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Involuntary Commitment and the Use of Seclusion and Restraint in Uruguay: A Comparison with the United Nations Principles for the Protection of Persons with Mental Illness

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COMMENT

INVOLUNTARY COMMITMENT AND THE USE OF SECLUSION AND RESTRAINT IN URUGUAY: A COMPARISON WITH THE UNITED NATIONS PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS

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I. INTRODUCTION

Behavior perceived as odd, ill or deranged exists in all nations and cultures.¹ Throughout the world, responses to this behavior have been problematic from Bedlam² to the present.³

1. HAROLD I. KAPLAN, M.D., AND BENJAMIN J. SADOCK, M.D., *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY*, at 284 (5th ed. 1989).

2. Bedlam was an eighteenth century asylum in England that kept inmates "chained, without clothes, sleeping on straw in cells that were unheated and covered with excrement." DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM*, at xxii (2d ed. rev. 1990).

3. *Id.* at 295.

Responding to growing concerns of the United Nations Human Rights Commission⁴ on the question of the protection of those detained on the grounds of mental illness,⁵ the United Nations adopted the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care [hereinafter "MI Principles"] in 1991.⁶ The MI Principles lay

4. The Human Rights Commission was established by the U.N. Economic and Social Council at its first session for the promotion of human rights pursuant to the Council's authority under article 68 of the U.N. Charter. 1946 U.N.Y.B. 470, U.N. Sales No. 1947.I.18. *See generally*, U.N. CHARTER art. 68.

5. The U.N. General Assembly acknowledged Human Rights Commission resolution 10 A(XXXIII) of March 11, 1977, requesting the Subcommittee on Prevention of Discrimination and Protection of Minorities [hereinafter "the Subcommittee"] study the problem of those detained on the grounds of mental illness with a view towards creating some guidelines for their protection. G.A. Res. 33/53, U.N. GAOR, 33d Sess., U.N. Doc. A/33/475, Dec. 14, 1978. The study by the Subcommittee's Special Rapporteur, Erica-Irene A. Daes, revealed that:

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

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

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

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

Principles, Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder, U.N. ESCOR, Comm'n on Hum. Rts., Sub-Comm'n on Prevention of Discrimination and Protection of Minorities, Report prepared by Erica-Irene A. Daes at 28, U.N. Doc. E/CN.4/Sub.2/17/Rev.1 (1983) [hereinafter *Daes Report*].

The *Daes Report* incorporates replies submitted by various governments and non-governmental organizations. For instance, the reply by the International Labour Office referred to a case brought before the Committee on Freedom of Association by the International Confederation of Free Trade Unions and the World Confederation of Labour against the U.S.S.R. The allegations of anti-union actions included the internment of trade unionists in psychiatric institutions. U.N. ESCOR, 36th Sess., Annex 3, Provisional Agenda Item 10, at 13, U.N. Doc. E/CN.4/Sub.2/17/Add.1 (1983). In this vein, the reply by Amnesty International "underlined the abuse of psychiatry for political purposes and present[ed] concrete complaints concerning the treatment of prisoners of conscience and other persons inside psychiatric hospitals in the Soviet Union." *Daes Report, supra*, at 16.

6. Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, at 188-92, U.N. Doc. A/46/49 (1991) [hereinafter MI Principles]. *See* Eric Rosenthal and Leonard S. Rubenstein, *International Human Rights Advocacy under the Principles for the Protection of Persons with Mental Illness*, 16 INT'L J.L. & PSYCHIATRY 257 (1993). *See also* Sophie Delaney, *Autonomy Denied: International*

down universal guidelines governing the treatment of mentally ill people.⁷

The Subcommittee on Prevention of Discrimination and Protection of Minorities⁸ developed these principles in 1988.⁹ Thereafter, governments,¹⁰ specialized agencies,¹¹ and non-governmental organizations¹² supplemented the draft principles with comments. Within one year, the U.N. Working Group on the MI Principles¹³ revised and approved the complete text of the draft instrument¹⁴ and the principles were adopted by the U.N. General Assembly.¹⁵

Human Rights and the Mental Health Act 1986 (Vic.), 18 MELB. U. L. REV. 445 (1992) (comparing the Australian Mental Health Act 1986 (Vic.) with the MI Principles).

