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INTERNATIONAL HUMAN RIGHTS STANDARDS AND INVOLUNTARY PSYCHIATRIC CARE – DEVELOPMENTS AND SERBIA'S PERSPECTIVE

ABSTRACT: Unlike the interpretation of the UN Committee on the Rights of Persons with Disabilities (hereinafter: CRPD Committee), which prohibits any deprivation of liberty on the basis of mental disability, the laws of member states continue to allow and implement involuntary psychiatric measures. The recent objection by the CRPD Committee to the adoption of a legally binding document at the Council of Europe level, which aims to regulate the protection of the human rights and dignity of individuals with mental disorders, could potentially have negative consequences. At this point, a legally binding agreement is more significant than a complete prohibition on placement in psychiatric institutions without consent or the exclusion of substitute decision-makers from providing consent for treatment. This is supported by Serbian legislation, which has certain deficiencies in the procedures for the placement and treatment of individuals with mental disorders. Involuntary measures should be applied only in exceptional cases, and a legally binding document that reflects genuine state consensus could be beneficial for creating laws and ensuring protection for those subjected to involuntary psychiatric measures.

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1. Introduction

Under certain circumstances, individuals with mental health issues may be subject to treatment and placement without their consent in the majority of states, as long as protective measures are implemented. Despite significant efforts to shift away from conventional coercive approaches in the field of mental health, this issue continues to be far from being realized. The potential harm of the excessively progressive approach adopted CRPD Committee in this subject should be considered.

Council of Europe's Committee on bioethics (hereinafter: DH-BIO) adopted a Draft Additional Protocol to the Convention on human rights and biomedicine concerning the protection of human rights and dignity of persons with regard to involuntary placement and involuntary treatment within mental healthcare services in 2018 (hereinafter: Draft). The basis for the Draft was the Recommendation Rec 2004 (10) of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder (Committee on Bioethics DH-BIO, 2018).

However, there was strong resistance to the adoption of the Draft within the CRPD Committee, and human rights experts called all State delegations to object to the draft, since it maintains an approach to mental health policy and practice that is based on coercion (OHCRC, n.d.). It was also stated that "The Council of Europe now has a unique opportunity to shift away from old-fashioned coercive approaches to mental health, towards concrete steps to promote supportive mental health services in the community, and the realization of human rights for all without discrimination on the grounds of disability" (OHCRC, n.d.). Numerous European countries have implemented mental health reforms, resulting in a transition towards more person-focused and recovery-led methods, however, involuntary placement and treatment remain common, although controversial, aspects of mental health systems and form components of national laws (Mental Health Europe, Brussels, 2017, p. 18). Consequently, no specific provision of the Draft was challenged, but rather the entire system of involuntary treatment and placement in psychiatric care.

Objections to the draft also came from the Council of Europe's Parliamentary Assembly, and the Council of Europe's Commissioner for Human Rights (Mental Health Europe: Advocacy & Support for Well-being, 2024). Council of Europe's Parliamentary Assembly stated that it has serious

doubts about the added value of a new legal instrument in this field, and also questioned the compatibility of the Draft with the United Nations Convention on the Rights of Persons with Disabilities (hereinafter: CRPD). It was emphasized that although the CRPD does not explicitly refer to involuntary placement or treatment of people with disabilities, Article 14 on liberty and security of the person clearly states that a deprivation of liberty based on the existence of disability would be contrary to the CRPD (Council of Europe, 2016).

The Council of Europe's Parliamentary Assembly and the CRPD Committee's interpretation of CRPD as forbidding any deprivation of liberty based on a mental disability contradicts the fact that psychiatric involuntary measures are still widely used and permitted by member state laws (Saya et al, 2019, p. 4–7). Even when other criteria, such as risk to oneself or others, are used to justify forced admission to psychiatric care. DH-BIO postponed the adoption of the Protocol until 2021. In the same year, both the Committee on the Rights of Persons with Disabilities and the Special Rapporteur on the Rights of Persons with Disabilities strongly advised against adopting the Draft, which promotes a mental health policy and practice that is based on coercion (CRPD, 2021). At the moment, the Draft has not been adopted.

