and be treated with the solicitude and respect due to the dignity of all human beings and to their autonomy over their own lives and health. The psychiatrist is responsible for treatment given by the staff members and owes them qualified supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help or the opinion of a more experienced colleague.

3. A therapeutic relationship between patient and psychiatrist is founded on mutual agreement. It requires trust, confidentiality, openness, co-operation and mutual responsibility. It may not be possible to establish such a relationship with some severely ill patients. In that case, as in the treatment of children, contact should be established with a person close to the patient and acceptable to him or her.

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.

...

5. No procedure must be performed or treatment given against or independent of a patient's own will, unless the patient lacks capacity to express his or her own wishes or, owing to psychiatric illness, cannot see what is in his or her best interests or, for the same reason, is a severe threat to others.

In these cases compulsory treatment may or should be given, provided that it is done in the patient's best interests and that, over a reasonable period of time, a retroactive informed consent can be presumed; whenever possible, consent should be obtained from someone close to the patient.

...

7. The psychiatrist must never use the possibilities of the profession for the maltreatment of individuals or groups, and should be concerned never to let inappropriate personal desires, feelings or prejudices interfere with the treatment.

The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to scientific or ethical principles the psychiatrist must refuse to co-operate.

...

9. To increase and propagate psychiatric knowledge and skill requires the 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 published, and all reasonable measures should be taken to preserve the anonymity and to safeguard the personal reputation of the subject.

...

For children and other patients who cannot themselves give informed consent, this should be obtained from someone close to them.

10. 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 programme in which he or she participates. This withdrawal, as well as any refusal to enter a programme, must never influence the psychiatrist's efforts to help the patient or subject.

The psychiatrist should stop all therapeutic, teaching or research programmes that may evolve contrary to the principles of this Declaration.[62]

2. The Ciba Foundation Symposium on Medical Care of Prisoners and Detainees

140. Lawyers, psychiatrists, doctors and prison administrators from North America, Europe and North Africa participated in the above-mentioned symposium and discussed, *inter alia*, how legislation affecting the physical or mental health of people held in prisons and camps might be implemented and improved. Also, other topics such as the management of disturbed or violent

[60] See the reply by this non-governmental organization and the document attached to it in the file at the secretariat of the Centre for Human Rights.

[61] This Congress was held in Honolulu (Hawaii) from 30 August to 5 September 1977. The seventh Congress was held in Vienna (Austria) on 10 July 1983 and four of the main topics of its agenda related to abuses in psychiatry.

[62] The full text of the "Declaration of Hawaii", as proposed, is contained in a collection of texts published by the Institute for Advanced Research in Asian Science and Medicine, *Comparative Medicine East and West*, (New York, Spring 1978), vol. VI, No.1, pp. 80-81.

offenders, experiments on prisoners, tension in camps, a medical psychiatric survey in Alabama State Prison, the interaction between prisoners, victims and other social networks were considered.[63]

3. The International Union of Judges

141. The International Union of Judges, during its meeting in Vienna in 1981, paid particular attention to the protection of the interests of mentally handicapped persons in private law.[64] This Union deals mainly with issues relating to the voluntary and involuntary admission to hospital of a patient, committal proceedings, safeguards, etc.

F. Selected international literature, international press (articles and comments) concerning mental illness, mental institutions and the patient

142. Important books have been published on the above-mentioned issues, describing their complexity and interdependence and urging States, Governments, regional organizations, the competent bodies of the United Nations and specialized agencies to take appropriate legal, medical, political, economic, social, administrative, cultural and environmental measures and to make an effective contribution to the promotion and protection of the human and legal rights of thousands of individuals all over the world whose rights and fundamental freedoms have been grossly and systematically violated on the grounds of mental illness or mental disorder.[65]

143. Other national associations, professional leagues etc., have proposed the creation of advocacy systems for representing the patient.

144. In advisory or judicial proceedings, the importance of counsel to represent not only the mentally disabled client (or those acting on his or her behalf) but also the State against which a claim is made should be recognised. Other organizations have analysed certain aspects of the subject matter and have, *inter alia*, stated that liberal progressives over the past century have urged that the courts treat the mentally ill as patients rather than criminals. In particular, the United States Helsinki Watch Committee, which seeks to monitor domestic and international compliance with the human rights provisions of the Helsinki Final Act,[66] had published a specific article on Mental Health in the United States.[67]

G. International press

145. In connection with the subject-matter under study, the following are the most difficult semantic points raised by the international and national press in recent years:

146. An article published in a daily newspaper[68] under the title "Technological progress bears perils for human beings".

147. Another newspaper has referred to a case in France in which a case of psychiatric confinement was examined nine years after the events.[69]

148. Another newspaper, in an article entitled "U.S. High Court Weakens Law on Mentally Retarded",[70] indicates that the United States Supreme Court has ruled that a federal "Bill of Rights" for the mentally retarded, enacted by Congress six years ago, did not oblige states to provide any particular level of care or training for retarded people in state institutions. In connection with this point, writing for the majority, one judge disagreed and said: "The law simply does not create substantive rights" but "does no more than express a congressional preference for certain kinds of treatment". Furthermore, in an article published in another newspaper under the title: "Helping the mentally disabled to thrive"[71], there was an appeal to help mentally handicapped persons because, among other things, they are also homeless persons: "There has to be someone who will create a place the handicapped will consider home". In the same newspaper an editorial comment was published under the title: "Who cares for the mentally ill?". It mentioned that: "New York State and city officials will attempt today to settle yet another clash in their protracted struggle over the care of the mentally ill. The dispute arose when a state official arranged surprise inspections of city hospital psychiatric wings, then ordered them to relieve overcrowding, perhaps by using empty beds in other wards. High-handed, says the city's hospital administration, blaming the crush of mental patients on the State's policy of 'deinstitutionalization'. They note that 60,000 patients have been released from large upstate mental hospitals in the last 16 years, without commensurate subsidy to the city in which most of them went to live. Instead of dipping into scarce funds to staff their new psychiatric wards, city officials want the State to declare a crowding emergency and take more patients into state hospitals."

149. With respect to the conditions in mental institutions, the death rate in them and mental services in

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[63] See the report of the Ciba Foundation, *Medical Care of Prisoners and Detainees* (Amsterdam, Elsevier, 1973), pp. 1-232.

[64] A copy of the general report of the meeting of the Union of Judges can be found in the file of the secretariat of the Centre for Human Rights.

[65] See T.S. Szasz, *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (New York, Anchor Books, 1970), and *Psychiatric Slavery* (New York, Macmillan (The Free Press), 1977). See also B. J. Enis and R. D. Emery, *The Rights of Mental Patients* (New York, Avon Books, 1978); M. Kindred and others, *The Mentally Retarded Citizen and the Law; the President's Committee on Mental Retardation* (New York, Macmillan (The Free Press), 1976). C. A. Butterworth and D. Skidmore, *Caring for the Mentally Ill in the Community* (London, Croom Helm, 1983). In connection with the ethnic minorities and psychiatry, see R. Littlewood and M. Lipsedge, *Aliens and Alienists* (Harmondsworth (Middlesex), Penguin Books, 1982), pp. 7-265. Also in connection with the treatment of aliens in general, see Baroness Elles, *International Provisions Protecting the Human Rights of Non-Citizens*, United Nations publication, Sales No. E.80.XIV.2, pp. 3-4.

[67] See A. A. Stone and L. A. Carty, "Mental health in the United States", *Helsinki Watch—A Helsinki Record* (New York), October 1980, pp. 1-16.

[68] See "Kathimerini" (Athens), 28 September 1979 (in Greek).

[69] See J.-Y. Nau, "Au Tribunal correctionel de Tours—Une affaire d'internement psychiatrique jugée neuf ans après les faits" (County court of Tours. A case of psychiatric confinement examined nine years after the events), *Le Monde*, 18 March 1982, p. 12.

[70] See *International Herald Tribune*, 22 April 1981, p. 5.

[71] See *The New York Times*, 21 October 1981, p. C.21.

general, the international and national press paints a grim picture.[72]

150. Nevertheless, a new day is dawning in the world's efforts to assure mental health for all. This is the basic message of hope for the mentally ill and society disseminated through an article published in the journal of WHO.[73] According to the author of this important contribution, "the scope of WHO's mental health programme is much broader than the traditional concepts of psychiatry and neurology". "While prevention and treatment of mental and neurological diseases and problems related to alcohol and drug abuse still constitute an important component of the programme", there are many other areas that figure prominently in the improvement of mental health. Some of these areas encompass psychosocial aspects of health care in general and of socio-economic development in particular. Thus the WHO programme is being strengthened by research endeavours in mental health and behavioural science, as well as from attempts to better understanding of spiritual and metaphysical needs. Also, it is underlined that "it would not be possible to achieve health for all by the year 2000 if the totality of man's needs—his inner life, his cosmos, historical reactions to his physical and emotional world—are not viewed with great concern and objectified [in WHO's programme] of health and development". Progress on the mental health front is mandatory. As the author emphasizes: "There is no health without its mental and/or spiritual component".[74]

H. The anti-psychiatric movement

151. This movement, which is supported by many lawyers, doctors, some psychiatrists, psychologists, some former patients and individuals, has been particularly concerned with the procedures provided for patients. The most radical abolitionist aspect this movement has nowadays proposed is that there ought to be no such legal procedure at all.[75]

152. The following are the most important arguments put forward by the "anti-psychiatry" movement on the issue of involuntary admission:

(*a*) Since in reality "mental illness" does not exist, involuntary admission and detention are by definition unjustifiable;

(*b*) The involuntary admission and detention of the mentally ill is not genuine therapy but in fact a form of social control. In this connection it should be noted that some States abuse their power, in particular, for political reasons and purposes by asking some psychiatrists to act as gaolers rather than as physicians;

(*c*) In certain cases the diagnosis of mental illness or mental disorder is inaccurate, with the principal consequence that involuntary admission and detention are arbitrary;

(*d*) The so-called argument of danger to self or to others or to the community is in many cases false and invalid.

