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# HUMAN RIGHTS AND SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS

## Principles and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder

## Report of the Secretary-General

## Addendum



GE.89-14035/1385B

# SWEDEN

[Original: ENGLISH]
[14 November 1989]

1. The General Assembly of the United Nations adopted by its resolution 43/173 of 9 December 1988 the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. That body of principles applies to the protection of all detained or imprisoned persons, including persons deprived of their liberty on the ground of mental illness. It is therefore important to carefully compare the present draft with the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment in order that the draft be consistent with existing standards and that unnecessary repetition be avoided. For the same reasons, it is important to compare the draft text with the standards laid down in the Declaration on the Rights of Disabled Persons.

2. The draft principles seem to be based on a model of control which is different from the one applied in Sweden. The Swedish system of control is based on the supervision of the medical personnel by disciplinary boards and by courts. The general penal system is of course applicable also in this field. In addition, the medical profession has its own ethical rules. For these reasons the approach chosen in the draft principles does not entirely correspond to the Swedish system. This is the background against which the specific comments below on different articles of the draft should be seen.

3. Article 3. The wording of paragraph 4 seems to indicate, a contrario, that a court decision on incapacity could deprive a person of his/her right to exercise any civil, political, economic, social and cultural rights. The paragraph must therefore be reformulated. All Swedish citizens who have reached 18 years of age have the right to vote. Mental disorder may thus never disqualify a person from the right to vote in Sweden.

4. Article 4. The right to oral and written information seems to be too extensive. It could for example be questioned whether written information always should have to be provided. The ability of the patient to understand any information must also be taken into account.

5. Article 5. Paragraph 2 puts such fundamental human rights as the right to practise one's religion or belief on equal footing with less fundamental rights such as the right to purchase items for daily living. This is not advisable. The limitations provided for in the chapeau of the paragraph are too wide as regards the fundamental human rights. The paragraph as it stands would therefore undermine these rights as laid down in existing human rights instruments.

6. The limitations provided for in the chapeau of paragraph 2 seem only to apply to the rights enumerated in that paragraph. A limitation of the patient's right to communicate may also be called for in the interests of the health or safety of the patient himself.

7. Article 9. The requirements in this article seem unrealistic when it comes to developing countries. An effective supervision of mental health facilities may be carried out without regular inspections of each facility. Paragraph 2 would thus seem too far-reaching.

8. Article 12. Paragraph 3. According to Swedish law the treatments referred to in this paragraph, with the exception of sterilization and castration in certain cases, might be applied without prior decision by an independent specialist authority. The National Board of Health and Welfare supervises medical treatment of patients in general. Cases of maltreatment are examined by a special disciplinary authority and, ultimately, by a court.

9. Paragraph 5. According to Swedish legislation, a patient might be subjected to such restraints as are necessary for the treatment. The criteria "to prevent immediate and imminent harm to the patient or others" seems too narrow.

10. Paragraph 8. Treatment referred to in this paragraph may, in Sweden, be given to a patient without his informed consent and without a determination made by an independent authority if such treatment is in the best interest of the patient according to the ethical standards of the mental health professions. The consent of the patient or his/her relatives is sought when it is deemed appropriate. Cases of emergency can be foreseen, where it is not feasible to have the appropriate treatment determined by an independent authority.

11. Paragraph 9. There is no requirement under Swedish law for a second professional opinion except in the case of involuntary admission to a mental health facility.

12. Article 15. Paragraph 1. In Sweden, the prerequisites for involuntary admission is not so directly linked to the likelihood that harm will be caused. The determining criteria for involuntary admission are the need for treatment and the consideration that such need might only be met by involuntary admission.

13. Paragraph 2. It might, in certain cases, be in the interest of the right to privacy of the patient that his/her family is not informed of the admission.

14. Article 16. Paragraph 5. In Sweden, a practitioner may not decide on the discharge in all cases. In some cases, a determination has to be made by a board or a court, for instance regarding offenders.

15. Paragraph 6. Under Swedish legislation a patient is not entitled to appeal to a higher court against any decision regarding the treatment. Neither may any interested person, not affected by the treatment, make a complaint.

