# HUMAN RIGHTS AND PRIVILEGES OF MENTALLY ILL PERSONS

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Since the dawn of human civilization, mentally ill persons have received scant care and concern of the community because of their unproductive value in the socioeconomic value system. They have not only been neglected but received step motherly treatment from the health planners especially in the developing countries. It was the plea of progressive incorporation of the norms of human rights and liberal jurisprudence in the respective legal system of nation states that created the necessity and urgency of initiating appropriate steps for the care and treatment of mentally ill persons.

It is admitted on all hands that barring few exceptions , the mentally ill person deserves the same privileges as enjoyed by any other human being. However, the stigma, the residual disability and its intolerance , and more importantly the inability of the mentally ill to protest against exploitation , have all made the basic human rights of the mentally ill a major cause of growing concern.

The term ***Human Rights*** in a broad sense means " those claim which every individual has or should have upon the society in which he/she lives. According to Richard Wasserstorm it means , one that ought to be claimed as entitlements (i.e human rights ) those minimal things without which it is impossible to develop ones capabilities and to live life as human beings.

In the context of mentally ill persons, it not only refers to their privileges but remedial right of protection against infringement of their human and other statutory rights.

The *first* human rights legal resolutions , such as 1948 Universal Declaration of Human Rights , did not specifically address the rights of mental health consumers. They codified more general, but still relevant , rights like right to life and liberty and right to be free from inhuman , degrading treatment.

Later resolutions such as the **Declaration on the Rights of Mentally Retarded Persons** (1971) and the **Declaration on the Rights Of The Disabled Persons**(1975), began the process of establishing international minimum standards for the treatment of persons with mental disabilities.

## RIGHT TO HEALTH IN CONSTITUTION OF INDIA

As citizens of India , the mentally ill are entitled to all those human and fundamental rights which are guaranteed to each and every citizen by the constitution of India , to the extent their disability do not prevent them from enjoying those rights or their enjoyment is expressly or impliedly barred by the constitution by any other Statutory law. The fundamental right to life and liberty as interpreted by the

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Supreme Court of India in number of landmark cases includes the right to live with human dignity and right to health . The supreme court has also laid down the maintenance and improvement of public health as one of the obligations that flow from Article 21 of the constitution . *This means that mentally ill have fundamental / human right to receive mental health care and to humane living conditions in the mental hospitals.*

The right to life in Article 21 of the Constitution means something more than survival of human existence . It would include within its ambit the right to live with human dignity, right to health , right to potable water , right to pollution free environment and right to education etc., which have been held to be part of right to life. In the context of mentally ill person , apart from above narrated rights, it also includes right to live , work as far as possible in the community , to privacy and to lead a normal family life.

The serious mentally ill are a special group with disabilities . The concern with this group is two fold , not only of providing the privileges to live in society along with other citizens but also ensuring their right to protection from exploitation.

The Human Rights of patients in Mental Hospitals will have to be considered against the following developments:

1) Advances in mental health
2) National mental Health Programme (1982)
3) Mental Health Act 1987
4) Persons with Disability Act 1995
5) United Nations Principles for the protection of persons with mental illness and for the improvement of mental health care (1991)
6) World Psychiatric Association , Declaration of Hawaii(1992)
7) Supreme Court Judgments

***Declaration Of Hawaii*** 1992 by General Assembly of World Psychiatric association also talks about the patients right to treatment and patients consent for treatment . It also talks of treatment under special circumstances, where if the patient does not have judgement into his condition then treatment is to be administered in his best interest . As soon as the condition for compulsory treatment are no longer applicable, psychiatrist should obtain voluntary consent and treat the patient.

In 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment 5,detailing the application of **the International Covenant on Economic, Social and Cultural Rights(ICESCR)** with regard to people with mental and physical disabilities. General Comments, which are produced by human rights oversight bodies, are an important source of interpretation of the articles of human rights conventions. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body.

*Major human rights standards applicable to mental health:*

- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991)
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Standard Rules, 1993)

**WHO TECHNICAL STANDARDS**

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* (see box below) and the

*Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the MI Principles and evaluate human rights conditions in institutions.

**Mental Health Care Law : Ten Basic Principles**

1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments in accordance with internationally accepted principles
4. Provision of least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodic review mechanism
9. Qualified decision-maker
10. Respect of the rule of law

*WHO, 1996*

This article discusses important rights of users of mental health services that should be formally protected by legislation . Persons with mental disorders, however, may require special and additional protection in view of a history of human rights abuses, stigma and discrimination and, at times, due to the peculiarities of mental disorders. People with mental disorders are sometimes treated as “non-persons”, akin to the way children or worse, animals are treated. They are often considered to lack adult decision making capacity, which results in a total disregard for their feelings and human dignity.

**1. CONFIDENTIALITY**

Persons with mental disorders have the right of confidentiality of information about themselves and their illness and treatment; such information should not be revealed to third parties without their consent. Mental health professionals are bound by professional codes of conduct that generally include rules for confidentiality. All professionals involved in the care of persons with mental disorders have a duty to prevent any breach of confidentiality. It is important that all members of the mental health team be aware of the rules that bind them to maintaining confidentiality.

Authorities in charge of mental health facilities should also make sure that adequate processes are in place to safeguard the confidentiality of persons with mental disorders. This means having an effective system in place so that only authorized individuals have access to patients' clinical notes or other data-recording mechanisms such as electronic databases.

Mental health legislation may also protect confidentiality by providing for sanctions and penalties for breaches of confidentiality, either by professionals or mental health facilities. Wherever possible, remedies other than legal prosecution, such as education of the person and appropriate administrative procedures, should be used where there has been disregard for patients' confidentiality. Nonetheless, in certain exceptional cases criminal sanctions may be necessary.

There are a few exceptional instances when confidentiality may be breached. Legislation may specify the circumstances when information on mental health patients may be released to other parties without the prior consent of the user. These exceptions may include situations such as life-

threatening emergencies or if there is likelihood of harm to others. The law may also wish to cover circumstances such as prevention of significant morbidity or suffering. However, the information disclosed should be limited only to that required for the purpose at hand. Also, when courts of law require the release of clinical information to judicial authorities (in criminal cases, for example), and if the information is pertinent to the particular case, mental health professionals are obliged to provide the information required.

There are other complicated issues concerning the need to maintain confidentiality and the need to share certain information with primary caregivers who are often family members. Legislation may ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to release information.

## 2. ACCESS TO INFORMATION

Persons with mental disorders should have a statutory right to free and full access to their clinical records maintained by mental health facilities and mental health professionals. This right is protected by general human rights norms, such as Article 19 of the ICCPR and the MI Principles.

It is possible that in exceptional situations, revealing clinical records of a person may put the safety of others at risk or cause serious harm to that person's mental health. For example, clinical records sometimes contain information from third parties, such as relatives or other professionals, about a severely disturbed patient, which, if revealed to that patient at a particular time may cause a serious relapse or, worse still, cause the patient to do harm to himself or herself or to others. Many jurisdictions therefore give professionals the right (and duty) to withhold such parts of records. Normally, withholding information can only be on a temporary basis, until such time as the persons are able to deal with the information rationally.

Legislation may ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to withhold information. Patients and their personal representatives may also have the right to request that their comments be inserted in the medical records without in any way altering the existing records.

Legislation (or regulations) may outline the procedure for patients to exercise their right of access to information. This may include:

- ✍ The procedure for making an application for access to information;
- ✍ Who is permitted to make such an application;
- ✍ The duration of time in which the mental health facility must make such records available upon receipt of the application;
- ✍ Professionals who should review the records before they are made available to the patient and/or their personal representatives and certify which parts should not be made available (if any), and their reasons for this;
- ✍ When only partial records are given to the patients and/or their personal representative, the
- ✍ Reasons for not providing the full record should be conveyed to them;
- ✍ Set out the exceptional circumstances when access to information may be denied.