2. CRPD and involuntary treatment and placement in psychiatric care

CRPD is based on the principles of equal treatment and it is not explicitly focused on involuntary treatment and placement. Article 14 of the CRPD states that "the existence of a disability shall in no case justify a deprivation of liberty". Article 25 of the CRPD recognizes the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination. In addition, health professionals need to "provide care of the same quality to persons with disabilities as to others, including based on free and informed consent".

Of 189 State Parties, just several made declarations concerning Article 14 of the CRPD. For example, Australia declared that it understands that the Convention allows for compulsory treatment of persons, including treatment of mental disabilities, as a last resort and subject to safeguards. Ireland, Netherlands, and Norway had similar declarations (United Nations Treaty Collection UNTC, n. d.). Nevertheless, other State Parties expressed their views in reports on the treaty's implementation, and they have also interpreted the CRPD in light of previous human rights standards, concluding that it

outlaws arbitrary interventions, which in their opinion include detention based solely on disability and clinical treatment that violates established medical practice and ethics (Nilsson, 2014, p. 461). On the other hand, subsequent interpretations of the CRPD by the Committee were not in line with this approach. Involuntary commitment of disabled people for health care purposes violates Article 25's principle of free and informed consent and Article 14(1)(b), which prohibits deprivation of liberty based on impairment, according to the CRPD Committee (CRPD, 2013, para. 3; CRPD 2014, Articles 12, 14 and 25; CRPD, 2015).

Concerning the non-consensual treatment during deprivation of liberty, and interpretation of Article 12 of the CRPD (equal recognition before the law), the CRPD Committee also stated that "in conjunction with the right to legal capacity on an equal basis with others, State parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities. All health and medical personnel should ensure appropriate consultation that directly engages the person with disabilities. They should also ensure, to the best of their ability, that assistants or support persons do not substitute or have undue influence over the decisions of persons with disabilities" (CRPD, 2015, para. 41).

In the Guidelines on Article 14, the CRPD Committee explicitly stated that it is contrary to Article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or others (CRPD, 2015, paras 13–14). Deprivation of liberty based on impairment or health conditions in mental health institutions which deprives persons with disabilities of their legal capacity, also amounts to a violation of Article 12 of the CRPD, which recognizes the right of all individuals to their legal capacity (CRPD, 2015, para. 15).

Interestingly, although the position of the CRPD Committee was known at the time of the adoption of the UN Human Rights Committee General Comment No. 35 related to the Liberty and security of person, the UN Human Rights Committee reinforced its earlier position on involuntary placement. Namely, limiting liberty due to disability is only acceptable if it is necessary and proportionate to protect the individual or others from serious harm. It should only be used as a last resort, with legal safeguards, and for a limited period (HRC, 2014, para. 19). The HRC's approval of the legality of such practices under specific circumstances implies that States are unlikely to feel obligated to align laws with the CRPD interpretation (Doyle Guilloud, 2019, p. 10).

3. European standards on involuntary treatment and placement in psychiatric care

I. Biomedicine Convention

The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (hereinafter: Biomedicine Convention) is the only legally binding international act that regulates the issue of patient consent in more detail. The Charter of Fundamental Rights of the EU, however, also has a general provision related to consent, (Article 3 (2) (a), however, the doctor-patient relationship is outside the jurisdiction of the EU, which is why this provision, has a limited scope (Michalowski, 2004, p. 299). In the Biomedicine Convention, a generally accepted distinction has been made from the general rule of consent concerning the protection of minors, persons with mental disorders, and persons in emergency situations. The basic rule is that: "an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit" (Article 6 (1)). The most crucial consideration is whether the individual's condition will also impair their decision-making, in which case the laws normally allow a responsible person or authority to make decisions in their best interest. According to the Biomedicine Convention, where according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, the intervention may only be carried out with the authorization of his or her representative or an authority or a person provided for by law (Article 6 (3)). Hence, the CRPD Committee's position that state parties must not allow substitute decision-makers to consent on behalf of persons with disabilities, is in opposition to the Biomedicine Convention and the majority of state laws. While some states implemented new models of supported decision making throughout Europe, the majority of countries continued to maintain plenary guardianship regimes and practice full deprivation of legal capacity (Mental Health Europe, Brussels, 2017, p. 40).