16. Article 17. The procedural rights seem to be too extensive as to an absolute right to attend (para. 4) or to have a public hearing (para. 6).

17. Annex A. Swedish legislation in this area is not based on the theory of criminal responsibility. Therefore, a person who also suffers from mental illness may be convicted of a crime. Such a person may then be sentenced to treatment in a mental health facility. Such treatment is carried out in the same manner as for other patients suffering from mental illness.

For these reasons, Sweden cannot support the paragraphs based on the theory of criminal responsibility and ability to stand trial, especially under V, VI and VII of Annex A.

WORLD MEDICAL ASSOCIATION

[Original: FRENCH]
[20 November 1989]

1. For many years, we have been much concerned with the protection of the rights of the patient, a question on which we adopted a Declaration at Lisbon in 1981, the text of which is attached.

LISBON DECLARATION

THE RIGHTS OF THE PATIENT

Adopted unanimously by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981.

2. Given the possibility of practical, ethical or legal difficulties, a physician must always act according to his conscience and in the best interest of the patient. This Declaration embodies some of the main rights which the medical profession believes should be enjoyed by patients.

3. Where legislation or Government action denies the patient these rights, physicians have an obligation to seek appropriate means of upholding or restoring them:

(a) the patient has the right to the free choice of a physician;

(b) the patient has the right to be treated by a physician free to take a clinical and ethical decision without any outside interference;

(c) after being properly informed of the treatment proposed, the patient has the right to accept or refuse it;

(d) the patient has the right to expect his physician to respect the confidential nature of all medical and personal information concerning him;

(e) the patient has the right to die in dignity;

(f) the patient has the right to receive or refuse spiritual and moral aid, including that of a minister of an appropriate religion.

WORLD PSYCHIATRIC ASSOCIATION (WPA)

[Original: ENGLISH]
[20 November 1989]

1. The main substance of the report concerns section IV: Draft body of principles and guarantees for the protection of mentally ill persons and for the improvement of mental health care.

2. From the introduction, it is obvious that the draft principles have, to a considerable degree, been influenced by the WHO document - and hence the WPA's points of view. Passages are transferred in nearly the same wording from the WHO paper. Among other things, it is stated that the principles and guarantees, in particular, focus on the small minority of patients suffering from mental illness who need to be admitted involuntarily to a mental health facility. Furthermore, the large majority of people with mental illness who receive treatment are not admitted to a hospital. Of the small minority who require admission, most enter hospital on a voluntary basis. Only a few require involuntary hospitalization. The importance of sufficient resources is stressed.

3. The draft principles still represent "minimum United Nations standards for protection of fundamental freedoms and human and legal rights of mentally ill persons". Governments should consider adapting their laws, if necessary, to the body of principles and guarantees, or should adopt provisions in accordance with them, when introducing new relevant legislation.

4. The following articles are not in accordance with this preamble, leaving an impression of inconsistency in the report.

The articles

Articles 1 and 3.5

5. The articles mostly deal with human rights in general and the application for mental patients in particular. Some articles are transferred from the Daes Report (latest revision August 1987). These articles can probably be generally accepted, even if they may convey a tinge of legalistic and suspicious approach to psychiatry, as if every psychiatric patient is in need of special protection.

6. If important matters are covered satisfactorily in international documents on human rights, it should be sufficient to refer to these documents in the preamble and to quote the relevant provisions. So it has been done in the WHO document (E/CN.4/Sub.2/1988/66). Reference could be made in particular to the Universal Declaration on Human Rights and the International Covenant on Civil and Political Rights, cf. article 3.4. A simplification could be expedient.

Article 2

7. The definitions of article 2 correspond, to a wide extent, to the WHO proposals - e.g., the decisive definition of "severe mental illness" used in article 15 on involuntary admission. It is noted that there is no definition

of "harm" - a key concept of article 15. The tone of the article seems to indicate that the definitions set out are for the purpose of the articles and are not intended to be for universal application.