It is also important that health facilities have a staff member available to review and explain the information in the patient's file or record to the patient and/or legal representative.

## 3. RIGHTS AND CONDITIONS IN MENTAL HEALTH FACILITIES

Persons with mental disorders residing in mental health facilities are often subject to poor living conditions, such as lack of or inadequate clothing, poor sanitation and hygiene, insufficient and poor quality food, lack of privacy, being forced to work, or being subject to physical, mental and sexual abuse from other patients and staff . Such conditions violate internationally agreed norms for rights and conditions in mental health facilities.

**MI Principles: Rights and conditions in mental health facilities**
1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
(a) Recognition everywhere as a person before the law;
(b) Privacy;
(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
(d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:
(a) Facilities for recreation and leisure activities;
(b) Facilities for education;
(c) Facilities to purchase or receive items for daily living, recreation and communication;
(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

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

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work. *(Principle 13, MI Principles)*

***Environment***
Patients admitted to mental health facilities have the right to be protected from cruel, inhuman and degrading treatment as set out in Article 7 of the International Convention on Civil and Political Rights (ICCPR).

The provision of a safe and hygienic environment is a health concern, and critical to a person's overall well-being. No individual should be subject to unsafe or unsanitary conditions when receiving mental health treatment.

The MI Principles state that the environment in mental health facilities must be as close as possible to

that of normal life. This includes facilities for leisure, education, religious practice and vocational rehabilitation.

Legislation (or accompanying regulations) should set out minimum conditions to be maintained in mental health facilities to ensure an adequately safe, therapeutic and hygienic living environment. Legislation can also include provisions for a "visiting board" to visit the facilities in order to ensure that these rights and conditions are being respected and upheld . It is important that the law stipulate the actions the visiting board can take if conditions are not met, because if they are not given legal powers, such boards can merely become a co opted part of an abusive system.

***Privacy***

Privacy is a broad concept limiting how far society can intrude into a person's affairs. It includes information privacy, bodily privacy, privacy of communications and territorial privacy. These rights are frequently violated with regard to people with mental disorders, particularly in psychiatric facilities. For example, patients may be forced to live for years in dormitory-like wards or "human warehouses" that provide little private space. Facilities such as cupboards for storage of personal belongings may be lacking. Even when patients have a single or double room, staff or other patients may be able to violate their personal space.

Legislation may make it mandatory for the physical privacy of patients to be respected and for mental health facilities to be structured to make this possible. However, this may be difficult in low-income countries with resource limitations; in such instances, the previously established principle of parity with other health care should be a first step.

Moreover, if adequate services are provided in the community, deinstitutionalization may in itself become a means towards many people obtaining greater privacy through discharge from crowded and impersonal hospital conditions. However, it is important to note that in mental health facilities the right to privacy does not mean that, in particular circumstances such as those involving a suicidal patient, that person cannot be searched or continually observed for his or her own protection. In these circumstances, the limitation on privacy needs to be carefully considered against the internationally accepted right.

**Communication**

Patients, especially those admitted involuntarily, have the right to communication with the outside world. In many institutions, intimate meetings with family, including one's spouse and friends, are restricted. Communication is often monitored, and letters opened and sometimes censored. Legislation can ban such practices in mental health facilities.

However, as with confidentiality and access to information (discussed above) there may be certain exceptional circumstances in which communication too needs to be restricted.

If it is reasonably demonstrated that failure to restrict communications would be harmful to the patient's health or future prospects, or that such communications would impinge on the rights and freedoms of other people, then it may be reasonable to restrict those communications. Legislation can set out the exceptional circumstances, as well as stipulating the right of people to appeal these restrictions.

***Labour***

Legislation can ban the use of forced labour in mental health facilities. This includes situations where patients are forced to work against their wishes (for example, due to staff shortages within the facility),

or are not appropriately and adequately remunerated for work performed, and where patients are made to perform the personal work of the institution's staff in return for minor privileges.

Forced labour should not be confused with occupational therapy. Nor should it be likened to situations where, as part of a rehabilitation programme, patients must make their own beds or cook food for people in their facility. However, there are certain grey areas, and any legislation should strive to provide as much clarity on these issues as possible.

**4. AWARENESS OF RIGHTS**

Although legislation may provide many rights to persons with mental disorders, they are frequently unaware of their rights and thus unable to exercise them. It is therefore essential that legislation include a provision for informing patients of their rights when interacting with mental health services.

**MI Principles: Notice of Rights**

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.
2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

*(Principle 12(1) and (2), MI Principles)*

The information should include an explanation of what these rights mean and how they may be exercised, and be conveyed in such a way that patients are able to understand it. In countries where various languages are spoken, the rights should be communicated in the person's language of choice.

Provisions can be made for communicating these rights to personal representatives and/or family members in the case of patients who lack the capacity to understand such information.

**5. RIGHTS OF FAMILIES AND CAREGIVERS OF PERSONS WITH MENTAL DISORDERS:**

Family members often bear the brunt of the person's behavior when he or she is ill or relapses, and it is usually the caregivers/family members that fundamentally love, care and worry about the person with the mental disorder. Sometimes they too become targets of stigma and discrimination. In some countries, families and caregivers also carry the legal responsibility for third-party liability arising from actions of persons with mental disorders. The important role of families needs to be recognized .

Family members and caregivers need information about the illness and treatment plans to be better able to look after their ill relatives. Legislation should not arbitrarily refuse information merely on grounds of confidentiality though the extent of an individual's right to confidentiality is likely to vary from culture to culture. For instance, in some cultures a patient's refusal to allow information to be released to family members or carers would need to be fully respected, while in others the family may be regarded as a unified, structured unit, and confidentiality may extend to culturally determined members of that family.

It is likely, in these situations, that patients themselves are more accepting of the need to provide family members with information. In countries where there is more emphasis on the individual, as opposed to the family, it is more likely that the individual himself/herself may be less inclined to share information. Many variations and gradations are possible depending on culturally accepted practices. Families can play an important role in contributing to the formulation and implementation of a treatment plan for the patient, especially if the patient is incapable of doing it alone.

Legislation can also ensure involvement of families in many aspects of mental health services and legal processes. For example, family members may have the right to appeal against involuntary admission and treatment decisions on behalf of their relative, if the latter lacks the capacity to do so himself/herself. Similarly, they may be able to apply for the discharge of a mentally ill offender. Countries may also choose to legislate that family groups should be represented on review bodies .

Legislation can also ensure that family members are involved in the development of mental health policy and legislation, as well as mental health service planning

**Families and caregivers of people with mental disorders: Key issues**
It is common for families and carergivers to assume major responsibility for looking after persons with mental disorders, and legislation needs to reflect this.
Legislation should not arbitrarily refuse information merely on the ground of confidentiality though the extent of an individual's right to confidentiality is likely to vary from culture to culture.
Families and carergivers can play an important role in contributing to the formulation and implementation of a treatment plan for the patient, especially if the patient is incapable of
doing this alone.
Legislation can ensure that families and caregivers have access to the support and services they require in caring for a person with a mental disorder.
Legislation can ensure involvement of families and caregivers in many aspects of mental health services, as well as the legal processes such as involuntary admission and appeal.
Legislation can also ensure that family members and caregivers are involved in the development of mental health policy and legislation, as well as mental health service planning.

**6. COMPETENCE, CAPACITY AND GUARDIANSHIP :**
Most persons with mental disorders retain the ability to make informed choices and decisions regarding important matters affecting their lives. However, in those with severe mental disorders, this ability might be impaired. In these circumstances, there must be suitable provisions that allow managing the affairs of people with mental disorders in their best interests.

Two concepts that are central to decisions about whether or not a person may make choices concerning various issues are "*competence"* and "*capacity*". These concepts affect treatment decisions in civil and criminal cases, and the exercise of civil rights by persons with mental disorders.