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[72] See the following articles: "Report analyses death rate at State's mental institutions", *The New York Times*, 5 December 1982; P. Healy, "Mental services near 'crisis' ", *The Times*, 20 July 1983, p. 33 and "Cover-up on mental health care denied", *The Daily Telegraph*, 21 July 1983.

[73] See T. A. Lambo, "A new day dawns", *World Health*, October 1982, p. 3.

[74] *Ibid.*

[75] One of the spokesmen of the "antipsychiatry movement" is the Australian psychologist, Professor R. Winkler. He has been mainly involved in "pseudopatient" studies. See R. Winkler "Research into mental health practice using pseudo-patients", the *Medical Journal of Australia*, (Glebe, N.S.W.), vol. 2, No. II (14 September 1974), p. 399. Another supporter of the objectives of the "antipsychiatry movement" is the American psychiatrist Thomas S. Szasz. See in this connection Szasz, *The Myth of Mental Illness* (New York, Harper and Row, 1974). In connection with his attitudes and views on the subject of "mental illness", see in particular J. Lardner's article "Dissident psychiatrist", *International Herald Tribune*, 1 June 1982, p. 12. According to this article Szasz wrote: "... I look upon this [mental illness] as slavery. I don't believe that in a free society anybody should be deprived of his liberty on any ground other than accusation, trial and being found guilty of a criminal charge—a view that has prevailed with many a judge and jury in recent years ...". The arguments put forward by T. Szasz are strongly supported, among others, by the Association for the Abolition of Involuntary Mental Hospitalization (a United States non-governmental organization). In this connection it should be also mentioned that some of the leaders of the American psychiatric establishment have defended themselves against Szasz's attacks. Miles F. Shore, Professor of Psychiatry at Harvard University says about Szasz: "He is a practising psychiatrist who has a point of view which he expresses vividly and with great force. Any live field which is dealing with serious issues has people with a variety of points of view. In this country [USA], they have a right to be heard, to be evaluated and to help keep people thinking straight." (Lardner, *loc. cit.*, p. 12.)

Chapter III

GENERAL CONSIDERATIONS RELATED TO THE PROBLEM OF MENTAL ILLNESS, PROCEDURES FOR ADMISSION TO MENTAL INSTITUTIONS, INVOLUNTARY DETENTION, TREATMENT AND CONSENT OF THE PATIENT

A. The problem of mental illness in contemporary society

153. In order to discuss, consider and propose principles, guidelines, guarantees, procedures and humanitarian, legal and administrative measures for the protection of the patient, it is necessary first to emphasize the importance of mental health and its social dimensions before discussing the problem of mental illness.

154. Health has been defined in the Constitution of WHO as a state of complete physical, mental and social well-being. Mental health is a vague term,[1] but there is no health without its mental and/or spiritual component.[2] Mental health problems remain universal and multiform, and are increasing in both the least developed and developed countries. Mental health is what enhances people's lives. Promoting health therefore must not only be concerned with enhancing the biological element of the human organism; it must also be concerned with enhancing mental life. Mental health technology can improve health care in general. The application of mental health knowledge could help prevent harmful psychosocial consequences of socio-economic change and facilitate harmonious development.[3]

155. The mental health of the child is of cardinal importance.

156. According to one source,[4] "at least 1,000 million children in the developing world grow up under great stress, facing constant danger to their very lives. Surveys of the general population show that the prevalence of persistent and socially handicapping mental health problems among children aged 3-15 years in developed countries is about 5-15 per cent, and more limited data from developing countries suggest a roughly similar rate". If these figures are correct, then in developing countries alone at least 100 million children suffer from mental disorders, often complicated by or complicating physical diseases.

157. As has already been mentioned, mental health theory and the law both deal with human rights and responsibilities.

158. The difficult problem is to balance the freedom of the individual and social responsibility. There is no health in a society afflicted by racism and discrimination. One aspect at least of the complex and problematic relationship between racism and mental health[5] should be briefly mentioned. This aspect is related in particular to the prevention and prohibition of any form of discrimination based on racism in the consideration and treatment of mentally ill persons. Faculties in the mental health disciplines have an obligation to convey through courses and teaching the facts, data, figures, concepts, ideas and issues relating to racism as it affects and is affected by mental health.

159. As early as 1799, Rush challenged the belief that blacks were born inferior, asserting that white claims of mental superiority were "founded alike on ignorance and inhumanity".[6]

160. Although in medical terms mental illness is just an "illness" among others and must be treated in conformity with modern medical scientific data, in certain cases the treatment of patients having this type of illness creates a number of extra-medical, particularly humanitarian and legal problems. In fact, as this illness affects behaviour and the capacity for making a sound judgement, people suffering from it may endanger their own lives and security, as well as those of others, and constitute a danger to the community. In order to avoid such dangers certain restrictions on the freedom of these patients are admitted in all member States and some constitutional and private law disabilities may also follow from this illness.

B. The meaning of "mental illness"

161. This is first of all a question of medical science and it is very difficult to give it a precise legal definition because as medical science progresses every day, the contents and extent of such a definition may change. However, despite the absence of a legal definition, the legislator may exclude certain mental disorders from the notion of "mental illness" if he wishes that some particular provisions on the mentally ill should not apply to the categories of persons suffering from such disorders. For instance, alcohol and drug dependence as well as sexual deviations may be excluded from the field of application of legislation to the treatment of mentally sick

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[1] As Thomas S. Szasz wrote: "regardless of how we define 'mental health', if we sacrifice essential liberty for it, we shall deserve—and in fact have—neither liberty nor mental health". See T. S. Szasz, *Law, Liberty and Psychiatry—an Inquiry into the Social Uses of Mental Health Practices* (New York, Macmillan, 1963), p.viii.

[2] Szasz, *op. cit.*

[3] World Health Organization, *Social Dimensions of Mental Health* (Geneva), 1981.

[4] See N. Sartorius, "The mental life of the child", *World Health*, October 1982, p. 16.

[5] The relationship between racism and mental health has been examined, particularly by C. V. Willie, B. M. Kramer and B. S. Brown, eds., in their book, *Racism and Mental Health* (Pittsburgh (Pa.), University of Pittsburgh Press, 1973).

[6] See A. Thomas and S. Sillen, *Racism and Psychiatry* (New York, Brunner/Mazel, 1972).

persons. The majority of national laws or statutes do not contain any specific definition of the concepts of "mental illness" or "mentally ill".[7] However, some national laws or statutes do use the concepts of "mental disorder" or "psychopathic disorder" or "psychiatric disorder" or "psychical illness" or "mental patient", "mental impairment", "insane person" or "mental disease" or "mental defect", "subnormality", "severe subnormality" and "psychopathy", "mental emotional disturbances" and contain a definition or give the meaning of these concepts.[8]

162. It is also generally accepted that abnormal behaviour in morals alone can never as such be considered as mental illness. However, if such types of behaviour are a symptom of a mental abnormality, they may then be considered as "mental illnesses" not because of their immoral or illegal character, but because they are considered as mental illnesses by medical science.

163. The term "mental illness" is also widely used to describe something very different from a disease of the brain. Although very few national laws contain precise definitions of the concepts "mental illness" or "mental disorder" or "mental weakness", they have none the less been sufficiently clarified by science and jurisdiction.[9] Thus, it was realized at an early stage that persons suffering from mental disorder or mental weakness generally belong to the group of the handicapped and consequently require the particular care of the State.

164. The law of the very few States which set a boundary between "mental illness", which in clinical practice means "psychosis" and "other mental disorder", defined mental illness according to university teachings on psychiatry and based it on the classification of diseases adopted by the World Health Organization in 1967.[10]

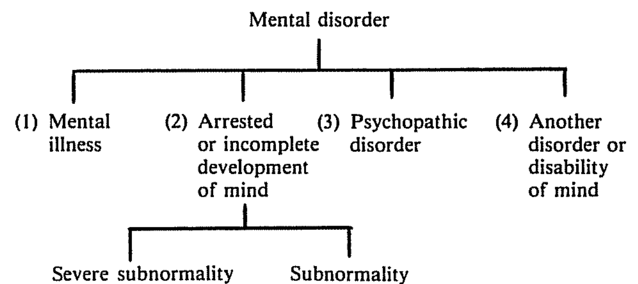
165. Furthermore, the definition of "mental illness" or "mental disorder" is difficult, since criteria change with time and from place to place, and since a whole new range of psychological disturbances has emerged, linked with working pressure, tension, environmental conditions, including pollution, and the socio-economic pattern of modern life.[11]

166. However, for the purpose of this study the meaning of "mental illness" will be the following: "Any psychiatric or other illness which substantially impairs mental health".