7. MI Principles, *supra* note 6.

8. The Subcommittee on Prevention of Discrimination and Protection of Minorities was established by the U.N. Economic and Social Council to assist the Human Rights Commission in the performance of its functions, pursuant to the Council's authority under article 68 of the U.N. Charter. 1948 U.N.Y.B. 91, U.N. Sales No. 1950.I.11. See generally, U.N. CHARTER art. 68.

9. *Report of the Sessional Working Group on the Question of Persons Detained on the Grounds of Mental Ill-Health or Suffering from Mental Disorder*, U.N. ESCOR Comm'n on Hum. Rts., Sub-Comm'n on Prevention of Discrimination and Protection of Minorities, 40th Sess., Agenda Item 11, U.N. Doc. E/CN.4/Sub.2/1988/23 (1988).

10. Governments which provided comments and suggestions include: Bahrain, Equatorial Guinea, Finland, the Netherlands, Spain, the United States of America, the United Kingdom of Great Britain and Northern Ireland, Venezuela, Sweden, Australia, Austria, Japan, and Nigeria. *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*, U.N. ESCOR, Comm'n on Hum. Rts., 46th Sess., Provisional Agenda Item 15, U.N. Doc. E/CN.4/1990/53 & Add.1-4 (1990).

11. The following specialized agencies were represented at the Working Group by at least one observer: U.N. Centre for Social Development and Humanitarian Affairs, The International Labour Organisation and the World Health Organization. *Report of the Working Group on the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, U.N. ESCOR, Comm'n on Hum. Rts., 47th Sess., Agenda Item 14, at 3, U.N. Doc. E/CN.4/1991/39 (1991) [hereinafter *Report of the Working Group*].

12. The following non-governmental organizations were represented by observers in consultative status at the meetings of the Working Group: Disabled Peoples' International, Friends World Committee for Consultation, International Association of Penal Law, International Commission of Jurists, International Educational Development, Inc., World Association for Psychosocial Rehabilitation, World Federation for Mental Health, and World Psychiatric Association. *Id.*

13. The Working Group on the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care was established by the Human Rights Commission in 1989. E.S.C. Res. 1989/40, U.N. ESCOR, 45th Sess., 51st mtg., Supp. No. 2, at 109, U.N. Doc. E/CN.4/1989/86 (1989).

14. See *Report of the Working Group*, *supra* note 11.

15. The Working Group submitted the Principles to the Human Rights Commis-

Although U.N. General Assembly resolutions are not directly binding on member states,¹⁶ they provide a model which member nations can use to shape their domestic law.¹⁷ Under the U.N. Charter, all member nations "pledge themselves to take joint and separate action in co-operation with the Organization"¹⁸ to promote "universal respect for, and observance of, human rights and fundamental freedoms"¹⁹ for all without distinc-

sion, which endorsed them on March 5, 1991, E/1991/22 (res. 1991/46). Also in 1991, the U.N. Economic and Social Council adopted the principles. E.S.C. Res. 29, U.N. ESCOR, 13th Meeting, U.N. Doc. E/1991/86 (1991) (the Economic and Social Council is one of the principal organs established by the United Nations at the time of its creation. U.N. CHARTER art. 7, para. 1). The U.N. General Assembly officially promulgated the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care on December 17, 1991. See MI Principles, *supra* note 6.

16. By its terms, the U.N. Charter limits General Assembly resolutions to recommendations, not mandates: "[d]ecisions of the General Assembly on important questions shall be made by a two-thirds majority of the members present and voting. These questions shall include: *recommendations* with respect to the maintenance of international peace and security, . . . (emphasis added)." U.N. CHARTER art. 18, para. 2. See generally Christopher Joyner, *U.N. General Assembly Resolutions and International Law: Rethinking the Contemporary Dynamics of Norm-Creation*, 11 CAL. W. INT'L L.J. 445 (1981).

17. See generally, Christina Cerna, *The Inter-American System for the Protection of Human Rights: An Example of International Human Rights Procedures*, 31 FED. B. NEWS & J. 215 (1984), at 217 (discussing the influence of an Inter-American Commission on Human Rights report in the approval of a resolution delegitimizing the government of a member nation for human rights violations).