**Definitions**
There is a tendency to use the terms "capacity" and "competence" interchangeably in relation to mental health; however, they are not the same.
Generally, ***capacity*** refers specifically to the presence of mental abilities to make decisions or to engage in a course of action , while ***competence*** refers to the legal
consequences of not having the mental capacity. In these definitions, "capacity" is a health concept, whereas "competence" is a legal concept.
Capacity refers to individual levels of functioning, and competence to their impact on legal and social standing

**Assessment of incapacity**
Ordinarily, there is a presumption of capacity and, consequently, of competence. Thus, a person is assumed to be capable and competent to make decisions unless proven otherwise. The presence of a major mental disorder does not in and of itself imply incapacity in decision-making functions. Hence, the presence of a mental disorder is not the overall determining factor of capacity, and certainly not of competence.

In addition, despite the presence of a disorder that may affect capacity, a person may still have the capacity to carry out some decision-making functions. Capacity and competence are thus function-specific. Therefore, because capacity may fluctuate from time to time, and is not an "all or nothing" concept, it needs to be considered in the context of the specific decision or function to be accomplished.
Some examples of specific capacities are the following:

**1 Capacity to make a treatment decision**
The person must have the ability to:
(a) understand the nature of the condition for which thetreatment is proposed;
(b) understand the nature of the proposed treatment; and
(c) appreciate the consequences of giving or withholding consent to treatment.

***2 Capacity to select a substitute decision-maker***
The person must have the ability to:
(a) understand the nature of the appointment and the duties
of the substitute decision-maker;
(b) understand the relationship with the proposed substitute;
(c) appreciate the consequences of appointing the substitute decision-maker.

***3 Capacity to make a financial decision***
The person must have the ability to:
(a) understand the nature of the financial decision and the choices available;
(b) understand the relationship to the parties to, and/or potential beneficiaries of , the transaction; and
(c) appreciate the consequences of making the financial decision.
A finding of lack of capacity should be time-limited (i.e. it will have to be reviewed from time to time), because a person may regain some or complete functionality over time, either with or without treatment of the mental disorder.

**Determining incapacity and incompetence**
Determination of *incapacity* may be made by a health professional, but a judicial body would determine *incompetence*. Capacity is the test for competence, and people should be judged as lacking competence only if they are actually incapable of making specific kinds of decisions at a specific time.
Mental health legislation (or other relevant legislation) can lay down the procedure for determining a person's competence. For example:
a) As competence is a legal concept, a judicial body would determine this.
b) Ideally, a legal counsel should routinely be made available to a person whose competence is in question. Where a person is unable to afford a counsel, legislation may require that counsel be provided to the beneficiary free of charge.
c) Legislation should ensure there is no conflict of interest for the counsel. That is, the counsel representing the concerned person should not also be representing other interested parties, such as the clinical services involved in the care of the concerned person and/or the family members of the concerned person.
d) Legislation may have provisions to appeal to a higher court against the decision by the concerned person, the counsel, family members or clinical team.
e) Legislation should contain a provision for automatic review, at specified periodic intervals, of the finding of lack of competence.

**Guardianship**

In certain circumstances where, due to a mental disorder, persons are unable to make important decisions and are incapable of managing their lives, it is important to appoint another person who is able to act on their behalf and in the best interest of the person. In the New South Wales Guardianship Act (No 257 of 1987) a "person in need of guardianship means a person who has a disability and who, by virtue of that fact, is totally or partially incapable of managing his or her person".

Although the concerned person can apply for guardianship, it is most often a family member, or others who care for the person with a mental disorder, who identify the need for guardianship and who make the necessary application for an assessment to determine whether a guardian should be appointed.

Whether or not to appoint a guardian is a complex decision, and consideration must be made within the context of the rights of persons to have as much control of their own lives as possible. Appointing a guardian does not imply that the person loses all decision-making powers, their ability to act for themselves in all circumstances and their dignity.

Other alternatives to guardianship that could be considered in certain situations include power of attorney and advanced directives

**Guardianship (key issues)**
Legislation may:

a) Determine the appropriate authority for appointment of a guardian. This may be the judicial body making the decision regarding competence (see above) or a separate judicial body such as a higher court.
b) Lay down the procedure for appointment of a guardian.
c) Specify the duration of the appointment.
d) Delineate the duties and responsibilities of the guardian.
e) Specify the penalties civil, criminal or administrative for failure of the guardian to perform the statutory duties.
f) Determine the extent and scope of the decision-making powers of the guardian. Any order must be tailored to ensure that it best suits the interests of the person who is subject to it. Through his, individuals with mental disorders can retain the ability to make most decisions about themselves, even when they cannot make all such decisions.
g) Make provision for patients to appeal against the appointment of a guardian.
h) Make provision for the review of guardianship and a provision for discharge from guardianship if the patient recovers competence with or without treatment

**7. VOLUNTARY AND INVOLUNTARY MENTAL HEALTH CARE**

**a) Voluntary admission and voluntary treatment**
Free and informed consent should form the basis of the treatment and rehabilitation of most people with mental disorders. All patients must be assumed initially to have capacity and every effort should be made to enable a person to accept voluntary admission or treatment, as appropriate, before implementing involuntary procedures.

**MI Principles: Informed consent**
No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 [of the present principles].

*(Principle 11(1), MI Principles)*

To be valid, consent must satisfy the following criteria (MI Principle 11)

a) The person/patient giving consent must be competent to do so, and competence is assumed unless there is evidence to the contrary.
b) Consent must be obtained freely, without threats or improper inducements.
c) There should be appropriate and adequate disclosure of information. Information must be provided on the purpose, method, likely duration and expected benefits of the proposed treatment.
d) Possible pain or discomfort and risks of the proposed treatment, and likely side-effects, should be adequately discussed with the patient.
e) Choices should be offered, if available, in accordance with good clinical practice; alternative modes of treatment, especially those that are less intrusive, should be discussed and offered to the patient.
f) Information should be provided in a language and form that is understandable to the patient.
g) The patient should have the right to refuse or stop treatment.
h) Consequences of refusing treatment, which may include discharge from the hospital, should be explained to the patient.
i) The consent should be documented in the patient's medical records.

The right to consent to treatment implies also the right to refuse treatment. If a patient is judged as having the capacity to give consent, then refusal of such consent must also be respected.

If admission is needed, one should aim to promote and facilitate voluntary admission to a mental health facility, after obtaining informed consent and treatment.

**MI Principles: Voluntary admission and treatment**

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

*(Principle 15(1), MI Principles)*

Voluntary admission brings with it the right to voluntary discharge from mental health care facilities.

The MI Principles state that patients not admitted involuntarily have the right to leave the facility at any time unless the criteria for involuntary admission are met.

Legislation should permit authorities to prevent self-discharge by voluntary patients only if all the conditions that warrant involuntary admission are met. All the procedural safeguards of involuntary admission should apply.

A problem which sometimes arises is when patients who lack the capacity to consent are “voluntarily” admitted to a hospital simply because they do not protest against the admission.

One example of this would be a patient who is admitted “voluntarily” but has no understanding of either the fact or the purpose of the admission. Another group of patients that runs this risk of so-called “voluntary” admission is those with mental retardation.

Other people may “accept” treatment or admission without protest merely because they are intimidated or because they do not realize they have the right to refuse. In these cases, their lack of protest should not be construed as consent, since consent must be voluntary and informed.

The concept of “voluntary” precludes the use of coercion; it implies that choices are available and that the individual has the ability and right to exercise that choice. In Brazil, the law states that “A person

who requests voluntary internment or who consents to internment shall be required to sign, at the time of his or her admission, a declaration signifying that he or she has chosen this regime of treatment" (Mental Health Law No 10.216 of 2001, Brazil).

**Voluntary admission & voluntary treatment: Key issues**

Where a person needs inpatient treatment, legislation should support voluntary admission and every effort shall be made to avoid involuntary admission.