The ability to offer informed consent is a complex question, and legal definitions of capacity to consent are sometimes unclear and vary between states. The answer to this question is heavily dependent upon the impartial assessment of the psychiatrist. It is crucial to evaluate the patient's capacity to provide informed consent, rather than making conclusions solely based on the general characteristics suggested by a particular diagnosis (Staden & Krüge, 2003, p. 43).

Importantly, the Biomedicine Convention states that subject to protective conditions prescribed by law, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health (Article 7). The widely accepted definition of the risk of serious harm to oneself and others is limited to self-harm. The Biomedicine Convention also permits patients to be treated against their will to protect other people's rights and freedoms (Article 26).

II. The Council of Europe's Recommendations and the Draft

The basis for the Draft was Recommendation 2004 (10) of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder (hereinafter: Recommendation 2004 (10)). Among other safeguards, Recommendation 2004 (10) establishes criteria and principles governing involuntary treatment and placement, procedures for making decisions for involuntary placement and/or treatment, termination of involuntary placement and/or treatment, and obligations related to reviews and appeals. Many of these issues were addressed in earlier recommendations, as well as the later Draft (Council of Europe, 2004). The European Court of Human Rights referred to the Recommendation 2004 (10) provisions in its decisions concerning involuntary treatment and placement.[1] In comparison to Recommendation 2004 (10), which applies to people with mental disorders, the Draft's scope is limited since it excludes minors and placement and treatment in the context of criminal law procedures. This is due to the various definitions of a "minor" and their legal status between the member states. When it comes to placement and treatment in the context of criminal law procedures, additional considerations are relevant, and legal frameworks also significantly differ across member states.

The Draft defines involuntary measure, which refers to involuntary placement and/or treatment, even if the individual's legal representative is willing to authorize it. Although the draft has limited scope compared to Recommendation 2004 (10), both documents require similar criteria for involuntary placement and treatment. According to the Draft, it is necessary that: the person's mental health condition represents a significant risk of serious harm to his or her health and his or her ability to decide on placement or treatment is severely impaired, or the person's mental health condition represents a significant risk of serious

[1] *M.H. v. the United Kingdom*, Application no. 11577/06, ECHR judgment, 22. 10. 2013, par. 50.

harm to others; the placement or treatment has a therapeutic purpose; and any voluntary measure is insufficient to address the risk(s) of serious harm (CE, 2004, Articles 17–18; DH-BIO, 2018, Articles 10–11).

The requirement of a substantial risk of harm to one's health or the health of others, or the dangerousness criterion has faced criticism in the literature due to its ambiguity and potential for misuse. Predicting the dangerousness of an individual is very difficult (Nilsson, 2014, p. 474). Some even argue that it is unwise from a human rights perspective to support autocratic regimes in implementing laws that permit the detention of individuals deemed dangerous, as this legislation can be easily exploited for political purposes (Bartlett, 2012, p. 752). Nevertheless, this norm continues to be one of the key criteria in comparative law when deciding on involuntary placement.

As stated in the Draft and Recommendation 2004 (10), involuntary treatment or placement is permissible solely upon the proper evaluation conducted by a minimum of one physician possessing the necessary expertise and experience. The court or another competent authority must render the decision, taking into account the individual's opinion on the matter. The extension of an involuntary measure is possible under the same conditions (CE, 2004, Articles 20, 24; DH-BIO, 2018, Articles 12, 14). Measure's continuing conformity with the legal requirements must be reviewed at regular intervals (CE, 2004, Article 25; DH-BIO, 2018, Article 15). Also, it must be possible to appeal to a court against the measure and to request a review by a court. An appeal may also be made and a review requested by the person's representative. It must be ensured that the person subjected to involuntary measures can be heard in person, with the support of a person of trust, if any, or through a representative (CE, 2004, Article 25; DH-BIO, 2018, Article 16). The Draft and Recommendation 2004 (10), additionally guarantee the right to information, communication, and visits of the person affected by involuntary measures, and regulates use of the seclusion and restraint, and treatment with irreversible effects. Therefore, the Draft, which is mostly in line with the earlier Recommendation 2004 (10), provides important safeguards for persons affected by involuntary measures.