167. Also for the purpose of this study, a "mentally ill person" means a person who, because of mental illness, requires care, treatment or control for his own protection, the protection of others or the protection of the community, and for the time being is incapable of managing himself or his affairs.

168. The term "mental disorder" is taken to mean arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.

169. The following plan reflects the position of the definition of the concept of "mental disorder" and the meaning of the concepts of "severe subnormality", "subnormality" and "psychopathic disorder", which are contained in some common-law countries.



C. Restrictions and limitations on the personal freedom of patients[12]

170. Such restrictions are usually enforced by detention of the patient in a mental institution and are aimed at protecting the patient himself and other persons from any danger to life or security which the patient's abnormal behaviour may cause. The competent persons to judge such necessity are always the medical authorities, who make their decision in accordance with current medical science, but legislation often requires the participation or supervision of a judicial or administrative authority in such important decisions, which result in substantial restrictions of an individual's freedom.

171. A brief examination of legislation in a number of States in Europe[13] shows that whatever system of detention procedure they prefer—judicial, administrative, mixed or purely medical—they all require, without exception, specialized medical opinion as to the

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[7] See, for example, in the first chapter of document E/CN.4/Sub.2/1983/17/Add.1, the summary of the replies of the Governments of Afghanistan, Belgium, Burkina Faso (previously Upper Volta), Bulgaria, Canada (province of Saskatchewan), Chile, Costa Rica, Cyprus, Denmark, Dominican Republic, Greece, Italy, Kuwait, Niger, Portugal, Senegal, Sweden, Syrian Arab Republic, Spain.

[8] See, for example, in the first chapter of document E/CN.4/Sub.2/1983/17/Add.1, the summary of the replies of the Governments of Australia, Bahamas, Barbados, Bulgaria, Canada (from the statutes of the provinces of Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan), Cyprus, Finland, France, Germany, Federal Republic of, Greece, Italy, Japan, Republic of Korea, Kuwait, New Zealand, Philippines, South Africa, Sweden, Thailand, United Kingdom of Great Britain and Northern Ireland, United States of America.

[9] See, for example, in the first chapter of document E/CN.4/Sub.2/1983/17/Add.1, the summary of the replies of the Governments of Austria and the Syrian Arab Republic.

[10] See, for example, in the first chapter of document E/CN.4/Sub.2/1983/17/Add.1, the summary of the reply of the Government of Finland.

[11] See recommendation 818 (1977) on the situation of the mentally ill, Council of Europe, Parliamentary Assembly, report of the Committee on Social and Health Questions (doc. 4014).

[12] In connection with the limitations on human rights, see E.-I. A. Daes, *The Individual's Duties to the Community and Limitations on Human Rights and Freedoms under Article 29 of the Universal Declaration of Human Rights* (United Nations publication, Sales No. E. 82.XIV.1), pp. iii and iv and 69 to 180.

[13] For example, Austria, Denmark, Federal Republic of Germany, Switzerland.

necessity of detention. Without such an opinion, judicial or administrative authorities are powerless to commit someone to a mental institution for mental illness.

172. Accordingly, the detention of a patient for mental illness being just a medical measure in order to protect the patient's life and security as well as the life and security of other persons, none other than strictly medical considerations (political, moral, religious non-conformism of a person, etc.) should be taken into account in a decision of involuntary admission and detention.

173. The conditions and experiences of a patient vary from mental institution to mental institution. The life of a patient in a mental institution is in many cases regulated by extensive, usually unwritten, rules that are enforced, for the most part, by non-professional staff. When a patient is accused of breaking these unwritten rules he is punished, sometimes severely, and the ward staff in some cases will write in the records that the patient was "aggressive" or "violent", etc.

174. Some limitations are sometimes intentionally imposed on a patient's freedom by the staff of the mental institution as therapy or punishment. Also, limitations on the personal freedom of the patient are imposed for the convenience of the staff and for more efficient operation of the mental institution.

D. What should be the right period of detention of a patient?

175. The period of detention depends absolutely upon the evolution of the illness of the patient and whether or not the danger he presents to his life and security and that of others has diminished. Only medical authorities are in a position to judge these facts.[14]

176. The participation of administrative or judicial authorities or both is admitted here as an additional guarantee, but the authorities act upon medical advice on the necessity to prolong or not the period of detention. As to the initial procedure of detention, no reasons other than purely medical ones can be advanced to prolong or continue the detention of the patient.

177. Involuntary admission and detention is a measure which has very serious implications for the patient because it affects and restricts his freedom and several of his human and legal rights. Although any decision of detention is taken upon medical advice in all member States, it is possible that medical authorities may fail in their judgement and diagnosis, thus reaching erroneous conclusions. Therefore it would be wise and humane to give the patient full rights to object and appeal against any decision of detention even if the patient cannot be considered as enjoying full legal capacity or if he is already in guardianship. It is not always prudent to give the exercise of these rights to the legal representative or guardian because at times, for various reasons, this person may not be totally impartial in demanding detention or continuation of it.

178. For these reasons several legal systems give the patient the right to object or appeal against a proposal or decision of detention, without making reference to his legal capacity.[15] In other legal systems, which make no reference to the patient, it is not impossible that the judge, on the patient's request, may order a re-examination by the control authorities.

179. The patient, while he may be given the right by legislation to object to a decision of detention and if necessary demand its re-examination, should also have the right to be heard before a competent authority.

E. Mental institutions and psychiatrists

180. The laws of a great number of States use various terms to describe differing types of mental institutions.

181. The mental institutions are usually run and supervised by the Ministry of Health or other health authorities.

182. In some countries,[16] in-patient care is provided mainly by psychiatric university clinics, psychiatric local authority hospitals, psychiatric wards and specialized clinics, such as those established for alcoholics. Complementary services exist in the form of temporary-stay homes, hostels and nursing homes to provide care for mentally ill or emotionally handicapped persons who no longer need hospital treatment. Care for the mentally handicapped also centres on ambulatory care in the form of day-education centres, special schools and workshops, some with hostels attached, etc. Depending on the extent of their handicap, mentally handicapped persons may need in-patient treatment provided by appropriate facilities usually operated by independent bodies. Most university clinics and psychiatric hospitals are run by the individual local authority or jointly by several local authorities, whilst psychiatric wards are operated in part by local authorities. Public health offices are the responsibility of either local authorities or the Länder.

Preventive psychiatric services:

Institutions providing psychosocial counselling:

(*a*) Education and youth guidance centres;

(*b*) Guidance centres for marital, family and general problems;

(*c*) Centres providing psychosocial guidance and ambulatory treatment for addicts and potential addicts;

(*d*) Welfare centres also serving mentally ill persons;

[14] However, the legislation of a number of States, such as Austria and several German Länder, requires that the decision of detention be made for a limited period of time, and if there is a reason to prolong it at its end, a re-examination must be carried out. In other States the legislation allows decisions of detention for an indefinite period (e.g. Belgium) but termination of it may be requested from competent authorities at any time if the reasons of detention no longer exist.

[15] For example, the laws of *Afghanistan* use the term: "lunatic asylum" "mental hospital", "mental health clinic in prisons"; Australia uses the terms "psychiatric hospital" and "private hospital", Burma, "psychiatric hospital" and "psychiatric wards", which are sections in general hospitals, German Democratic Republic "psychiatric hospital", "psychiatric clinics", Kenya "mental institution", Niger "psychiatric ward", Mexico "psychiatric hospital, "psychiatric wards" in general hospitals, etc.

[16] For a summary of the reply by the Federal Republic of Germany, see document E/CN.4/Sub.2/1983/17, Add.1, chap. II.

(*e*) Social psychiatric services run by public health offices, specialized hospitals, independent organizations or district welfare bodies.

Ambulatory services (examination and treatment):

Established neurologists.

183. In other countries the care and treatment of persons suffering from mental disorder can take place in one of the following facilities:

(*a*) Primary health care centre;

(*b*) Psychiatric out-patients department of a general hospital;

(*c*) In-patient department of a general hospital;

(*d*) Out-patient department of a psychiatric hospital;

(*e*) Prison psychiatric out-patient department.[17]

184. In a few countries the local community is involved in the care and treatment of people suffering from mental disorder inasmuch as there are local doctors who use traditional methods of healing. The local community also takes care of a large number of non-violent patients at home.[18]

185. Like all other public institutions, mental institutions are often managed by persons appointed by the Government. The institutions are autonomous in the performance of their duties, subject to supervision by the Government.