If the law permits the authorities to retain voluntary patients when they attempt to leave, this should only be possible if the criteria for involuntary admission are met.

On admittance to the mental health facility, voluntary patients may be informed of the fact that mental health professionals of the facility may exercise the authority to prevent their discharge should they meet involuntary admission criteria.

Voluntary patients must be treated only after obtaining informed consent.

Where the patient has the capacity to give informed consent, such consent is a prerequisite for treatment.

"***Non-protesting" patients***

Legislation in some countries makes provision for users who are incapable, due to their mental health status, to give consent to treatment and/or admission, *but who do not refuse* mental health interventions. This would include people described in the previous section as not fulfilling the requirements as voluntary patients, but who also do not meet the criteria for involuntary admission (for example, people with severe mental retardation).

While in some countries the "incapacity" legislation linked with comprehensive guardianship laws are able adequately to deal with people with mental disorders who are unable to give consent but do not refuse admission/treatment, other countries find it important to legislate in this area.

The important of this category is to provide "non-protesting" patients with safeguards, while at the same time providing necessary admission and treatment to people *unable to give informed consent*. It has the important advantage of ensuring that people who are not resisting treatment are not incorrectly made either involuntary or voluntary patients; it also helps prevent a potentially huge increase in the number of people being incorrectly admitted as involuntary patients.

The criteria for being allowed admission and/or treatment are usually less stringent than in the case of involuntary users. This makes it possible for users who are unable to give informed consent but who require treatment and admission for their (mental) health to receive necessary care and treatment even if, for example, they are not a safety risk to themselves or to others. The "need for

hospitalization" is sometimes regarded as a sufficient criterion. This, or a criterion such as "required for a person's health", is often less demanding than, for example, the criteria for involuntary admission .

The person making the application for care of a non protesting patient is usually a close relative or a person who has the interest of the user at heart.

The use of "surrogates" for non-protesting patients is common in a number of countries. If users object to their admission or treatment they must immediately stop being regarded as "non protesting" and the full criteria for determining involuntary admission and treatment must be applied.

It is crucial that the rights of non-protesting patients be protected in a similar manner as those of involuntary users. For example, an assessment of capacity and suitability may need to be

undertaken, and agreed, by more than one practitioner. Non-protesting patients should, like involuntary users, qualify for mandatory automatic review procedures. This may include initial confirmation of their status as well as ongoing periodic assessments to determine whether their condition has changed. If, following their admission/treatment, they regain the capacity to make informed decisions, they must be removed from this status. Moreover, non-protesting patients should have the right to appeal their position. Non-protesting patients will also enjoy all other rights afforded to other patients, such as the right to notification of their rights, to confidentiality, to adequate standards of care and other rights .

The fundamental principles of "least restrictive environment" and "in the best interest of the patient" must similarly be applied to non-protesting patients.

Countries that have provision in legislation for non-protesting patients include Australia, which has a section for "informal treatment of patients incapable of consenting" (Mental Health Act, 1990, New South Wales, Australia), and South Africa, which makes provision for "assisted users" in its Mental Health Care Act (2002)

**Non-protesting patients: Key issues**

Legislation in some countries makes provision for users who are incapable, due to their mental health status, to give consent to treatment and/or admission, *but who do not refuse* mental health interventions.

The criteria for being allowed admission and/or treatment are usually less stringent than in the case of involuntary users (criteria may be, for example, the "need for hospitalization" or "required for a person's health")

If users object to their admission or treatment, they must immediately stop being regarded as "non-protesting" and the full criteria for determining involuntary admission and treatment must be applied. Similarly, if, following their admission/treatment, they regain the capacity to make informed decisions, they must be removed from this status.

It is crucial that the rights of non-protesting patients are protected in a similar manner to those of involuntary users (for example, the right to assessment of capacity, to automatic review procedures, the right to appeal their status).

Non-protesting patients should also enjoy all other rights afforded to other patients, such as the right to being informed of their rights, to confidentiality, to adequate standards of care and other rights.

## 8. INVOLUNTARY ADMISSION AND INVOLUNTARY TREATMENT

Involuntary, or compulsory, admission to mental health facilities and involuntary treatment are controversial topics in the field of mental health as they impinge on personal liberty and the right to choose, and they carry the risk of abuse for political, social and other reasons.

On the other hand, involuntary admission and treatment can prevent harm to self and others, and assist some people in attaining their right to health, which, due to their mental disorder, they are unable to manage voluntarily.

Several international human rights documents, such as the MI Principles (1991), European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and The

Declaration of Hawaii (1983), accept the need, at times, for involuntary admission and treatment of persons with mental disorders.

However, it is important to stress that involuntary admission and treatment is required only for a minority of patients who suffer from mental disorders; in many instances where patients are admitted and treated involuntarily, if humane treatment and a proper opportunity for voluntary care were provided, involuntary admission and treatment could be reduced further.

It is acknowledged that some user and advocacy groups, such as Mind Freedom Support Coalition International, are vehemently opposed to the idea of involuntary treatment, including the involuntary administration of psychotropic medicines, under any circumstances.

**MI Principles: Involuntary admission and treatment**

1. A person may
   - (a) be admitted involuntarily to a mental health facility as a patient; or
   - (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:
     - (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
     - (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.
2. In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.
3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

*(Principle 16 (1) and (3), MI Principles)*

***Combined versus a separate approach to involuntary admission and involuntary treatment***

Mental health legislation may combine involuntary admission and involuntary medical treatment into one procedure or it may treat them as separate .

Under the "combined" approach, once patients are admitted involuntarily, they may be treated involuntarily without having to undertake a separate procedure for sanctioning treatment.

Even with involuntary users subject to a single, combined process, it is good practice for the practitioner to always try and get cooperation and approval for treatment from the patient.

Under a fully "separate" approach, the admission and treatment procedures are independent of each other. First, the person is assessed for involuntary admission, then, if an involuntarily admitted patient requires involuntary treatment, the treatment need has to be assessed and a separate procedure for sanctioning such treatment is necessary

Many individuals and organizations, especially user groups, object to combining involuntary

admission and involuntary treatment and argue that a person's consent or refusal to admission and to treatment, are separate issues. Persons may require involuntary admission but not involuntary treatment, or, indeed, involuntary treatment without having to be placed outside their homes or communities. Moreover, it is argued that capacity is issue-specific, in that a person who is judged to be lacking capacity to make decisions regarding admission to a mental health facility may still retain the ability (capacity) to make decisions regarding treatment. It is agued that involuntary treatment violates fundamental human rights principles. For example, General Comment 14 to Article 12 of the ICESCR provides that the right to health includes the right to be free from non-consensual medical treatment. It is further argued that it is possible that an independent authority, for example a court or a review board, may commit a person to a psychiatric facility due to a mental illness, but this same authority, or a separate one, may find that the person has not lost his/her capacity to make treatment decisions. Assessment to determine incapacity to consent to treatment is thus necessary.

Furthermore, advocates of a separate approach argue that the provision of two independent procedures for invoking involuntary admission and involuntary treatment ensures an extra layer of rights protection for persons with mental disorders.

On the other hand, advocates of the combined approach contend that with the separate approach there is a risk that if too much time elapses between the two processes, treatment can be seriously delayed, with detrimental effects for the individual concerned, as well as, possibly, to health care workers and other patients if the person is highly aggressive. In addition, due to the unavailability of human and financial resources in many low-income countries, it can be difficult to institute two separate procedures for involuntary admission and involuntary treatment.

**Involuntary admission: Key issues**

Involuntary admission is generally permitted only if *all* the following criteria are met and the patient is refusing voluntary admission:

a) there is evidence of a mental disorder of specified severity, and;
b) there is a serious likelihood of immediate or imminent harm to self or others, and/or a deterioration in the patient's condition if treatment is not given,
c) admission includes a therapeutic purpose, and;
d) this treatment can only be given by admission to a mental health facility.