8. Only a difference of degree is found between "mental illness" and "severe mental illness". Even the definition of "mental illness" corresponds grossly to the psychiatric concept of "psychosis" or to cases in the borderland of psychosis. Disturbance of reality is decisive in the concept of psychosis.

9. In this way, categories of non-psychotic patients apparently are excluded from admission to mental health facilities, cf. in particular article 13 on voluntary admission, although article 20 seems to hint that persons who are not mentally ill may be admitted. Considering the difficulties and differences of definitions, the WPA has previously suggested that each country should provide in its law a specific definition and an attempt to rationalize it, taking into account the key protection, which here is laid down in the following article 6.

Article 3

10. It seems to be an example of the apparent assumption that a patient does not stay in a mental health facility, unless he is forced to. The article does not correspond to the situation of the vast majority of patients in mental health facilities, namely, voluntary patients, whose freedom and rights are intact. 3.2 is a proposal of discrimination of the mentally ill. 3.3 is a proposal against discrimination of the mentally ill.

Article 4

11. The article is not in concordance with the assumption that voluntarily admitted patients have the same rights as patients with any other illness.

Articles 7-11

12. Article 7 is remarkably encouraging community psychiatry in accordance with an internationally accepted trend in psychiatric care and with the mental programmes of WHO.

13. A suspicious attitude appears again, for instance in article 8.2 and article 11.1. So the tendency of extensive control is underlined corresponding to the impression that a stay in a psychiatric institution is at any time unwanted.

14. The latest WHO document (E/CN.4/Sub.2/1988/66) has treated the subject in a more simple way, namely superior guidelines and no detailed specification.

Article 12

15. It is reasonable that the principle of informed consent is underlined with the inevitable exception in emergencies. The same principles are laid down in the WHO paper in a more simple manner, and the article appears rather complicated and bureaucratic.

16. A distinction is apparently made between incompetent and competent patients. The decision of an independent authority in case of non-urgent treatment of incompetent patients, unable to consent, is hardly compatible with adequate psychiatric practice and marks an undesirable degree of legal control (article 12.8).

17. It should be recognized that the provisions imply possible conflict where a patient may be admitted involuntarily in accordance with article 15, but not treated - which was the purpose of the admission. It is noted that the article includes acceptable provisions on physical restraint and on clinical trials and experimental treatment. No trials or experimental treatment should be carried out on patients involuntarily, irrespective of voluntary or involuntary hospitalization. In the United States, research is forbidden on any subject deprived of personal liberty.

Article 13

18. The article is - as it now stands - a combination of the WHO proposal and the Daes articles. 13.1 and 13.2 have nearly the same wording as the WHO document, whereas 13.3 is just slightly changed from the original Daes article. This very important provision still seems to reflect an attitude and an apprehension of a psychiatric department as some kind of prison. It is a strain being a psychiatric patient, but admission is worse! It might deter a patient from seeking the mental health facility, and the possibility of self-referral is not included. A citizen should find it as natural to apply for help in the psychiatric ward as in the emergency room of a general hospital. A remarkable contradiction exists between 13.1 and 13.2 on the one hand and 13.3 on the other.

19. The possibility of voluntary admission is - as mentioned above in article 2 - restricted to patients suffering from "mental illness", which excludes some non-psychotic patients, who are "likely to benefit from admission for care and treatment". Furthermore, patients who do not understand the purpose of admission, i.e. non-protesting, incompetent patients may not be admitted voluntarily. These persons should, according to some legislations, be treated as voluntary, informal patients in order to avoid the stigma and possible legal consequences of involuntary admission, comparing their situation with that of somatic patients.

20. The WPA is still of the opinion that it should be sufficient to state that a patient can be admitted to a mental health facility by a medical practitioner or he can address himself to the facility and ask for assistance. Nor is it necessary to define such a psychiatric patient. Article 13.3 discriminates against persons who suffer from mental illness. The article should be deleted - or, at least, radically changed. Article 13.4 has no specific meaning, and should be deleted.

Article 15

21. Article 15.1 is transferred unchanged from the WHO proposal (which again is in agreement with the WPA points of view).