186. The psychiatrists officially attached to mental institutions are auxiliaries of the State insofar as they are part of the government machinery, but they are independent in their professional work.

187. In a few countries the administration of hospitals is under the direction of democratically elected hospital boards[19] whose activities are always open to public scrutiny and questioning. In these countries psychiatrists holding appointments at all hospitals hold them on precisely the same basis as any member of the medical staff of a general hospital and are expected to exercise independent professional judgement in accordance with the clinical requirements of their patients.

188. One of the most serious problems in mental hospitals is overcrowding, which often leads to unsatisfactory living conditions, lack of privacy, poor food services, defective administration, bad relationships between the patient and the doctors and nurses, and inadequacy of standards of treatment in general.

189. It should be stated that modifications to the laws of certain States for the protection of the legal and human rights of the mentally ill or of persons suffering from mental disorder will be in effect negated if the whole mental health care system is inadequately financed or if a proper relationship is not maintained between central institutions, community care centres and institutions such as nursing homes.

[17] For a summary of the reply of Kuwait, see document E/CN.4/Sub.2/1983/17/Add.1, chap. II.

[18] For a summary of the reply of Kenya, see document E/CN.4/Sub.2/1983/17/Add.1, chap. II.

[19] For a summary of the reply by New Zealand, see document E/CN.4/Sub.2/1983/17/Add.1, chap. II.

F. Treatment and consent[20]

190. Only the legislation of a small number of States provides clearly the extent to which treatment may be imposed without consent on involuntarily detained mentally ill persons or on persons suffering from mental disorder.

191. However, as new technologies evolve, there is no comprehensive means of assuring that they are scientifically sound and that they are administered only in appropriate cases and only by qualified persons. Drugs are a partial exception. New medications are subject to testing by competent national bodies prior to marketing.[21]

192. In certain cases inadequate regulation of mental health technologies with regard to safety, efficacy and appropriate standards is compounded by the lack of guidelines for implementation in individual cases. In such situations provision should be made to improve the decision-making process relating to treatment. Such improvements would include measures designed to assure voluntary and informed consent in all possible cases; to guard against coercion where special need appears for persons unable to defend themselves, who are not guilty by reason of insanity or have undergone prolonged institutionalization, and to prevent inappropriate use (whether voluntary or involuntary), of hazardous techniques on persons who lack the capacity to make their own informed decisions about treatment.

193. In cases of hazardous and harsh treatments, where voluntariness is not well assured and where the patient's ability to make informed decisions is in question, checks are needed on consent[22] to assure that it is voluntary and informed. Where the individual is unable to make his own treatment decisions, there must be protection against abusive or inappropriate administration of treatment.

194. Protection of the right to adequate treatment could be construed narrowly as a judicial guarantee that those who seek treatment will in fact receive it.Thus, the

[20] In connection with informed consent, see the following information submitted by Cyprus:

> "Fully informed consent of the mental patient should be the basis of all mental health intervention and generally without it such an intervention cannot morally be justified and in some cases (psychotherapy, behaviour therapy) its success is to some extent contingent on informed consent. The only exception would be in the case of a patient judged incompetent, preferably by a court or a tribunal. The right of a patient to informed consent should include the kind of treatment the mental health personnel may or may not carry out. It can be said that such a right is the cornerstone or the basis of the moral relationship underlying the patient-clinician's contracts for treatment" (E/CN.4/Sub.2/446, para. 26).

See also L. O. Gostin, "Consent to unusually hazardous, unestablished or irreversible treatment in psychiatry: a review of the draft guidelines", Association internationale de droit pénal, *The protection of persons suffering from mental disorder* (Toulouse, Erès (Nouvelles études pénales), 1981), pp. 73-86.

[21] See "Legal issues in State mental health care: proposals for change", *Mental Health Standards and Human Rights, Mental Disability Law Reporter* (Washington, D.C., September-December 1977), pp. 293 and 294.

[22] "Informed consent" is consent obtained freely without threats or improper inducements after appropriate discussion with the patient of matters related to his mental illness, the nature, purpose and duration of the treatment, possible pain and discomfort, possible side-effects and expected benefits of the treatment.

right would then encompass only those who enter hospitals either willingly for treatment or who are willing to explore the benefits which therapy might provide because they themselves are bewildered and troubled by their behaviour.

195. As long as the right to treatment remains so closely tied to involuntary treatment and indeterminate detention, a real danger exists that society will continue to abuse the individual in the name of safeguarding his welfare, never acknowledging the equally strong wish to keep him safely tucked away.

196. In some States, including the Soviet Union, compulsory treatment does not in any way represent a punishment but differs from it fundamentally. According to one source,[23] "the difference lies mainly in the fact that although in the Soviet Union such treatment is imposed by the court, it does not determine its term". The same author emphasizes that the system of compulsory treatment imposed by the court differs fundamentally from an indefinite sentence. "When a cure has taken place or the signs of antisocial behaviour disappear following a change in the subject's mental condition, the patient is relieved from compulsory treatment by the decision of the hospital medical board."

197. Whatever the reason for compulsory treatment, there are persons whose wishes to be left alone should be respected lest the right to treatment become an instrument for the invasion of personality and privacy, which is other areas of life the law seeks increasingly to protect.[24]

198. The view that certain technical therapeutic procedures entailing permanent lesion (e.g. lobectomy) should be prohibited has prevailed in a great number of countries.[25]

199. Enforced treatment causes concern even beyond that relating to the individual's right to privacy, as has already been explained in the preceding paragraphs, because certain treatment techniques, such as psychosurgery—including lobectomies and electroconvulsive therapy (ECT)[26]—often present real dangers to the patient.

200. Psychotropic drugs[27] have serious and in certain cases irreversible side-effects.

201. For the above-mentioned reasons and especially in relation to certain types and methods of treatment which have been referred to above, a number of advocates have expressed reservations about some types of treatment[28] and others have sought to establish safeguards which include "the right to refuse treatment".

G. Procedures for admission to and detention in mental institutions;[29] involuntary detention[30]

202. Almost all legal systems provide for procedures for the admission and discharge of voluntary patients hospitalized in mental institutions on the ground of mental illness or mental disorder.

203. Most of the legal systems examined also provided certain procedures for the involuntary admission of patients to mental institutions on the grounds of mental illness or mental disorder. These procedures vary in the various political and legal systems. Thus, many legal systems provide that a decision to admit a person to a mental institution as an involuntary patient shall be taken by a competent court[31] or a competent mental health tribunal. These legal systems also require a judicial hearing as a prerequisite to involuntary admission and detention.

204. In addition to the formal committal procedures, some States authorize summary committals. The difference between formal procedure and summary procedure is clear only in some legal systems (for example in Norway, Japan, Greece, Portugal and Scotland). In Ireland the difference is slight, since a police officer may take a patient into custody directly and ask a doctor for a recommendation of commital.

205. Generally in such urgent cases a certificate of a health officer will be sufficient when immediate hospitalization is deemed necessary. In Liechtenstein urgent committal is resorted to in order to prepare a medical report for the formal procedure. A similar proceeding exists in Japan, but it is based on the consent of the patient's relatives.

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[23] See E. A. Babayan, *Legal Aspects of Psychiatry in the Soviet Legislation* (Moscow, undated), pp. 23 and 24.

[24] See G. H. Morris, *The Mentally Ill and the Right to Treatment* (Springfield, Ill., C. C. Thomas, 1970), p. 12.

[25] See, for example, Babayan, *op. cit.*, p. 16.

[26] In the United Kingdom, the Mental Health (Amendment) Act of 1982, which will be implemented on 30 September 1983, permits electro-convulsive treatment to be administered without the patient's consent after a multidisciplinary committee has given a second opinion that he either is incapable of giving informed consent or has not consented, but that in either case it is right that the treatment should be given. For a summary of the reply of the United Kingdom, see document E/CN.4/Sub.2/1983/17/Add.1, chap. III.

[27] For example, the death of a young man, while undergoing a "sleep cure" at the Bel-Air Clinic in Geneva, has stirred public emotions. See J. N. Cuénod, "Après la mort d'un jeune homme à la Clinique de Bel-Air—Non à la politique du silence!" (After the death of a young man at the Bel Air Clinic—we say "no" to the policy of silence!), *Tribune de Genève*, 4 July 1980, p. 15. See also K. Bishop, "The expanding rights of mental patients", *California Lawyer* (San Francisco), vol. 2, No. 8 (September 1982), p. 69: "When Alan D. entered a hospital for treatment for mental illness, he had never suffered from hallucinations. But after being given a combination of powerful antipsychotic drugs, he did ... These and similar accounts of mental patients' unhappy experiences with antipsychotic drugs are becoming increasingly familiar as patients speak out their objections to being treated, often by forcible injection with such commonly prescribed psychotropics as thorazine, haldol, melazil, stelazine and prolixin. The strength of their feelings on this issue is reflected in the label many patients choose for their movement—psychiatric inmates' liberation".

[28] See, for example, the editorial comments on "Psychotherapy by ballot", according to which "a referendum unusual even by California standards prevailed in the city of Berkeley last week: the use of electro-shock therapy by psychiatrists was declared a misdemeanor ..." The *New York Times*, 9 November 1982, p. A30).