***Procedure to be followed for involuntary admission:***

a) Two accredited mental health practitioners (one of whom ideally should be a medical doctor) should certify that criteria for involuntary admission are fulfilled and recommend involuntary admission.
b) An application for involuntary admission should be made in accordance with local culture and conditions.
c) The mental health facility should be accredited as providing adequate and appropriate care and treatment, and therefore permitted to admit involuntary patients.
d) An independent authority (review body, tribunal or court) should authorize involuntary admission. This should be done as soon as possible after an application is made or, if not possible, as soon as possible after admission; legislation should lay down the time frame required for such a review. The person should be entitled to a legal representative at the hearing.
e) Patients, their families and legal representatives should be informed immediately of the grounds for involuntary admission and of the patient's rights.
f) Patients, their families and/or their legal representatives should have a right to appeal to a review body and/or a court against involuntary admission.

- There needs to be a provision for regular, time-bound review of involuntary admissions by an independent review body.
- Patients must be discharged from involuntary admission when they no long longer fulfil the criteria for involuntary admission.

*Procedure to be followed for involuntary* ***treatment:***

a) The treatment plan should be proposed by an accredited mental health practitioner having sufficient expertise and knowledge to undertake the proposed treatment.
b) A second independent accredited mental health practitioner should be required to agree to the treatment plan.
c) An independent authority (review body) should meet as soon as possible after involuntary treatment has been recommended to review the treatment plan. It should meet again at set intervals to assess the need for continued involuntary treatment.
d) Where the sanction for involuntary treatment is for a limited period, continued treatment can only be administered if the sanctioning process is repeated.
e) Involuntary treatment should be discontinued when patients are judged to have recovered their capacity to make treatment decisions, when there is no longer a need for treatment or when the sanctioned time has elapsed whichever happens earliest.
f) Patients and their families and/or personal representatives should be immediately informed of involuntary treatment decisions being made and, as far as is feasible, they should be involved in developing the treatment plan.
g) Once involuntary treatment is sanctioned, patients, families and personal representatives must be informed of their rights to appeal to a review body, tribunal and/or court against the involuntary treatment decision.

**Proxy consent to treatment**

Proxy consent may be given to a personal representative, a family member or a legally appointed guardian who has the right to give consent to treatment on the patient's behalf.

Rules governing involuntary treatment “by proxy” should incorporate safeguards. For example, patients should have the right to appeal.

“Advance directives” give patients an opportunity to make decisions for themselves during periods when they are able to give informed consent for periods when they are not so capable. If a law provides for the use of advance directives or other forms of substitute decision-making, it should define such terms clearly and consistently.

**Community-based involuntary care**:

Community-based involuntary treatment (community treatment orders) and community supervision orders can represent a generally less restrictive alternative to inpatient involuntary treatment. The procedural requirements for community-based supervision should be similar to those for hospital-based involuntary treatment orders (as outlined above).

Community-based supervision and treatment legislation should be introduced only in the context of accessible, quality community-based mental health services that emphasize voluntary care and treatment as the preferred option.

As in cases of involuntary admission and treatment, where community orders are implemented they must be regularly reviewed and the orders revoked when the criteria are no longer met. People subject to involuntary care in the community should have a right to appeal their status. Involuntary care in the community should be considered as an alternative option to involuntary admission in a mental health facility, rather than as an alternative to voluntary community care.

## 9. EMERGENCY SITUATIONS: KEY ISSUES

To be an emergency, it must first be demonstrated that the time required to follow substantive procedures would cause considerable delay, resulting in harm to the concerned person or others.

In an emergency, involuntary admission and treatment should be permitted on the assessment and advice of a qualified medical or other appropriate practitioner.

Emergency treatment must be time-limited (usually no longer than 72 hours), and substantive procedures for involuntary admission and treatment, if necessary, must be initiated as soon as possible and completed within this period.

- *Emergency treatment should not include:*

> depot neuroleptics
> ECT
> sterilization
> psychosurgery and other irreversible treatment.

**Procedure for emergency admission and treatment**:

A qualified practitioner should examine the person and certify that the nature of the emergency requires immediate involuntary admission and treatment.

a) A treatment plan should be drawn up under the supervision of a medical or mental health professional.
b) Procedures for involuntary admission and/or involuntary treatment should be initiated immediately if it is assessed that the person is likely to require involuntary care beyond the stipulated time limit for emergency treatment.
c) It is inappropriate to reapply emergency powers when a patient has been released following completion of the procedure for involuntary admission, unless there is a substantial change in the nature of the emergency.
d) Patients' family members, personal representatives and/or a legal representative should be immediately informed of the use of emergency powers.
e) Patients, their families and/or personal representatives have the right to appeal to a mental health tribunal and courts against emergency admission and treatment

## 10. SPECIAL TREATMENTS

Countries may decide to enact legislation to protect people against abuses in the use of certain treatments such as major medical and surgical procedures, ECT, psychosurgery or other irreversible treatments. Some countries may also need to specifically ban certain interventions if they are being unjustifiably utilized as treatments for mental disorders. Sterilization as a treatment for mental illness is an example of this. In addition, the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent.

MI Principles: Sterilization shall never be carried out as a treatment for mental illness.
*(Principle 11(12), MI Principles)*

### 10.1 **Major medical and surgical procedures**

MI Principles: Major medical or surgical procedures

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

*(Principle 11(13), MI Principles)*

**Special treatments: Key issues**
Sterilization is not a treatment for mental disorder, and having a mental disorder should not be a reason for sterilization (or abortion) without informed consent.
Ethical standards that govern major medical and surgical procedures that are applicable to all patients should also be applied to persons with mental disorders.
Major medical and surgical procedures should be performed only with informed consent, except under exceptional circumstances. In these circumstances, proposed medical or surgical treatment should either be authorized as involuntary treatment by an independent review body or by proxy consent.
Emergency medical and surgical treatments for people with mental disorders should be treated in the same manner for all patients who need such emergency treatment without consent.
Psychosurgery and other irreversible treatments should not be permitted as involuntary treatment, and, as additional protection, all such treatment should be reviewed and sanctioned by an independent review body.
ECT should be administered only after obtaining informed consent. Modified ECT should be utilized. Legislation should prohibit the use of ECT on minors.

**11. SECLUSION AND RESTRAINT**
MI Principles: Seclusion and restraint
Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.
It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.
*(Principle 11(11), MI Principles)*

Seclusion and restraint: Key issues
Seclusion and restraint may be permitted by legislation when they are the only means available to prevent immediate or imminent harm and danger to self and others.
Seclusion and restraints must be used for the shortest period of time (lasting minutes or a few hours). One period of seclusion and restraint should not be followed immediately by another.
There needs to be ongoing active and personal contact with the person subject to seclusion and restraint, which goes beyond passive monitoring.
Legislation should ban the use of seclusion and restraints as punishment or for the convenience of staff.
Legislation should also promote infrastructure and resource development so that seclusion and restraints are not used due to such deficiencies.
Procedure for exceptional use of seclusion and restraints:
a) They should be authorized by an accredited mental health practitioner;
b) The mental health facility should be accredited as having adequate facilities for undertaking such procedures safely;
c) The reasons and duration of seclusion and restraint and the treatment given to ensure speedy termination of these procedures, should be entered in the patients' clinical records by the mental health professional authorizing these procedures.

Records of all seclusion and restraint should be recorded in a register, which is accessible to a review body.
Patients' family members and/or their personal representatives may need to be immediately informed when patients are subjected to seclusion or restraint.