22. The concept of "harm" is not defined in article 2. The WHO paper suggests this definition: "A physical or a psychological harm or injury." The term "harm" is broader than the term "danger" and does not imply physical violence

to the same extent as "danger". Following this, it must be assumed that the indication of urgent treatment is maintained, because given the patient's severe mental illness, "the omission of admission for treatment would lead to a considerable deterioration of his condition". The WPA has previously stressed the necessity of involuntary admission on account of "urgent treatment" of a severely mentally ill person who refuses treatment. This is the case mostly with paranoid and manic patients who may not be evaluated as "really" dangerous and yet may be in need of treatment.

23. The concept of "severe mental illness" - as defined in article 2 - fits into the context here. It is appropriate to underline involuntary admission as ultimum refugium and the principle of the least restrictive alternative.

24. It should be noted that a "mental health practitioner" - as in article 13 - is entitled to certify an involuntary admission (cf. the definition in article 2). In many countries, this access is restricted to "authorized medical practitioners". The procedure indicated in the article does not seem to be opposed to the WHO proposal, but is more elaborate. The definition in article 15.3 of the "best interests" is in accordance with the proposal of the WHO draft.

Article 16

25. This article on review and appeal is in agreement with the principle suggested by WHO and the WPA. The necessity for the deprivation of liberty shall be reviewed at regular and fixed intervals as described by national law. It is appropriate to state the superior principles and then refer to national legislation considering the different systems of the individual countries. So it is reasonable that only the final decision to admit or detain a patient in a mental health facility shall be taken by a review body, which might be a court or other impartial body, cf. article 15.

26. Article 16.5: It is remarkable that an authorized mental health practitioner (in the sense of the definition of article 2) may discharge a patient if satisfied that the medical conditions for discharge are satisfied. So, for instance, a psychologist is entitled to judge medical conditions in this difficult situation.

Articles 17 and 18

27. These articles on the procedural rights of the patient are - as were the Daes articles - more elaborate than the WHO proposals. The provisions appear as a legalistic repetition of a person's rights in connection with a court hearing. It must be the assumption that article 17 is referring to the involuntary patient and article 18 to all patients, but it is not pointed out.

28. The access to records and other papers is still a controversial subject, but the necessary exceptions are indicated. It is noted that the patient and his representative are entitled to "an independent medical report and any other relevant evidence". It is difficult to foresee how such a controlling procedure will work in practice.

Article 19

29. WHO and the WPA have proposed that the principles for treatment in the articles should be applied to mentally ill offenders to the widest possible extent. Article 19.2 preserves the original Daes articles on criminal proceedings as the "guidelines" of Annex A. Apparently, the working group had not revised these articles at the meeting in August 1988.

30. It should be remembered that the section on criminal proceedings is transferred nearly unchanged from the so-called Siracusa guidelines of 1981 (the International Association of Penal Law and the International Commission of Jurists). It seems to be rooted in the tradition of the English-speaking countries with regard to procedures and concepts. It has been indicated by the WPA and several member countries that it might be difficult to adapt these provisions to national legislation and tradition outside the anglophone system, even if they are formulated in general terms. The guidelines do not conform to the penal law procedure in various countries. There is a wide variation in the definitions, treatment and criminal procedures among different countries, and conflicts with national legislation must particularly be envisaged within this field. Thus, reasonable doubt has been expressed whether this United Nations instrument should at all include a section concerning mentally abnormal offenders. The question has not yet been thoroughly discussed.

31. If the body of principles should include provisions on criminal proceedings, it is worth considering whether these articles should be simplified in such a way that specific procedures and concepts are avoided.

Minors

32. The Daes report had a few articles on minors, but the final resolution of these problems was postponed in 1984 by the United Nations working group. The present Palley report does not deal with this very intricate problem. At any rate, it ought to be resolved whether the principles and guarantees should include a section on minors.

Article 20

33. The impact of this article is difficult to interpret, as the instrument is otherwise reserved for patients with "mental illness" or "severe mental illness" as defined in article 2.