III. The European Court of Human Rights

The European Court of Human Rights (hereinafter: ECtHR) frequently receives applications revealing violations of the European Convention on Human Rights (hereinafter: ECHR) as a result of involuntary measures. The ECtHR in its practice developed numerous standards regarding the protection

of individuals affected by involuntary measures in psychiatric care. The Court cited the CRPD as a relevant document. However, there was never a case in the practice in which the ECtHR stated that the imposition of the involuntary measure was a violation of a human right, due to an absolute ban on involuntary placement, or concerning the involuntary treatment, due to the CRPD Committee's stance on not allowing substitute decision-makers to provide consent for persons with disabilities (although according to ECtHR their opinion must be taken in consideration). When assessing whether it is necessary to place the person in an institution, the ECtHR stated that any measure taken without prior consultation of the interested person will as a rule require careful scrutiny".[2] In this case, the ECtHR stated that the applicant detention was contrary to domestic law since the measure can only be imposed on a person if he poses a danger to society, but also stated that "such detention is open to question, particularly in the light of the provisions of Article 14 § 1 (b) CRPD".[3] However, following preliminary efforts to reconcile with the CRPD Committee, the ECtHR declined the abolishment of involuntary hospitalization (Fiala-Butora, 2024, p. 11).[4]

4. Republic of Serbia and involuntary placement and treatment in psychiatric care

In Serbian law, the matter of patient consent is regulated in line with the Biomedicine Convention (Articles 5-9 of the Biomedicine Convention).[5] The Law on Protection of Persons with Mental Disorders (hereafter: Law) provides more detailed regulations on the matter of involuntary placement and treatment. In the context of medical interventions, "an individual with a mental disorder who can make a decision and express his will and who comprehends the nature, consequences, and risks of the proposed medical measure may only undergo the procedure with his written consent." A psychiatrist evaluates the capacity of an individual to provide informed consent for the proposed

[2] *N. v. Romania, Application* no. 59152/08, ECHR judgment, 28. 11. 2017, par. 146.

[3] *N. v. Romania, Application* no. 59152/08, ECHR judgment, 28. 11. 2017, paras 158–159.

[4] "The Court considers that Article 5, as currently interpreted, does not contain a prohibition on detention on the basis of impairment, in contrast to what is proposed by the UN Committee on the Rights of Persons with Disabilities in points 6-9 of its 2015 Guidelines concerning Article 14 of the CRPD*" Rooman v. Belgium*, Application no. 18052/11, ECHR judgment, 31. 01. 2019, par. 205.

[5] Except in exceptional circumstances authorized by law, no medical procedure may be conducted without the informed consent of the patient. (Articles 15-16 of the Law on patients' rights).

medical treatment and a written report and opinion regarding capacity are appended to the medical records (Article 16 of the Law).

If an individual with a mental disorder is unable to provide consent for a proposed treatment and also lacks a legal representative or there are no means to obtain consent from a legal representative, he may undergo a medical intervention without consent under exceptional circumstances.[6] The CRPD Committee recommended the replacement of substituted decision-making with supported decision-making regimes that honor the individual's autonomy, will, and preferences and implement clear safeguards (CRPD, 2016, paras 21–22).

Concerning the placement without consent of a person with a mental disorder, a medical doctor or psychiatrist determines that an individual with a mental disorder poses a serious and direct threat to their own or others' life, health, or safety, and they may be involuntarily placed in a psychiatric institution if no less restrictive treatment options are available (Article 21 of the Law). The provision allowing a medical doctor, such as a general practitioner, to undertake an initial assessment is certainly concerning. However, when a person with a mental disorder is admitted to a psychiatric institution, the facility's council determines if the person will need additional hospital treatment or be discharged (Article 24 (4) of the Law).