## 12. CLINICAL AND EXPERIMENTAL RESEARCH

ICCPR: Clinical and experimental research
No one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subject without his free consent to medical or scientific experimentation.
*(Article 7, International Covenant on Civil and Political Rights (ICCPR))*
Article 7 of the ICCPR (1966) prohibits clinical and experimental research without informed consent. This Article is an important part of the ICCPR and has been designated as one of the provisions that is non-derogable; it can never be limited even under conditions of national emergency. The UN Human Rights Committee has made it clear that "Article 7 (of the ICCPR) allows no limitation … no justification or extenuating circumstances may be invoked to excusea violation of Article 7 for any reasons". Article 7 therefore prohibits research on subjects who lack the capacity to consent.
*On the other hand, MI Principle 11* states that, "clinical trials and experimental research shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose".
The *International Ethical Guidelines for Biomedical Research Involving Human Subjects*,prepared by the Council for International Organizations of Medical Sciences (CIOMS, 2002),allows biomedical research with proxy consent, or consent from a properly authorized representative, involving individuals who are incapable of giving informed consent. Where informed consent cannot be obtained, should be carefully followed.

**Clinical & experimental research: Key issues**
Informed consent for participation in clinical or experimental research must be obtained from all patients who have the capacity to consent. This is applicable to both voluntary and involuntary patients.
In countries where clinical and experimental research is permitted with patients who are unable to consent, legislation should include the following safeguards:
1. When patients are lacking capacity to give informed consent, they may participate in clinical and experimental research, provided that proxy consent is obtained from legally appointed guardians and/or family members and/or personal representatives, or by obtaining consent from an independent review body specifically constituted for this purpose.
2. Participation of patients who are lacking capacity to consent, by obtaining consent from proxies or an independent review body, should only be considered when:
   a) this research cannot be performed on patients who are capable of giving consent;
   b) the research is necessary to promote the health of the individual patient and the population represented;
   c) adequate procedural safeguards are followed.

**Human Rights and Mental Health Act, 1987- INDIAN Scenario**

Chapter VIII of this Act contains a very novel and explicit provision of protection of human rights of mentally ill persons. Section 81 provides that-

**1.** No mentally ill persons shall be subjected during treatment to any indignity whether physical or

mental or cruelty.

**2.** No mentally ill person under treatment hall be used for the purpose of research unless (i) such research is of direct benefit to him for the purpose of diagnosis or treatment, or (ii) such person being a voluntary patient has given his consent in writing or where such person is incompetent by reason of minority or otherwise to give valid consent, on his behalf, has given his consent in writing, for such research.

**3.** Subject to any rules made in this behalf under Section 94 for the purpose of preventing vexatious or defamatory communication or Communications pre-judicial to the treatment of mentally ill persons, no letter or other communications sent by or to a mentally ill persons under treatment shall be intercepted, detained or destroyed. The doctrine of informed consent is partially recognized under the Mental Health Act 1987, when a patient voluntarily admits himself in the hospital or accepts treatment without any admission.

When a mentally ill patient detained as an inpatient and does not have property to bear the cost of treatment, in such cases his expenses shall be borne by the Government of the State. (Sec. 78)

If a mentally ill patient owns a property and he is not in a position to manage his property, the Court may entrust the management of such property to the Court of wards, Section 54(1).

Under Section 97 of the Act when a mentally ill person is not represented by a legal practitioner in any proceedings under Mental Health Act 1987 before a District Court or a Magistrate and such a patient does not have sufficient mean to engage a legal practitioner then the District Court or Magistrate shall assign a legal practitioner to represent him at the expense of the State.

The above provisions clearly indicate that the Act does not spell out much on Human Rights, nor does it covers neglect or cruelty to mental patient sustained in families or alternate system of care like magicians, healers and quacks. The Mental Health Act 1987 also does not spell out any enforceable right of the mentally ill to minimum standard of care and treatment.

The Good faith clause (Section 92) dispenses with accountability of the government or its servants for any negligence in the care and treatment of inmates of asylums. The provision for legal aid to the mentally ill (Section 91) restricts the facility to proceedings before a District Court or a Magistrate. The Act is silent on the right to legal aid and counseling at all stages including the facility of approaching the High Court or the Supreme Court.

The Mental Health Act also by its definition of mentally ill persons excludes from its regime the mentally retarded. It also does not differentiate between the various degrees of mental illness that requires specialized care and treatment. However, it permits the commitment to hospitals of the criminal mentally ill. It makes no special provision for their care, treatment and discharge. Beside the above, there is no provision for compensating those wrongfully incarcerated or negligently treated or victimized in any manner by misuse of powers under the Act. Another important shortcoming in this context is that there is no right to rehabilitation of those mentally ill discharged after being found fit.

Mental Health Act 1987 talks about cruelty towards mentally ill persons in mental hospitals / Private Psychiatric Nursing homes . There is a provision of penalty on Incharge Psychiatrist and relatives of a mentally ill who neglect their kith and kin who has mental illness.(Section 25 and chapter IX of MHA 1987). However the act remains silent on cruelty towards mentally ill outside the premises of mental hospitals at centres of faith healing , Tantriks Ojhas etc.

***IMPLEMENTATION OF HUMAN RIGHTS IN INDIA***

The following are the specific activities that need to be taken up in the Indian situation.

1. Physical facilities for care
2. Professional staff
3. Treatment facilities
4. Formation of Board of Visitors
5. Formation of State Mental Health Authorities
6. Licensing of psychiatric facilities
7. Information to patients of their rights
8. Review body in psychiatric hospitals
9. Informed consent of patients
10. Procedure for research
11. Outpatient services
12. Aftercare as a responsibility of the institution
13. Placement for destitute chronically ill
14. Regular training and improving staff sensitivity

There is a need to develop institutional mechanisms to achieve these.

**THE ROLE OF LEGISLATION**

The supreme court petition petition by the voluntary organization *Saarthak* has triggered off a debate on the treatment of persons with mental disorders in India.

Mental Health Legislation has an important role to play in the protection of human rights . Mental Disorders sometimes affect people's decision making capacities and they may not always seek or accept treatment for their problems. Rarely, persons with mental disorders may pose a risk to themselves and others due to impaired decision making abilities. Most importantly, persons with mental disorders face stigma, discrimination and marginalization.

Legislation must strike a fine balance between the individual's rights to liberty and dignity, and society's need for protection . It must address issues such as integration into the community , access to high quality care , and protecting the rights of persons with mental disorders, including in areas such as employment , education and housing.

From this perspective , MHA 1987 , is inadequate as it focuses entirely on the provision of treatment in what it calls psychiatric hospitals and psyxhiatric nursing homes. The chapter dealing with human rights contains only one section on research on persons with mental disorders. There is little understanding of the need to protect the rights of persons with mental disorders when treatment is administered without their consent.

Mental Health legislation in many countries also gives persons under involuntary treatment the right to review . Under the MHA 1987 , the state mental health authority is charged with supervisory function. But as mentioned in the Saarthak petition these authorities have not been established in many states.

The Saarthak petition has to be viewed in the broader context of provision of mental health in India . The petition and the consequent debate presents an opportunity to discuss the ( lack of) provision of mental health care, and related human rights issues.

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## APPENDIX

### Key international and regional human rights instruments related to the rights of people with mental disorders

The requirements of international human rights law, including both UN and regional human rights instruments, should form the framework for drafting national legislation that concerns people with mental disorders or regulates mental health and social service systems. International human rights documents broadly fall into two categories: those which legally bind States that have ratified such conventions, and those referred to as international human rights “standards”, which are considered guidelines enshrined in international declarations, resolutions or recommendations, issued mainly by international bodies. Examples of the first are international human rights conventions such as the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966). The second category, which includes UN General Assembly Resolutions such as Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991), while not legally binding, can and should influence legislation in countries, since they represent a consensus of international opinion.

### 1 INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

There is a widespread misconception that because the human rights instruments relating specifically to mental health and disability are non-binding resolutions, rather than obligatory conventions, mental health legislation is therefore subject only to the domestic discretion of governments. This is not true, as governments are under obligation, under international human rights law, to ensure that their policies and practices conform to binding international human rights law and this includes the

protection of persons with mental disorders.