Articles 21 to 24

34. These articles on remedies and implementation are in principle in agreement with the previous Daes articles and the WHO document. Article 21 adds other safeguards for every mentally ill person. Article 21.2 ought to be reformulated to avoid complaints of obviously psychotic nature. The new article 22 suggests a "multi-disciplinary commission" to control the psychiatric field. Finally, article 23 repeats the purpose of the principles and guarantees. Article 24 is a new formulation, which undoubtedly will find general acceptance.

November 1989
Hans Adserballe, WPA Ethics Committee
Fini Schulsinger, Secretary-General
Costas Stefanis, President

## PROPOSALS FOR NEW BASIC ARTICLES

1. Health legislation should provide for adequate and effective treatment for all patients, including psychiatric patients, and safeguard their right to treatment in or outside institutions of an acceptable standard. There should be no discrimination of psychiatric patients in this context. Psychiatry should be integrated in the health care system.

### Voluntary treatment

2. Access to voluntary treatment shall not be administered differently from access to treatment of physical illness. A patient, who voluntarily is admitted to a mental health facility or addresses himself and asks for assistance, shall be protected by the same legal safeguards and ethical rules as patients with any other type of illness.

### Involuntary treatment

3. Involuntary treatment is a great infringement of the human rights and the fundamental freedom of the patient, and therefore a patient shall be admitted to a mental health facility as an involuntary patient only if:

A. (1) An authorized medical practitioner states, after a personal examination, that the patient, because of severe mental illness, */ is likely to cause serious harm to himself and/or others;

(2) Or if, because of the patient's severe mental illness, the omission of admission for treatment would lead to a considerable deterioration of his condition.

B. The patient refuses voluntary admission for treatment, which cannot be carried out by any other means in accordance with the least restrictive principle.

4. National legislation shall provide for directions with regard to: which kind of persons are authorized to request an involuntary admission, and which organization is authorized to carry out the physical force that may be necessary for the implementation of the involuntary admission.

5. The final decision to admit or detain a patient in a mental health facility as an involuntary patient shall be taken only by a court or a competent independent body prescribed by law - and only after appropriate preparation and proper hearing. The patient shall be informed of his rights. The patient has the right of appeal and to be heard personally by the judge or the body.

6. The lawful necessity for the deprivation of liberty shall be reviewed at regular and fixed intervals as prescribed by national law.

7. A patient, who is deprived of his liberty, shall have the right to a qualified guardian or counsel to protect his interests.

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*/ See definition.

8. A patient, who is deprived of his liberty, has the need and right to be treated under the same professional, environmental and ethical conditions as any other ill person. In particular, he has the right to receive appropriate treatment and care in accordance with the highest available standards. Thus, national legislation shall provide for guidelines for the appropriate physical setting and the staff of the wards, in which involuntary hospitalization takes place. Such guidelines must serve the patient's need for privacy as well as contact with mental health professionals, and also the patient's need for physical activity and meaningful occupation.

The criminal mentally ill patient

9. The principles for treatment, as outlined in articles 3 to 8, should be applied to the widest possible extent to mentally ill offenders who are sentenced to involuntary treatment.

Proposals for definitions

"Patient" (involuntary treatment): A person suffering from severe mental illness.

Voluntary treatment: No definition is necessary (cf. Proposal for New Basic Articles 1 and 2).

"Mental health facility": Any establishment or unit of an establishment, which as its primary function has the care and treatment of patients, suffering from severe mental illness.

"Severe mental illness": A substantial disturbance of thought, mood, perception, orientation or memory, which grossly impairs judgement, behaviour, and capacity to recognize reality, and which may require involuntary treatment.

(A diagnosis of severe mental illness shall be determined in accordance with internationally accepted medical standards. Physicians, in determining whether a person is suffering from mental illness, should do so in accordance with medical science. Difficulty in adapting to moral, social, political, or other values, in itself should not be considered a mental illness.)

"Harm": The term covers not only the case where the danger is immediately evident, but also where there is a serious possibility of injury being caused to the patient himself or to another person. This makes it possible to take an appropriate decision in cases where, although the mental illness does not obviously reflect harmful behaviour, the physician has every reason to believe that injury to persons may be caused.