The procedure for involuntary detention is delineated in the legislation (Articles 21–37). However, the lack of specific rules regarding the placement procedure is a serious shortcoming in the law (Stojanović, 2014, p. 160). Although the law acknowledges two distinct procedures – for detention without consent (Article 2(10)) and for placement without consent (Article 2(11)) – in the sections defining the meaning of the terms used, there is no explicit procedure for placement in the legislation, except a few brief references to the placement procedure. Because there are no particular procedure provisions on placement, it can be assumed that the provision linked to the prolongation of detention has the effect of placement. More specifically, the court may extend detention without consent in a psychiatric institution for up to three months from the date of the expiry of the time determined by the court's decision on detention without consent; any additional detention without the consent of a

[6] If: 1) the treatment is essential to prevent a substantial decline in his state of health; 2) medical intervention is aimed at restoring the capacity to provide consent to the proposed medical measure; 3) it is necessary to prevent endangering the life and safety of that person or the life and safety of other individuals. Healthcare facility must notify the appropriate guardianship authority and suggest that the process for designating a legal representative be initiated if an individual with mental disabilities lacks such representation (Article 19 of the Law).

person with mental disorders may be extended by a court decision for up to six months (Article 34 (2) (3)). The length of extended detention can be more closely related to the term of placement, as is customary in comparative law.

Provisions of Law on Non-Contentious Proceedings are applied to the procedure for detention in matters that are not expressly governed by the Law (Article 27 (2) of the Law). The court decides on involuntary detention after a psychiatric institution that detained a person without consent informs the court (within 24 hours of the consular examination) that the facility's council has decided on detention, along with medical documentation and reasons for detention. (Article 25(2); Article 27(1)).

The law requires the court to personally hear the person whose involuntary hospitalization is decided (Article 29); however, it is noted that there is no explicit obligation to hear the legal representative of a legally incompetent person, nor a special set of rules on representing a person who is forced to be hospitalized (Petrušić, 2013, p. 337). Also, an obligation to inform and consult a legal representative is not explicitly mentioned, although this is required in Recommendation 2004 (10) (Article 19 (2) i.), therefore, the law does not require the court to deliver the summons for the hearing to the legal representative (Petrušić, 2013, p. 340). In the Draft also, there is an obligation to "consult the representative of the person, if any" (Article 12 (2) v.).

Before deciding whether a person with a mental disorder should be detained without consent or released from a psychiatric facility, the court must seek a written report and opinion from one of the psychiatrists on the list of permanent court experts (Article 32 (1) of the Law). A significant concern regarding the involuntary hospitalization procedure is that neither the facility's council nor the psychiatrist's opinion can be contested. Courts in these proceedings are limited to determining whether involuntary hospitalization is justified on legal grounds, which creates a dilemma regarding the ability to seek compensation for damages where deprivation of liberty was unjustified, because of unfounded doctor opinion (Petrušić, 2013, p. 341). Regardless, the patient's position in a civil lawsuit against the physician is unfavorable. (Stefanović, 2020, p. 22).

The CRPD Committee recommended repealing the Law, prohibiting impairment-based detention and hospitalization, and accelerating deinstitutionalization (CRPD, 2016, paras 25–26). No substantial attention or review was given to compulsory placement and treatment in accordance with CRPD Committee recommendations. On the other hand, following a mass shooting at a primary school by a 13-year-old boy that caused nine casualties, the Ministry of Health introduced a Draft Law proposing changes

to the Law on Protection of Persons with Mental Disorders (Ministry of health, Republic of Serbia, 2023). The Draft Law applies to non-criminally liable children who, due to mental disorders, commit serious criminal offenses (prescribed prison sentence of at least ten years) and pose a substantial threat to others. Based on the Draft Law, a child can be detained in a psychiatric institution without consent but the decision is not limited in duration, although the court must review the conditions for detention and treatment every six months. In the event of a well-founded suspicion that a child in a psychiatric institution intends to acquire weapons or psychoactive controlled substances, arrange escape, plan the execution of a criminal offense, or protect the health and safety of a child or others, visits, and contacts may be temporarily prohibited, including even close family members. Security issues are subject to regulations that govern facilities for treatment and placement without consent. Fortunately, the proposed legislation was not enacted, since it creates a less favourable environment for patients below the age of 14, and it seems that the Draft Law was a hasty reaction to a tragic event.