Treaty monitoring bodies at the international and regional levels have the role of overseeing and monitoring compliance by States that have ratified international human rights treaties. Governments that ratify a treaty agree to report regularly on the steps they have taken to implement that treaty at the domestic level through changes in legislation, policy and practice.

Nongovernmental organizations (NGOs) can also submit information to support the work of monitoring bodies. Treaty monitoring bodies consider the reports, taking into account any information submitted by NGOs and other competent bodies, and publish their recommendations and suggestions in "concluding observations", which may include a determination that a government has not met its obligations under the treaty. The international and regional supervisory and reporting process thus provides an opportunity to educate the public about a specialized area of rights. This process can be a powerful way to pressure governments to uphold convention-based rights. The treaty bodies of the European and Inter-American human rights system have also established individual complaints mechanisms, which provide the opportunity for individual victims of human rights violations to have their cases heard and to seek reparations from their governments. This section provides an overview of some of the key provisions of international and regional human rights instruments that relate to the rights of persons with mental disorders.

*1.1 International Bill of Rights*

The Universal Declaration of Human Rights (1948), along with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), together make up what is known as the "International Bill of Rights". Article 1 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, provides that all people are free and equal in rights and dignity. Thus people with mental disorders are also entitled to the enjoyment and protection of their fundamental human rights. In 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment 5, detailing the application of the International Covenant on Economic, Social and Cultural Rights (ICESCR) with regard to people with mental and physical disabilities. General Comments, which are produced by human rights oversight bodies, are an important source of interpretation of the articles of human rights conventions. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body. The UN Human Rights Committee, established to monitor the ICCPR, has yet to issue a general comment specifically on the rights of persons with mental disorders. It has issued General Comment 18, which defines protection against discrimination against people with disabilities under Article 26. A fundamental human rights obligation in all three instruments is the protection against discrimination. Furthermore, General Comment 5 specifies that the right to health includes the right to access rehabilitation services. This also implies a right to access and benefit from services that enhance autonomy. The right to dignity is also protected under General Comment 5 of the ICESCR as well as the ICCPR. Other important rights specifically protected in the International Bill of Rights include the right to community integration, the right to reasonable accommodation (General Comment 5 ICESCR), the right to liberty and security of person (Article 9 ICCPR) and the need for affirmative action to protect the rights of persons with disabilities, which includes persons with mental disorders.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right of everyone to the enjoyment of the highest attainable standard of physical and

mental health. The right to health is also recognized in other international conventions, such as Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and Article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1996, as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10). General Comment 14 of the Committee on Economic, Social and Cultural Rights aims to assist countries in implementation of Article 12 of ICESCR. General Comment 14 specifies that the right to health contains both freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements also include the right to a system of health protection that provides people with equality of opportunity to enjoy the highest attainable level of health. According to the Committee, the right to health includes the following interrelated elements: (i) *Availability*, i.e. health care facilities and services have to be available in sufficient quantity. (ii) *Accessibility*, which includes: • non-discrimination, i.e. health care and services should be available to all without any discrimination; physical accessibility, i.e. health facilities and services should be within safe physical reach, particularly for disadvantaged and vulnerable populations; • economic accessibility, i.e. payments must be based on the principle of equity and affordable to all; and information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues. (iii) *Acceptability*, i.e. health facilities and services must respect medical ethics and be culturally appropriate.

(iv) *Quality*, i.e. health facilities and services must be scientifically appropriate and of good quality. General Comment 14 further states that the right to health imposes three types or levels of obligations on countries: the obligations to *respect*, *protect* and *fulfil.* The obligation to *respect* requires countries to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. The obligation to *protect* requires countries to take measures to prevent third parties from interfering with the guarantees provided under Article 12. Finally, the obligation to *fulfil* contains obligations to facilitate, provide and promote. It requires countries to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Article 7 of the ICCPR provides protection against torture, cruel, inhuman or degrading treatment, and it applies to medical institutions, especially institutions providing psychiatric care. The General Comment on Article 7 requires governments to “provide information on detentions in psychiatric hospitals, measures taken to prevent abuses, appeals process available to persons admitted to psychiatric institutions and complaints registered during the reporting period”.

*1.2 Other international conventions related to mental health*

The legally binding UN Convention on the Rights of the Child contains human rights provisions specifically relevant to children and adolescents. These include protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child. A number of its articles are specifically relevant to mental health: • Article 23 recognizes that children with mental or physical disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community. • Article 25 recognizes the right to periodic review of

treatment provided to children who are placed in institutions for the care, protection or treatment of physical or mental health. • Article 27 recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 32 recognizes the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical, mental spiritual, moral or social development.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) is also relevant to those with mental disorders. Article 16, for example, makes States that are party to the Convention responsible for preventing acts of cruel, inhuman or degrading treatment or punishment. In certain mental health institutions there are a vast number of examples that could constitute inhuman and degrading treatment. These include: lack of a safe and hygienic environment; lack of adequate food and clothing; lack of adequate heat or warm clothing; lack of adequate healthcare facilities to prevent the spread of contagious diseases; shortage of staff leading to practices whereby patients are required to perform maintenance labour without pay or in exchange for minor privileges; and systems of restraint that leave a person covered in his or her own urine or faeces or unable to stand up or move around freely for long periods of time. The lack of financial or professional resources is not an excuse for inhuman and degrading treatment. Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment that is respectful of individual dignity. There is no specific UN convention that addresses the special concerns of individuals with disabilities. However, on 28 November 2001, the United Nations General Assembly adopted a resolution calling for the creation of an ad hoc committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities". Work is currently under way to draft this convention. Persons with mental disorders would be among beneficiaries.

Apart from the various international systems for monitoring human rights, there are also a number of regional conventions for the protection of human rights. These are discussed briefly below.

***African Region***

*African (Banjul) Charter on Human and Peoples' Rights (1981)* This is a legally binding document supervised by the African Commission on Human and People's Rights. The instrument contains a range of important articles on civil, political, economic, social and cultural rights. Clauses pertinent to people with mental disorders include Articles 4, 5 and 16, which cover the right to life and the integrity of the person, the right to respect of dignity inherent in a human being, prohibition of all forms of exploitation and degradation (particularly slavery, slave 12 trade, torture and cruel, inhuman or degrading punishment), and the treatment and the right of the aged and disabled to special measures of protection. It states that the "aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs". The document guarantees the right for all to enjoy the best attainable state of physical and mental health.

*African Court on Human an d People's Rights* The Assembly of Heads of State and Government of the Organization of African Unity (OAU) now the African Union established an African Court on Human and People's Rights to consider allegations of violations of human rights, including civil and

political rights and economic, social and cultural rights guaranteed under the African Charter and other relevant human rights instruments. In accordance with Article 34(3), the Court came into effect on 25 January 2004 after ratification by a fifteenth State. The African Court has the authority to issue binding and enforceable decisions in cases brought before it.

***European Region***

*European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)* The European Convention for the Protection of Human Rights and Fundamental Freedoms, backed by the European Court of Human Rights, provides binding protection for the human rights of people with mental disorders residing in the States that have ratified the Convention.

Mental health legislation in European States is required to provide for safeguards against involuntary hospitalization, based on three principles laid down by the European Court of Human Rights:

- Mental disorder is established by objective medical expertise;
- Mental disorder is of a nature and degree warranting compulsory confinement; and
- For continued confinement, it is necessary to prove persistence of the mental disorder

(Wachenfeld, 1992).

The European Court of Human Rights provides interpretation of the provisions of the European Convention and also creates European human rights law. The evolving case law of the Court has led to fairly detailed interpretations of the Convention concerning issues related to mental health. *European Convention for the Protection of Human Rights and Dignity of the Human Being, with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1996)* This Convention, adopted by Member States of the Council of Europe and other States of the European Community, was the first internationally legally binding instrument to embody the principle of informed consent, provide for equal access to medical care and for the right to be informed, as well as establishing high standards of protection with regard to medical care and research.