18. U.N. CHARTER art. 56.

19. These human rights and fundamental freedoms include, in pertinent part, the following:

Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

Article 3

Everyone has the right to life, liberty and the security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person

tion as to race, sex, language, or religion."²⁰ Accordingly, all member nations must make a good faith effort towards the implementation of U.N. standards protecting basic human rights.²¹

The MI Principles are one such set of standards, aimed particularly at the protection of human rights and fundamental freedoms for people who are mentally ill.²² These principles "constitute the most detailed and comprehensive international statement of the rights of people with mental disabilities to date."²³ They are the result of extensive research in many coun-

before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Universal Declaration of Human Rights, G.A. Res. 217(III)A, U.N. GAOR, 3d Sess., arts. 1-9, U.N. Doc. A/811 (1948).

20. U.N. CHARTER art. 55.

21. U.N. CHARTER art. 2, para. 2. "All Members, in order to ensure to all of them the rights and benefits resulting from membership, shall fulfil in good faith the obligations assumed by them in accordance with the present Charter." *Id.* See discussion of the legal authority of the MI Principles in Rosenthal and Rubenstein, *supra* note 6, at 267.

22. "The present Principles shall be applied without discrimination on any grounds, such as disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth." See MI Principles, *supra* note 6, at "Application."

23. See Rosenthal and Rubenstein, *supra* note 6, at 259. The total number of Principles is twenty-five, and they address the following:

Principle 1 - Fundamental Freedoms and Basic Rights;

Principle 2 - Protection of Minors;

Principle 3 - Life in the Community;

Principle 4 - Determination of Mental Illness;

Principle 5 - Medical Examination;

Principle 6 - Confidentiality;

Principle 7 - Role of Community and Culture;

Principle 8 - Standards of Care;

Principle 9 - Treatment;

Principle 10 - Medication;

Principle 11 - Consent to Treatment;

Principle 12 - Notice of Rights;

Principle 13 - Rights and Conditions in Mental Health Facilities;

Principle 14 - Resources for Mental Health Facilities;

Principle 15 - Admission Principles;

tries around the world.²⁴ They protect the fundamental rights of patients²⁵ and "[t]he human personality and its physical and intellectual integrity."²⁶ Further, they are unique in that they specifically protect against political misuse of psychiatry: "[p]sychiatry shall never be used for the purpose of violating human rights and for the subversion of the political and legal guarantees of a patient's freedom; in particular, it shall never serve as an instrument for enforcing political conformity[.]"²⁷

Moreover, the MI Principles have significant practical value. They provide specific guidelines which member nations can follow to create international uniformity in the protection of the mentally ill.²⁸ They also facilitate compliance by member states with U.N. Charter provisions, thereby avoiding potential international reproach.²⁹

Growing international concern with the protection of mentally ill people led to the creation of Mental Disability Rights

Principle 16 - Involuntary Admission;

Principle 17 - Review Body;

Principle 18 - Procedural Safeguards;

Principle 19 - Access to Information;

Principle 20 - Criminal Offenders;

Principle 21 - Complaints;

Principle 22 - Monitoring and Remedies;

Principle 23 - Implementation;

Principle 24 - Scope of Principles Relating to Mental Health Facilities; and,

Principle 25 - Saving of Existing Rights.

See MI Principles, *supra* note 6.

24. Forty-nine countries and twenty non-governmental organizations provided substantive information for the Daes Report. *Daes Report, supra* note 5, at 32.

25. Specifically, they recognize and require respect for "the inherent dignity and the inalienable rights of every patient" pursuant to the Universal Declaration of Human Rights and the International Covenants on Human Rights. *Daes Report, supra* note 5, at iv.

26. *Id.*

27. *Id.* at v.

28. For instance, Australia recently federalized its mental health law, and reports of its work referred to the requirements of the MI Principles. See Harvey A. Whiteford, *Australia's National Mental Health Policy*, 44 HOSP. & COMMUNITY PSYCHIATRY 963, at 964 (1993).

29. All U.N. members are required to fulfill "in good faith" their obligations under the Charter. U.N. CHARTER art. 2, para. 2. If a nation fails to comply, the United Nations may take preventive or enforcement action against the non-complying nation by which all other members must abide. *Id.* art. 5. For the proposition that "[i]t is a basic principle of international law that a demand by one state that another state live up to its international obligations does not constitute an illegal intervention into domestic affairs of that state," see THOMAS BUERGENTHAL ET AL., PROTECTING HUMAN RIGHTS IN THE AMERICAS: SELECTED PROBLEMS, at 31 (2d ed. 1986).