The Law governs compulsory treatment and placement in mental institutions for those who have not committed any criminal offenses. In the case of criminal offenders, a different set of regulations is relevant, and the Criminal Code security measures (Criminal Code, 2005). According to Article 81 of the Criminal Code, the court can order compulsory psychiatric treatment and confinement in a medical institution to "an offender who committed a criminal offense in a state of substantially impaired mental capacity if, due to the committed offense and the state of mental disturbance, it determines that there is a risk that the offender may commit a more serious criminal offense and that to eliminate this risk they require medical treatment in such institution". The procedure for ordering this security measure and compulsory psychiatric treatment at liberty is regulated in the Criminal Procedure Code (Criminal Procedure Code, 2011, Articles 522-532). After nine months, the court that imposed the security measure must assess whether the need for treatment and confinement in a medical institution ceased (Article 231 (1)). There are numerous arguments in favor of limiting the measure's duration. It is difficult to justify the indefinite duration of mandated psychiatric treatment and placement for an offender with substantially diminished mental competence, regardless of the length of the prescribed prison sentence (Bejatović, 2019, p. 63).

5. Conclusion

The majority of state laws are inconsistent with the Committee on the Rights of Persons with Disabilities' subsequent interpretations of Article 14 of the CRPD. Treatment and involuntary placement continue to be regarded as essential components of psychiatric care. Given that this is the current reality, human rights violations must be prevented through comprehensive regulation, particularly given their heavy reliance on professional staff for the assessment and treatment of individuals. The ECtHR didn't uphold CRPD interpretation and its practice also demonstrates the significance of adequate laws and guidance to ensure uniformity in the implementation of involuntary measures.

Although it can be argued that progressive interpretation may ultimately result in consensus, this prospect is typically associated with well-established international bodies that safeguard basic human rights, and when the issue is closer to being agreed upon. CRPD Committee activities can contribute to the acceptance of a new perception of the human rights of people with psychosocial disabilities (Škorić & Fabijanić, 2020, p. 73). However, the CRPD Committee is a relatively new entity (formed in 2008), and interpretations that lack adequate consensus among state parties may, at this point, even undermine the CRPD Committee's authority. There is still a lack of general agreement on this issue, and deinstitutionalization requires substantial resources.

Since the majority of Council of Europe member states routinely implement and permit involuntary measures in psychiatry, the CRPD Committee's opposition to the Draft's adoption could potentially even have adverse consequences. A legally binding document at the European level, with additional safeguards and even wider application, that includes treatment and placement in the context of criminal law procedures is more valuable at this point than an absolute ban on placement or the prohibition of substitute decision-makers from providing consent to treatment. This is also supported by Serbian law, which has some flaws in procedures for the placement and treatment of people with mental disabilities. There is also a risk that fundamental human rights could be endangered by unforeseen and disturbing occurrences when the public demands an immediate response. Involuntary measures should be exceptional, and a legally binding document that demonstrates a genuine consensus among states may be advantageous in creating laws and ensuring protection for those with mental disorders subjected to involuntary measures.

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MEĐUNARODNI STANDARDI LJUDSKIH PRAVA I PRINUDNA PSIHIJATRIJSKA ZAŠTITA – RAZVOJ I POGLED IZ SRBIJE

APSTRAKT: Za razliku od tumačenja Komiteta UN za prava osoba sa invaliditetom (u daljem tekstu: CRPD komitet) prema kojem je zabranjeno bilo kakvo lišavanje slobode na osnovu mentalnog invaliditeta, zakoni država članica i dalje dozvoljavaju i primenjuju prinudne psihijatrijske mere. Nedavni prigovor CRPD Komiteta na usvajanje pravno obavezujućeg dokumenta na nivou Saveta Evrope, koji ima za cilj da reguliše zaštitu ljudskih prava i dostojanstva osoba sa mentalnim smetnjama, potencijalno bi mogao da ima negativne posledice. U ovom trenutku, pravno obavezujući sporazum ima veći značaj od potpune zabrane smeštaja u psihijatrijsku ustanovu bez pristanka ili isključivanja zastupnika od davanja saglasnosti za lečenje. Ovo je podržano srpskim zakonima, koji imaju određene nedostatke u procedurama za smeštaj i lečenje osoba sa mentalnim smetnjama. Prisilne mere se primenjuju izuzetno, a pravno obavezujući dokument koji pokazuje istinski konsenzus država može biti od koristi u kreiranju zakona i obezbeđivanju zaštite za one koji su podvrgnuti prinudnim psihijatrijskim merama.

***Ključne reči**: ljudska prava, pristanak, lečenje, smeštaj, mentalne smetnje.*

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