[29] See also the report by the Secretary-General entitled "Medical measures that may properly be employed in the treatment of persons detained on the grounds of mental ill-health" (E/CN.4/Sub.2/446), paras. 10 to 68.

[30] On the question of the human rights of persons subjected to any form of detention or imprisonment, see the report of the Working Group on that subject (E/CN.4/Sub.2/1982/34).

[31] For example the legislation of Greece, Syrian Arab Republic, Ukrainian Soviet Socialist Republic and Union of Soviet Socialist Republics; for the replies by the Governments of the above-mentioned countries, see document E/CN.4/Sub.2/1983/17, Add.1, chap. III.

206. After a short period the patient must be released, unless a formal committal order has been obtained in the interval. In Switzerland the administrative Board of Guardianships can order urgent committal without a previous expert report. The law does not fix an automatic expiry and leaves to the concerned patient the initiative of an appeal to the courts.

207. The Swiss cantons can authorize physicians to order urgent committal of mentally ill persons.

208. Sometimes in urgent cases committal is decided by a different authority. For instance, in the Federal Republic of Germany and Senegal an administrative authority (instead of the local court) can order urgent committal, either to prepare an expert report or for dangerous patients, but the decision is subject to immediate control of the judiciary. In the Netherlands commitment is ordered by the mayor in such cases, on the basis of a medical certificate; in the normal procedure the courts would be competent. In Belgium urgent committal can be ordered only by communal authorities, even before the issue of a medical certificate.

209. In France, urgent committal of dangerous patients can be ordered by the prefect without medical examination; the same applies in Tunisia, where committal may be ordered by the mayor.

210. The legal systems of very few States require *ipso jure* that there should be a judicial review or an appeal of involuntary admission once it has occurred.

211. The legal systems of many States permit an appeal to the courts against a committal issued by administrative authorities (for example, Switzerland), or against a refusal of discharge issued by the director of a hospital or by a technical review board (for example, Australia, Belgium, Denmark, Italy, Luxembourg, Netherlands, Norway).

212. Committal may sometimes be requested by the patient himself, more frequently by his relatives or friends, by physicians, administrative authorities or by the public prosecutor. In some countries (e.g. Belgium) great power is given to the guardian of a patient. Some laws, such as those of Japan, Switzerland and Luxembourg, seem to identify the interest of the patient with the behaviour of his family; other laws consider the interest of a mentally ill person objectively, in a quite independent way.

213. The opinion of one or several doctors is generally heard before committal; it may be expressed in a certificate or recommendation (as for example in South Australia, Sweden, Denmark and Ireland), and also in the form of an expert judgement (Switzerland, Liechtenstein); sometimes there may be a previous examination in the same hospital (Finland).

214. Committal may be ordered by the director or superintendent of a mental hospital (Japan, Finland, Denmark, Norway), but more frequently it will be for the local or administrative authority to provide for this (government, prefect, mayor, town council, as for example in Italy, France, Switzerland, Liechtenstein, Japan and Ivory Coast).

215. The opinion of an expert body composed of doctors, lawyers and sometimes laymen is often heard in this procedure.

216. In Greece, a commission of doctors has the power to order committal in certain cases; in other countries the patient or his family is entitled to appeal to a technical review commission against the committal order given by another authority (Sweden, Ireland, Norway). Such commissions are composed of doctors, lawyers and sometimes laymen.

217. Some legal systems try to ensure a fair debate in the administrative proceeding (for example, Switzerland and Liechtenstein).

218. Most legal systems limit the period of time a person may be held and fix specific rules for periodic re-examination of the case (Italy, Federal Republic of Germany, Netherlands, Sweden, Finland) and possible extension of committal (Australia and Ireland).

219. In Greece and Morocco the prosecutor may order committal of dangerous patients on the basis of a medical examination.

220. In some cases a judge is called to check all committal orders (Italy, Luxembourg).

221. In other countries a court is able to order committal directly, after a complete debate, including sometimes an expert judgement (Federal Republic of Germany, Netherlands, Senegal), or after hearing the opinion of a technical commission (Portugal).

222. In Scotland the sheriff (district judge) is called to approve the recommendations of two doctors. In Western Australia and Victoria a patient may be referred to a hospital by a justice of the peace as well as by a medical practitioner.

223. Several safeguards are offered to the patient in the various legal systems. Some of them have combined a certain number of devices to ensure the maximum respect of liberty in the committal procedure.

Chapter IV

CONCLUSIONS

224. From the foregoing analysis and study of the replies by Governments, specialized agencies, regional organizations, non-governmental organizations, and judgements, other informative material and relevant literature, the following main conclusions may be drawn.

225. The problems created by mental illness exist practically everywhere nowadays, but these problems vary from country to country in accordance with a number of factors, including the political and legal systems, medical standards, financial resources and the community's understanding, concern and compassion. Thus, we are painfully aware that:

(*a*) Psychiatry in some States of the international community is often used to subvert the political and legal guarantees of the freedom of the individual and to violate seriously his human and legal rights;

(*b*) In some States, psychiatric hospitalization and treatment is forced on the individual who does not support the existing political régime of the State in which he lives;

(*c*) In other States persons are detained involuntarily and are used as guinea pigs for new scientific experiments; and

(*d*) Many patients in a great number of countries who should be in the proper care of a mental institution because they are a danger to themselves, to others, or to the public, are living freely and without any supervision.[1]

226. The meaning of the concepts of "mental illness", "mentally ill" and "mental disorder" has not yet been standardized.

227. No legislative uniformity or harmonization exists in connection with the definition or the meaning of the concepts "mental illness", "mentally ill" and "mental disorder".

228. The majority of national laws or statutes do not contain any specific definition of the concepts "mental illness" or "mentally ill". However, some of them do use the concepts of "mental disorder", "psychological disorder", "psychiatric disorder", "psychical illness", "mental patient", "mental impairment", "insane person", "mental disease", "mental defect", "mental weakness", "subnormality", "severe subnormality, "psychopathy" or "mental emotional disturbances", and give the meaning of these concepts.

229. In some countries the above-mentioned concepts have been sufficiently clarified by science and jurisprudence.

[1] See J. Barnes, "Ticking time bombs who stalk streets", *Sunday Times* (London), 24 July 1983, p. 11. This article discusses the scandal of the nation's outcasts.

230. In a few States the concept "mental illness" is defined according to university teachings on psychiatry and based on the classification of diseases adopted by WHO.

231. For the purpose of this study the meaning of "mental illness" will be the following: "any psychiatric or other illness which substantially impairs mental health"; "mental disorder" is taken to mean "arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind".

232. Also for the purpose of this study a "mentally ill person" means a person who, owing to mental illness, requires care, treatment or control for his own protection, the protection of others or the protection of the community.

233. An important distinction exists between the concepts of "mental illness", "drunkenness", "mental retardation *per se*" or "senility *per se*", although at least some persons treated under any of these definitions may also be mentally ill.

234. In spite of recent economic, social and medical advances, the maintenance of high standards in mental health institutions is not automatically a constant priority of Governments.

235. One of the most serious problems in many mental hospitals is the overcrowding of patients, which often leads to unsatisfactory living conditions, lack of privacy, poor food services, defective administration, bad relationships between the patient on the one hand and doctors and nurses on the other, and inadequacy of treatment standards in general.

236. In particular, there is a conspicuous lack of adequate services and trained personnel to handle the increasing numbers of patients in a great number of countries, and especially in the least developed countries.

237. There is also a failure in a great number of countries to establish proper community-care facilities, which forces former patients into non-psychiatrically oriented facilities, in particular into improperly organized nursing homes. These nursing homes have been also used for purposes of political and economic expediency by the Governments of certain States.

238. There is a growing tendency to integrate mental health services with those for other illnesses. Evidence of this is the use of general hospitals as psychiatric and out-patient clinics.

239. Many countries place great reliance on community care, operating in association with the social services as a supplement, if not replacement, for institutional treatment. The improvement is considerable for both the patient and the health authorities.

240. Progress in some areas of science, and in particular of medicine, has reached the stage where the application of advanced medical technology can permit the survival of a patient, but after surgical intervention or the use of certain types of drugs the patient sometimes remains severely handicapped or suffers a substantial personality change.

241. It is necessary to consider the differences between mental illness and most other diseases. In some instances mental illness strikes at a person's ability to make rational judgements in the conduct of his life. Normally, when a person experiences a physical disease, he is aware that he is ill and seeks appropriate help. Often this is not the case with mentally ill persons, who do not recognize their disturbance and its effects upon their ability to function. Hence, the relevant humanitarian, medical and legal procedure for involuntary institutional care of the patient should be implemented.

242. There is a general pattern to the legislation in many jurisdictions concerning certain key aspects of involuntary admission and detention, notably:

(*a*) They permit involuntary admission to mental institutions on the grounds of mental illness;

(*b*) They are heavily inclined towards reliance on medical discretion;

(*c*) They do not provide *expressis verbis* for a full judicial hearing as a prerequisite to involuntary admission; and

(*d*) They do not specify explicitly the extent to which treatment may be imposed without consent on involuntarily detained patients.