Position statement on the rights and legal safeguards of the mentally ill

(Adopted by the WPA General Assembly in Athens, 17 October 1989)

Preamble

The present WPA Executive Committee has been involved in several contexts with the rights and legal safeguards of the mentally ill.

The EC has been assisted very productively by members of the WPA Ethics Committee, not least by its co-ordinator, Dr. Hans Adserballe.

The following is a catalogue of the main viewpoints which the WPA has tried to promote, especially in the work with the Daes-Palley Report.

Position statement

Persons suffering from mental illness shall enjoy the same human rights and fundamental freedoms as all other citizens. They shall not be the subject of discrimination on grounds of mental illness.

Mentally ill persons have the right to professional, humane and dignified treatment. They shall be protected from exploitation, abuse and degradation, in accordance with the ethical standards of the Declaration of Hawaii, revised and approved by the General Assembly of the World Psychiatric Association in Vienna, 1983.

The World Psychiatric Association adheres to the general principles outlined in the Declaration of Hawaii, which clearly specifies the minimal requirement for ethical standards of the psychiatric profession. The Declaration of Hawaii states that the aim of psychiatry is to treat mental illness and to promote mental health. It denounces abuse of psychiatry in all respects and emphasizes that the psychiatrist shall serve the best interests of the patient, consistent with accepted scientific knowledge and ethical principles.

Health legislation shall provide for adequate and effective treatment of all patients, including psychiatric patients, and safeguard their right to treatment in or outside institutions of an acceptable standard. There shall be no discrimination of psychiatric patients in this context. Wherever possible, psychiatric services shall be integrated into the health and social care system. All patients shall be treated and cared for, as far as possible, in the community where they live.

Psychiatric patients should, as a principle, be treated along the same lines as other patients, favoured by the fact that the great majority of patients may be treated informally and voluntarily in out-patients facilities without hospitalization.

Voluntary treatment should be encouraged, and access to voluntary treatment should not be administered differently from access to treatment of physical illness. Patients, who are voluntarily admitted to a mental health facility or apply for assistance, shall be protected by the same legal safeguards and ethical rules as patients with any other type of illness.

Involuntary intervention is a great infringement of the human rights and the fundamental freedom of a patient. Therefore, specific and carefully defined criteria and safeguards are needed for such intervention. Hospitalization or treatment against the will of a patient should not be carried out, unless the patient suffers from serious mental illness. Involuntary intervention must be carried out in accordance with the least restrictive principle.

A diagnosis that a person is mentally ill shall be determined in accordance with the internationally accepted medical standards. Physicians, in determining whether a person is suffering from mental illness, should do so in accordance with medical science.

The seriousness of the mental illness and the seriousness of the harm that the patient may cause himself and/or others shall be determined by definition in national legislation.

Difficulty in adapting to moral, social, political, or other values, in itself should not be considered a mental illness.

National legislation shall provide directions with regard to which kind of persons are authorized to request an involuntary admission, and which body is authorized to carry out the physical force that may be necessary for the implementation of the involuntary intervention.

The final decision to admit or detain a patient in a mental health facility as an involuntary patient shall be taken only by a court or a competent independent body prescribed by law - and only after appropriate preparation and proper hearing.

Patients shall be fully informed of their treatment and rights. They have the right of appeal and to be heard personally by the court or competent body.

The necessity for the deprivation of liberty shall be reviewed at regular and fixed intervals as prescribed by national law.

Patients, who are deprived of their liberty, shall have the right to a qualified guardian or counsel to protect their interests.

Clinical trials and experimental treatments shall never be carried out on patients involuntarily hospitalized.

Patients have the right to receive appropriate treatment and care in accordance with the highest available standards. The quality of treatment also depends on appropriate physical settings, staff and resources.

Patients deprived of their liberty shall have the right to free communication, limited only as strictly necessary in the interests of the health or safety of themselves or others.

The principles set out in these articles shall to the widest possible extent apply to mentally ill offenders, who are admitted to a mental health facility.

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