*Recommendation 1235 on Psychiatry and Human Rights (1994)* Mental health legislation in European States is also influenced by Recommendation 1235 (1994) on Psychiatry and Human Rights, which was adopted by the Parliamentary Assembly of the Council of Europe. This lays down criteria for involuntary admission, the procedure for involuntary admission, standards for care and treatment of persons with mental disorders, and prohibitions to prevent abuses in psychiatric care and practice.

*Recommendation Rec (2004)10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (2004)* In September 2004, the Committee of Ministers of the Council of Europe approved a recommendation which calls upon member states to enhance the protection of the dignity, human rights and fundamental freedoms of people with mental disorders, in particular, those subject to involuntary placement or involuntary treatment.

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***Other European Conventions*** *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987)* provides another layer of human rights protection. The 8th Annual Report of the Committee on Torture, Council of Europe, stipulated standards to prevent mistreatment of persons with mental disorders.

*The revised European Social Charter (1996)* provides binding protection for the fundamental rights of people with mental disabilities who are nationals of the States that are parties to the Convention. In particular, Article 15 of the Charter provides for the rights of these persons to independence, social integration and participation in the life of the community. Recommendation No R (83) 2, adopted by the Council of Ministers in 1983, is another important legal protection of persons with mental disorder who are placed in institutions as involuntary patients.

***Region of the Americas***

*American Declaration of the Rights and Duties of Man (1948)* This provides for the protection of civil, political, economic, social and cultural rights.

*American Convention on Human Rights (1978)* This Convention also encompasses a range of civil, political, economic social and cultural rights, and establishes a binding means of protection and monitoring by the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. The Commission's recent examination of a case entitled *Congo v Ecuador* has provided an opportunity for further interpretation of the Convention in relation to mental health issues.

*Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (1988)* This Convention refers specifically to the rights of persons with disabilities. Signatories agree to undertake programmes aimed at providing people with disabilities with the necessary resources and environment for attaining the greatest possible development of their personalities, as well as special training to families (including specific requirements arising from the special needs of this group). Signatories also agree to these measures being made a priority component of their urban development plans and to encouraging the establishment of social groups to help persons with disabilities enjoy a fuller life. *Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999)* The objectives of this Convention are to prevent and eliminate all forms of
discrimination again st persons with mental or physical disabilities, and to promote their full integration into society. It is the first international convention that specifically addresses the rights of persons with mental disorders. In 2001, the Inter-American Human Rights Commission issued a Recommendation on the Promotion and Protection of Human Rights of Persons with Mental Disabilities (2001), recommending that countries ratify this Convention. The Recommendation also urges States to promote and implement, through legislation and national mental health plans, the organization of community mental health services, in order to achieve the full integration of people with mental disorders into society.

## 2 MAJOR HUMAN RIGHTS STANDARDS APPLICABLE TO MENTAL HEALTH

### 2.1 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991)

In 1991, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, see Annex 3) established minimum human rights standards of practice in the mental health field. International oversight and enforcement bodies have used the MI Principles as an authoritative interpretation of the requirements of international conventions such as the ICESCR.
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The MI Principles have also served as a framework for the development

The MI Principles have also served as a framework for the development of mental health legislation in many countries. Australia, Hungary, Mexico and Portugal, among others, have incorporated the MI Principles in whole or in part into their own domestic laws. The MI Principles establish standards for treatment and living conditions within mental health facilities, and they create protections against arbitrary detention in such facilities. These principles apply broadly to persons with mental disorders, whether or not they are in psychiatric facilities, and they apply to all persons admitted to a mental health facility whether or not they are diagnosed as having a mental disorder. The last-mentioned

provision is important because in many countries long-term mental health facilities serve as repositories for people who have no history of mental disorder or no current mental disorder, but who remain in the institution due to the lack of other community facilities or services to meet their needs. The MI Principles recognize that every person with a mental disorder shall have the right to live and work, as far as possible, in the community.

The MI Principles have, however, been subject to some criticism. In 2003 the UN Secretary- General in a report to the General Assembly noted that the MI Principles *"offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment. In this regard, some organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles (and in particular, principles 11 and 16) and their consistency with existing human rights standards in the context of involuntary treatment and detention."* (United Nations, 2003)

**2.2 Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Standard Rules, 1993)**

The World Conference on Human Rights, which took place in Vienna in 1993, reiterated the fact that international human rights law protects people with mental and physical disabilities, and that governments should establish domestic legislation to realize those rights. In what has come to be known as the Vienna Declaration, the World Conference declared that all human rights and fundamental freedoms are universal, and thus unreservedly include persons with disabilities.

The *Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)* were adopted at the end of the Decade of Disabled Persons (1982-1993) by General Assembly Resolution 48/96. As a policy guidance instrument, the Standard Rules reiterate the goals of prevention, rehabilitation and equalization of opportunities established by the World Programme of Action. These 22 rules provide for national action in three main areas: preconditions for equal participation, targets for equal participation, and implementation measures. The Standard Rules are a revolutionary new international instrument because they establish citizen participation by people with disabilities as an internationally recognized human right. To realize this right, governments are expected to provide opportunities for people with disabilities and organizations made up of people with disabilities to be involved in drafting new legislation on matters that affect them. The Standard Rules call on every country to engage in a national planning process to bring legislation, policies and programmes into conformity with international human rights standards.

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**3. TECHNICAL STANDARDS**

In addition to UN General Assembly resolutions, UN agencies, world conferences, and professional groups meeting under UN auspices have adopted a broad array of technical guidelines and policy statements. These can be a valuable source of interpretation of international human rights conventions.

**3.1 Declaration of Caracas (1990)**

The *Declaration of Caracas* (1990), adopted as a resolution by legislators, mental health professionals, human rights leaders and disability activists convened by the Pan American Health Organization (PAHO/WHO), has major implications for the structure of mental health services . It states that exclusive reliance on inpatient treatment in a psychiatric hospital isolates patients from their natural environment, thereby generating greater disability.

The Declaration establishes a critical link between mental health services and human rights by concluding that outmoded mental health services put patients' human rights at risk.

The Declaration aims to promote community-based and integrated mental health services by suggesting a restructuring of existing psychiatric care. It states that resources, care and treatment for persons with mental disorders must safeguard their dignity and human rights, provide rational and appropriate treatment, and strive to maintain persons with mental disorders in their communities. It further states that mental health legislation must safeguard the human rights of persons with mental disorders, and services should be organized so as to provide for
enforcement of those rights.

**3.2 Declaration of Madrid (1996)**

International associations of mental health professionals have also attempted to protect the human rights of persons with mental disorders by issuing their own sets of guidelines forstandards of professional behaviour and practice. An example of such guidelines is the Declaration of Madrid adopted by the General Assembly of the World Psychiatric Association (WPA) in 1996 . Among other standards, the Declaration insists on treatment
based on partnership with persons with mental disorders, and on enforcing involuntary treatment only under exceptional circumstances.

**3.3 WHO technical standards**

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* (see box below) as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. In 1996, WHO also developed *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the MI Principles and evaluate human rights conditions in institutions.**MentalHealth Care Law:Ten Basic Principles**

1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments in accordance with internationally accepted principles
4. Provision of least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodic review mechanism
9. Qualified decision-maker
10. Respect of the rule of law

*WHO, 1996*

**3.4 The Salamanca Statement and Framework for Action on Special Needs Education (1994)**

In 1994, the World Conference on Special Needs Education adopted *The Salamanca Statement and Framework for Action on Special Needs Education*, which affirmed the right to integrated education for children with mental disabilities. The *Salamanca Declaration* is of particular importance in implementing the *World Declaration on Education for All* (WDEA) and enforcing the right to education established under the ICESCR.