243. By involuntary admission and detention of a patient many of his human and legal rights can be collectively violated, such as the right to life, right to liberty, freedom from fear and want, respect of his inherent dignity, the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment, the right not to be subjected to arbitrary arrest or detention, the right to privacy, freedom of movement and residence, the right to property, the right to an adequate standard for health, the right to work, etc.

244. An "emergency" situation justifying treatment without consent requires a pressing and immediate threat to life or health which cannot reasonably be put off.

245. The basic goal of protecting a patient from his own dangerous behaviour can in part be fulfilled by a properly limited procedure of involuntary admission, detention and treatment. "Dangerousness" within the framework of mental illness is a pejorative term.

246. It is not satisfactory to generalize about "dangerousness" in the abstract. One must distinguish between "danger to self", "danger to others", and "danger to the public". Also within the framework of the concept "danger to self", one must distinguish between "danger of suicide", "danger of serious bodily injury to self", "danger of causing oneself financial or social embarrassment" and "danger of neglect of one's person or affairs", Under the concept "danger to others", one must distinguish "danger of causing family and social disruption" and "danger of causing public disturbances".

247. The argument of "overprediction of dangerousness" poses a grave threat to the human rights and fundamental freedoms of the patient, because although it is not always possible accurately to predict dangerousness to self or to others, this constitutes the basic ground upon which the mental health legislation of a great number of States allows involuntary admission and detention.

248. It has become increasingly evident that some of the scientific and technological advances have adverse effects and in certain cases they pose threats to the physical and intellectual integrity of the patient. Thus, the side-effects of the major tranquillizing and antidepressant drugs can be very severe; for example the administration of strong tranquillizing or antidepressant drugs over a long period may be such as to cause unpredicted personality changes in the patient.

249. Mental health records must be safeguarded if the treatment given to the patient is to be meaningful and he is to be free from stigma, discrimination and harm.

250. If the mental health care system as a whole is characterized by neglect and confusion, if the financing is inadequate and the administration weak, if the psychiatrists and other physicians do not respect the codes of medical ethics, then even the most modern and perfectly adapted legislative and administrative measures for the protection of the fundamental freedoms, human and legal rights of the patient will be irrelevant.

Chapter V

RECOMMENDATIONS

251. The conclusions drawn from the research and analysis of the subject of this study indicate an imperative need for action, in particular by States, for the protection of the fundamental freedoms and human and legal rights of the patient.

252. The Special Rapporteur therefore proposes that the Sub-Commission on Prevention of Discrimination and Protection of Minorities should consider making the following basic recommendations to the Commission on Human Rights for the consideration of Governments; namely, the Governments should:

(*a*) Adapt their laws, if necessary, to the draft body of principles, guidelines and guarantees for the protection of the mentally ill or persons suffering from mental disorder annexed to this study, or adopt provisions in accordance with the above-mentioned draft body of principles, guidelines and guarantees when introducing new legislation;

(*b*) Elaborate and implement programmes for social and community care of the patient and allocate adequate resources for the improvement, if necessary, of medical services and mental institutions. In this connection, it should be once again clarified that it is almost impossible to expect to find a single formula for the elaboration of relevant programmes, applicable to all countries, in view of differences among cultures, economic and social development and local conditions. Nevertheless, a careful study of programmes that have had a visible impact in particular circumstances may enable other countries to adapt the best features of such programmes to their own conditions;

(*c*) Ensure respect for the basic principles of legality, the rule of law, due process of law,[1] a fair and public hearing, equality and non-discrimination and the writ of habeas corpus;[2]

(*d*) Recognize the rights of the patient to receive treatment, and to refuse treatment, the right to rehabilitation and to protection from harm for involuntarily detained patients;

(*e*) Safeguard confidential information in mental health records in order to protect the patient from stigma, discrimination and harm;

(*f*) Recognize the patient's right to have complete information on the medical diagnosis and report, the nature of treatment, its risks, the possibility of alternative treatment, the patient's right to consult his own file, notably the medical file, the relevant social file and nursing file;

(*g*) Ensure access of patients in detention or correctional institutions to appropriate mental health services on a voluntary basis; such access should not be connected with release considerations;

(*h*) Implement the policy that involuntary admission to and detention in a mental institution should not be justified if the basic standards of housing, food or medical care and treatment fall below acceptable civilized standards;

(*i*) Impose respect for the codes of medical ethics and provide expressly in the relevant legislation that psychiatrists and other physicians, in determining whether a person is suffering from mental illness and requires admission to a mental institution, should do so only in accordance with medical science and ethics. The difficulty which a person may have in adapting to certain moral, social, political, religious or other values should not in itself be considered as grounds for determining that a person is mentally ill;

(*j*) Prohibit *expressis verbis* psychological and psychiatric abuses, in particular for political purposes or other non-medical grounds;

(*k*) Recognize that committal to a mental institution subjects the patient to the loss of his freedoms. The restrictions on personal freedom[3] of the patient should be limited only to those which are necessary because of his state of health and for proper treatment to be effective;

(*l*) Seek new ways of humanizing the care of the patient by observing the humanitarian elements and the quality of care and treatment, as opposed to sophisticated technology, and by reconsidering in this context the appropriateness, conditions and control of utilization of certain therapies which may leave permanent brain damage or change the personality of the patient;

(*m*) Provide care in a humane physical and psychological environment and an individualized treatment plan for every patient;

(*n*) Establish modern and suitable mental institutions and develop adequate medical services, which should call for good quality mental health workers and produce more and better teachers and teaching in mental health centres. These can in turn produce the staff needed in the mental health field and can also serve as examples by which standards of mental care are set;

(*o*) Establish and provide special services for minor and juvenile patients, who have special needs and

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[1] See K. Bishop. "The due process fight for juvenile mental patients" and the relevant judgements of the California Supreme Court, *California Lawyer* (San Francisco), vol. 2, No. 8, September 1982, pp. 70-72 and 108.

[2] In this connection, see E.-I. A. Daes, *The Individual's Duties to the Community and the Limitations of Human Rights and Freedoms under Article 29 of the Universal Declaration of Human Rights* (United Nations publications, Sales No. E.82.XIV.1), pp. 132-136.

[3] *Ibid.*, pp. 112 and 132.

require special programmes for their education and training facilities;

(*p*) Guarantee mental health education and encourage that in mental health activities the focus should be on the establishment of a sense of community care;

(*q*) Afford the patient judicial protection, if necessary;

(*r*) Encourage and instruct local authorities and communities to be more involved in the socio-professional rehabilitation of ex-patients and their integration as far as possible in normal life, by creating selective placement programmes, workshops and accommodation, and in particular, by setting up information programmes aimed at changing attitudes towards current or former patients;

(*s*) Take action and measures to end the needless discrimination against the patient in society. To eliminate, in particular, any form of discrimination against patients belonging to racial, ethnic, religious or linguistic minorities;

(*t*) Establish advocacy systems for a proper representation of the patients;

(*u*) Educate and mobilize public opinion through the mass media, disseminate information concerning the protection of the fundamental freedoms and the human and legal rights of the patient, in particular against any threat arising from certain scientific and technological developments, and convince people that mental health enhances the individual's life.

ANNEXES

Annex I

LIST OF GOVERNMENTS AND NON-GOVERNMENTAL ORGANIZATIONS WHICH HAVE REPLIED TO THE SPECIAL RAPPORTEUR'S QUESTIONNAIRE

As of 15 June 1983, substantive comments referring to the questionnaire prepared pursuant to Sub-Commission resolution 11 (XXXIII) have been received from the Governments of the following States:

1. Afghanistan
2. Australia
3. Austria
4. Bahamas
5. Barbados
6. Belgium
7. Bulgaria
8. Burkina Faso
9. Burma
10. Canada
11. Chile
12. Colombia
13. Costa Rica
14. Cyprus
15. Denmark
16. Dominican Republic
17. Finland
18. France
19. German Democratic Republic
20. Germany (Federal Republic of)
21. Greece
22. Iraq
23. Italy
24. Japan
25. Jordan
26. Kenya
27. Korea (Republic of)
28. Kuwait
29. Madagascar
30. Mauritius
31. Mexico
32. Netherlands
33. New Zealand
34. Niger
35. Philippines
36. Portugal
37. Senegal
38. South Africa
39. Spain
40. St. Vincent and the Grenadines
41. Sweden
42. Syrian Arab Republic
43. Thailand
44. Ukrainian Soviet Socialist Republic
45. Union of Soviet Socialist Republics
46. United Kingdom of Great Britain and Northern Ireland
47. United Republic of Cameroon
48. United States of America
49. Zimbabwe

The following non-governmental organizations also sent substantive information:

1. American Psychiatric Association
2. American Psychological Association
3. Amnesty International
4. Association pour les Droits des Usagers de la Psychiatrie
5. Commission Suisse pour la Protection des Droits de l'homme contre les Abus Psychiatriques
6. Commonwealth Medical Association
7. Council for Science and Society
8. International Association of Democratic Lawyers
9. International Association of Penal Law
10. International Commission of Jurists

12. International Federation of Human Rights
11. International Council of Nurses
13. International Human Rights Law Group
14. Rehabilitation International
15. World Council of Churches
16. World Federation of Mental Health
19. World Medical Association
17. World Federation of Neurology
18. World Federation of Neurosurgical Societies
20. World Psychiatric Association

Annex II

DRAFT BODY OF PRINCIPLES, GUIDELINES AND GUARANTEES FOR THE PROTECTION OF THE MENTALLY ILL OR PERSONS SUFFERING FROM MENTAL DISORDER

I. Introductory comments

Scientific and technological developments provide ever-increasing opportunities to better the conditions of life of peoples and nations in a number of instances, but they can give rise to social problems as well as threaten the fundamental freedoms and the human rights of the individual.

Improved medical and psychotherapeutic technology can in some cases constitute a threat to the physical and intellectual integrity of the individual.

There are reports that scientific and technological products, means and methods have already been misused in some States of the international community in a disturbing number of cases, in particular in the treatment of persons detained on grounds of mental ill health or mental disorder.

Mental health law proceedings are of cardinal importance in terms of the freedom of the patient, who ought to be entitled to protect his human and legal rights by every means.

The following principles, guidelines and guarantees are not intended to cover every legal, medical, economic and social aspect related to the patient's admission to an institution or to his detention, treatment, discharge and rehabilitation in the community. Also, in view of the great variety of legal, medical, social, economic and geographical conditions in the world community, it is obvious that not all of the principles, guidelines and guarantees are capable of immediate application in all countries at all times. This applies particularly to some of the least developed countries, where matters related to mental health are acute and important but where other urgent health problems in the fields of nutrition, infectious diseases and sanitation absorb the greater part of the already limited resources available for the national health plan.

Thus, these principles, guidelines and guarantees are *inter alia* intended to serve as a guide to Governments, specialized agencies, national, regional and international organizations, competent non-governmental organizations and individuals, to stimulate a constant endeavour to overcome economic and other practical difficulties in the way of their adoption and application, since they represent, as a whole, minimum United Nations standards for the protection, in general, of the fundamental freedoms, human and legal rights of the mentally ill and of persons suffering from mental disorder.

Accordingly, Governments should adapt their laws, if necessary, to the following body of principles, guidelines and guarantees for the protection of the patient, or adopt provisions in accordance with the body of principles, guidelines and guarantees when introducing new relevant legislation. These principles, guidelines and guarantees set the minimum United Nations standards for the protection of the patient.

II. Principles, guidelines, procedures and guarantees

APPLICATION

Article 1

These principles, guidelines and procedures shall be applied impartially.

Article 2

1. There shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. A background of treatment or hospitalization of any patient in the past shall not justify any discrimination at the present.

DEFINITIONS

Article 3

For the purpose of this body of principles, guidelines, procedures and guarantees, the concepts of:

(*a*) "Mental illness" means "any psychiatric or other illness which substantially impairs mental health";

(*b*) "Mentally ill" means a person who, owing to mental illness, requires care, treatment or some control for his own benefit or with a view to the protection of other persons or of the community;

(*c*) "Mental disorder" means arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of the mind"; and

(*d*) "Mental institution" covers the terms: "mental hospital", "care centre", "psychiatric hospital" and "psychiatric clinic" but not the term "nursing centre".

FUNDAMENTAL FREEDOMS AND BASIC RIGHTS OF THE PATIENT

Article 4

1. Every patient shall be treated with humanity and respect for the inherent dignity of the human person.

2. Every patient, save as hereinafter provided, shall enjoy the same human rights and fundamental freedom as his fellow citizens.

3. Every patient shall, in particular, have the right to protection from exploitation, abuse and degrading treatment.

4. There shall be a definite time-limit on the permissible period of conditional status of a patient. After that time he shall be treated as his fellow citizens are treated.

Article 5

1. A diagnosis that a person is a patient shall be determined in accordance with internationally accepted medical standards.

2. Difficulties of adaptation to certain moral, social, cultural or political values or religious beliefs shall not be a determining factor in diagnosing a mental illness or a mental disorder.

Article 6

1. Every patient shall be treated and cared for, as far as possible, in the community in which he lives.

2. Whenever possible a patient shall be treated in a mental institution near his home or the home of his relatives or friends.

3. Community-based facilities shall assist in satisfying basic everyday needs as well as providing medical, nursing and rehabilitation services.

Article 7

1. Every patient shall be entitled to the best care and treatment in accordance with the highest attainable standards of physical and mental health.

2. Every patient shall have a legal right to receive whatever social and medical services and assistance are necessary to protect him from any harm, including chemical intrusions, abuse by other patients and staff or acts causing mental distress.

3. These rights shall be guaranteed by the national Constitution.

Article 8

1. A mental institution in which patients can be treated shall have access to:

(*a*) Adequate and regular supplies of medication;

(*b*) Diagnostic and therapeutic equipment for the patient;

(*c*) Qualified medical and nursing staff in sufficient numbers, and adequate space to provide the patient with a programme of appropriate and active therapy and privacy where possible.

2. Mental institutions shall only accept a certified patient. A patient shall not be certified unless mental illness or mental disorder has reached a stage at which it is obvious to a competent court or mental health tribunal.

3. Every mental institution shall be inspected by the higher competent authorities at least once every month.

Article 9

1. Every patient shall have the right to the least restrictive alternatives necessary to fulfil the purpose of his treatment.

2. The treatment and care of every patient shall be based on an individually prescribed plan, reviewed regularly, revised as necessary and administered by qualified medical staff.

3. Certain therapies and treatments, such as psychosurgery and electroconvulsive treatment, shall never be applied without the patient's consent or the consent of his legal representative.

4. Psychiatric knowledge and skills shall only be employed for the diagnosis, therapy, and rehabilitation of the patient and shall never be abused by being employed for non-medical purposes.

Article 10

1. Medication shall be given to a patient only for therapeutic purposes and shall not be administered as a punishment or used for the purpose of restraint or for the convenience of the medical and nursing staff.

2. All medication shall be recorded in the patient's records and be prescribed by a qualified medical practitioner or by a qualified member of the nursing staff.

Article 11

1. Every patient shall have the right to refuse treatment.

2. Every patient, as a principle, shall have the right to refuse medication at least for twenty-four hours before the hearing of his case.

Article 12

Every patient who has the legal capacity to make decisions about his treatment and life shall have the right to an informed consent.

ADMISSION TO MENTAL HOSPITAL

Article 13

A patient shall be admitted to a mental institution as a voluntary patient if:

(*a*) Two qualified medical practitioners consider, after a proper personal examination, that the patient is suffering from mental illness or mental disorder and is likely to benefit from admission for care and treatment;

(*b*) The patient has been informed of and understands the purpose of admission; and

(*c*) He requests, consents or does not object to such admission without undue influence or inducement.

Article 14

Every voluntary patient shall have the right to leave the mental institution at any time unless there are serious grounds for him to be retained as an involuntary patient. In this case all the relevant provisions of article 16 for involuntary patients shall apply.

Article 15

1. No one shall be admitted to a mental institution for observation for a period exceeding forty-eight hours, and during that time he shall be examined by the superintendent of the medical hospital or a second medical practitioner.

2. Preventive detention of a patient shall be prohibited.

INVOLUNTARY ADMISSION

Article 16

1. Involuntary admission is a great infringement of the human rights and fundamental freedoms of the patient, and therefore he shall be admitted to a mental institution as an involuntary patient only if:

(*a*) There is a medical recommendation of at least two medical practitioners recommending the admission for care and treatment of the patient on the ground that he is suffering from severe mental illness or mental disorder and is dangerous to himself, or too dangerous to others or to the community;

(*b*) In accordance with a decision taken by a competent court or a competent health tribunal.

2. In an emergency one medical practitioner can admit a patient to a mental institution and shall immediately inform the administration of the mental institution and the competent court or the competent mental health tribunal, which shall pronounce its decision in accordance with article 17 and in the shortest possible time.

Article 17

A decision to admit a patient to a mental institution as an involuntary patient shall be taken only by a competent court or a competent mental health tribunal after appropriate preparation and proper hearing of the case.

NOTICE

Article 18

1. A notice given a reasonable time in advance of any judicial hearing of the case of the patient shall be required by law.

2. The notice shall be written in a language which the patient understands and shall contain the time and place of the hearing, the name and address of the lawyer who will represent him, the legal and medical standards under which he may be committed, the legal rights which he has prior to the hearing and at the hearing, the grounds and specific facts that are alleged to justify commitment and the names, profession and addresses of all persons who will testify in favour of or against his hospitalization.

Article 19

In the proceedings before the court the patient shall be entitled:

(*a*) To be represented by a trained lawyer and experienced advocate;

(*b*) To be heard personally;

(*c*) To attend and participate in the hearing; this right of the patient shall only be restricted on the ground that the behaviour of the patient in the court so obviously disrupts the proceedings that they cannot continue without his expulsion;

(*d*) To see any relevant reports and documents submitted to the court, except where, or to the extent that, the court considers it would pose a substantial risk of harm to the patient's health;

(*e*) To call a free and independent expert witness; and

(*f*) To request the presence of any other person of his family or any friend.

MAIN FUNCTIONS OF THE LAWYER

Article 20

The lawyer who appears for a patient in the mental health proceedings shall have the following main functions:

(*a*) To advise the patient generally of his human and legal rights;

(*b*) To prepare the case of the patient in accordance with the law and the material relating to the actual facts of the case; in particular to produce or request an independent medical report or any other evidence and to study and evaluate all reports and documents submitted to the court;

(*c*) To prepare for appearance in other cases before other courts in which the status or the interests of the patient are discussed;

(*d*) Generally to constitute a "legal presence" in the court and in the mental institution promoting an atmosphere of sincere concern for the protection of the human and legal rights of the patient.

Article 21

1. The court shall give its decision in writing, stating its findings and the reasons of its decision.

2. Ratified copies of the decision shall be furnished to the patient, to his lawyer or to his legal representative.

Review and appeal procedures

Article 22

1. The periodic judicial review of the cases of patients shall be provided by the national Constitution.

2. A decision to admit an involuntary patient shall be reviewed at specified reasonable intervals by the court and the patient shall be entitled to be released unless the court is convinced that the requirements in article 16 still apply.

3. The patient shall have the right to apply periodically to the court for his release.

Article 23

The patient, represented by his lawyer or any interested person or assisted by a court-appointed lawyer or counsellor, shall have the right to appeal to a higher court against the decision to admit him to a a mental institution as an involuntary patient.

Article 24

1. The law shall specify in every case the maximum permissible duration of involuntary detention and treatment on the grounds of "danger to self", "danger to others", and "protection of the community".

2. The patient or his legal representative or any interested person shall have the same rights of appeal as provided by articles 22 and 23 against a decision to renew his detention in a mental institution.

The right to communicate

Article 25

1. Every hospital patient shall have the right to communicate with people outside the mental institution.

2. He shall have the unrestricted right to receive and send uncensored communications or letters from and to his lawyer, or guardian or other legal representative or competent authority, or his family or friends.

3. He shall have the right to receive visitors regularly, limited only as strictly as necessary in the interest of his health and the protection of himself and others.

Other basic rights

Article 26

A hospital patient shall further have the following rights, limited only, as strictly as necessary, in the interest of his health and the protection of himself and others:

(*a*) To practise his religion;

(*b*) To privacy;

(*c*) To enjoy facilities for education and vocational training;

(*d*) To enjoy facilities for reading, recreation and sport; and

(*e*) To purchase essential items for daily living, including clothes, recreation, sport and communication.

Article 27

1. Any patient who has not been declared incapable by a court shall not be treated as if he were incapable only on the ground that he is or has been hospitalized in a mental institution.

2. Every patient shall have the right to be registered and vote, unless he has been declared, by a court, incapable of exercising this basic right.

3. Every patient who has not been declared incapable by a court shall have the right to exercise all his civil, political, social or cultural rights, including the right to manage his own financial affairs and control the disposition of his assets.

Article 28

1. Forced labour in mental institutions shall be prohibited.

2. The labour of a patient shall not be exploited to the detriment of his own interests. He shall, as far as possible, be compensated for his labour commensurate with the quantity, quality and value of his work.

3. A patient shall have the right to active occupation suited to his social, cultural and training background and designed to promote his rehabilitation and reintegration into the community.

Guardian

Article 29

Every patient shall have the right to a qualified guardian appointed by a competent court, when this is required to protect the patient's well-being and interests.

Criminal proceedings

Article 30

1. If during the investigation, prosecution, or trial of a criminal matter, a person or his legal representative states that he is a patient or a court has reason to suspect that a suspected or accused person suffers or suffered at the relevant time from mental illness or mental disorder, it should order a proper medical, and in particular, psychiatric report and should, if necessary, order the person to be admitted to a mental institution.

2. Medical and especially psychiatric reports shall, *inter alia*, deal with all relevant legal issues, such as the ability of the patient to stand trial, as well as recommendations on criminal responsibility.

3. A suspected, accused, convicted or detained person shall have the right to an independent psychiatric examination and report, whenever his mental condition is relevant to legal proceedings.

Article 31

Neither criminal charges nor criminal conviction shall be a sufficient reason for varying the procedures and standards for determining the presence or absence of mental illness or mental disorder.

Article 32

1. Police, prosecutors, judges, medical practitioners and psychiatrists engaged in criminal investigations or proceedings shall regard with particular caution and responsibility any apparent consents, confessions or acquiescent conduct of suspected or accused patients.

2. No patient shall be compelled to testify against himself during a criminal proceeding.

Article 33

Prosecuting authorities or judges empowered to institute or approve criminal charges shall have regard, in the light of psychiatric recommendations and reports, to a suspected or accused person's present mental condition, or his mental condition at the time of the commitment of his alleged crime, when deciding whether to prosecute further or whether to allow him to have voluntary or involuntary treatment by community-based facilities or a mental institution.

Article 34

1. If there is serious reason to suspect that an accused patient is not fit to stand trial because of severe mental illness or mental disorder, the court shall inquire into the question, if necessary upon its own authority.

2. In such a case, if the accused patient is found to be incapable, owing to severe mental illness or mental disorder, of understanding the nature or object of the proceedings in general, the proceedings shall be suspended and the court shall declare that the patient is unfit to stand trial.

3. If in the course of criminal proceedings against a patient found not fit to stand trial it can be shown that a material element is lacking in the offence with which he is charged, the court shall definitively terminate the proceedings in favour of the accused patient by a judgement.

Article 35

On the basis of the principle *nullum crimen sine mente rea*, a person shall not be held criminally responsible if by reason of severe mental illness or mental disorder he was unable to control or restrain his criminal impulses, or was unable to appreciate the criminal nature of his acts.

Article 36

A condition of mental illness or mental disorder which does not fully eliminate criminal responsibility should be considered as diminishing responsibility and should be taken into consideration by the court in determining the sentence.

Article 37

1. A patient who is acquitted because of failure to establish a material element of the offence with which he is charged should be admitted to a mental institution only as a voluntary patient or, following a decision by the court, as an involuntary patient, in accordance with the requirements of article 16.

2. If a person is acquitted by a court on the ground of lack of criminal responsibility because of severe mental illness or mental disorder, but the material facts of a crime are otherwise established against him, the court shall have the power, if he is amenable to care and treatment, to order either community-based treatment or, if the requirements of article 16 apply, treatment in a mental institution.

Article 38

1. Where a patient is admitted to a mental institution by order of a court, he shall have the same human and legal rights and protections as other involuntary patients.

2. Every patient confined to a mental institution under the criminal law and as a result of penal proceedings shall have substantially the same appeal and review rights as a patient confined in a mental hospital under civil law proceedings.

Article 39

A convicted prisoner suffering from mental illness or mental disorder shall be provided with adequate mental health care and treatment and shall be transferred from prison to an ordinary mental hospital if adequate mental care and treatment and appropriate special space is not available in the prison.

Article 40

At the end of his sentence, a patient shall be released and shall not be admitted to or retained in a mental institution as an involuntary patient unless in accordance with the requirements of article 16.

Minors and juvenile patients

Article 41

Every minor or juvenile patient shall have the same right to resist hospitalization on the same grounds and under the same standards and procedures as adults.

Article 42

Every minor or juvenile patient in a mental institution shall be treated as normally as possible.

Article 43

Every minor or juvenile patient shall have the right to a public education, regardless of the degree of mental, emotional or physical handicap. In particular, every minor or juvenile patient shall be individually evaluated and receive, if possible, an individualized educational or training programme.

Article 44

The administration of a mental institution shall be required, at frequent and regular intervals, after relevant recommendations and reports by the medical staff, to examine the propriety of the hospitalization of each minor or juvenile patient.

Legal aid

Article 45

A patient who at any time is unable to secure the services of a qualified lawyer shall have the right to such legal aid and advice services, if possible free of charge.

III. Remedies

Article 46

(a) *National level*

1. Every patient shall have the right to an effective remedy by a competent court for acts under civil and criminal law, negligence or treatment contrary to the provisions of international instruments on human rights, to the law and medical ethics or to the present guidelines and principles. Such remedies shall be recognized by the Constitution.

2. Professional medical bodies shall investigate any complaint by a patient against a medical practitioner for professional misconduct.

(b) *Regional and United Nations level*

3. Every patient or his guardian or legal representative shall be entitled to submit any application, petition or communication to the competent organ of a regional organization or to the competent organs or bodies of the United Nations and specialized agencies established under relevant regional or international human rights instruments, in cases where the Government or other national authorities violate his human rights and fundamental freedoms or the present principles and guidelines.

IV. Implementation

Article 47

States should implement these principles and guidelines through appropriate legislative, judicial and administrative measures and means, which shall be reviewed periodically.

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