International (MDRI) in August 1993.³⁰ MDRI "is the first human rights organization devoted especially to the international recognition and enforcement of the rights of people with mental disabilities."³¹ One of the primary goals of MDRI is to support the development of locally-based mental disability advocacy groups around the world.³² In its first six months of operation, MDRI sent interdisciplinary teams of attorneys and mental health professionals to Uruguay, Ukraine, and Hungary, upon the request of concerned advocates in those countries.³³ In each country, MDRI visited mental health facilities and evaluated the conditions in the facilities.³⁴ MDRI will issue reports on the enforcement of the international human rights of the people in the mental health systems of each country.³⁵

MDRI's first project was to evaluate the protection afforded to people with mental disabilities in Uruguay.³⁶ The "Instituto de Estudios Legales y Sociales del Uruguay" [Uruguayan Institute for Legal and Social Studies] (IELSUR), a Montevideo based human rights organization, contacted MDRI to request the evaluation.³⁷ IELSUR is presently working on a proposal to bring Uruguay's mental health law to a level consistent with U.N. standards.³⁸ MDRI will assist IELSUR advocates in using the report's findings to press the Uruguayan authorities for

30. MDRI Mission Statement. For inquiries, contact Eric Rosenthal, Director of MDRI, Washington College of Law, American University, 4400 Massachusetts Avenue N.W., Washington, D.C., 20016-8084; Tel.: (202) 885-1068.

31. *Id.*

32. *Id.*

33. Telephone Interview with Eric Rosenthal, Director of MDRI (Mar. 21, 1994).

34. *Id.*

35. *Id.* A preliminary report on the Uruguay visit is available through MDRI. It is entitled *Human Rights and Mental Health: Uruguay*, Mental Disability Rights International Preliminary Report, (Aug. 8, 1994) [hereinafter MDRI Preliminary Report]. The report is currently under review by the Ministry of Health of Uruguay. Once Uruguay has prepared its comments, MDRI will release the report in full. MDRI's final report can be obtained from Eric Rosenthal, Director of MDRI. See *supra* note 30.

36. Telephone Interview with Eric Rosenthal, Director of MDRI (Oct. 14, 1993).

37. IELSUR arranged for the MDRI group to visit Uruguay and inspect mental health facilities. *Id.*

38. Instituto de Estudios Legales y Sociales del Uruguay (IELSUR), Plaza Independencia 1376, ap. 8, 11100 Montevideo, Uruguay; Tel.: (598)-2-987803. Since 1986, IELSUR has been working on a project they call "Derechos Humanos y Salud Mental" [Human Rights and Mental Health]. Letter from Dr. Francisco José Ottonelli, Executive Director, IELSUR, to Eric Rosenthal, Director, MDRI (Mar. 2, 1993) (on file with MDRI).

reform.³⁹ As an international organization, MDRI can effectively support the domestic reform movement by providing international scrutiny.⁴⁰

In view of MDRI's visit and IELSUR's involvement, it is especially timely to compare existing Uruguayan laws on mental health with the MI Principles. Specifically, this article will focus on the principles that protect a patient's fundamental right to freedom. Although all rights protected under the MI Principles are extremely important,⁴¹ most of them are triggered only after some state authority determines that a patient may be deprived of his liberty. Therefore, it is crucial to analyze how and when this liberty may be taken away.

Accordingly, this article will focus on the Uruguayan laws and MI Principles that set forth (1) the involuntarily commitment standard,⁴² (2) the involuntary commitment process,⁴³ and (3) the use of seclusion and restraint in the treatment of mental patients.⁴⁴ Thereafter, it will briefly examine the enforcement of the relevant Uruguayan provisions in light of MDRI's preliminary findings. This comparison will show that the Uruguayan standards are too subjective and, therefore, fail to protect a patient's fundamental rights. Adoption of the MI Principles will allow Uruguay to fulfil its international obligation under the U.N. Charter.⁴⁵ Adoption will also be consistent with Uruguay's constitution⁴⁶ by recognizing and protecting the fundamental rights embodied in these Principles.

39. See Telephone Interview with Eric Rosenthal, *supra* note 33. IELSUR organized a conference in Montevideo, on August 18 and 19, 1994, at which MDRI released a summary of its findings to government representatives, service providers, and advocates from Uruguay and Argentina. MDRI is incorporating the feedback it received at the conference into its final report.

40. See Rosenthal and Rubenstein, *supra* note 6, at 286; see also Christina Cerna, *supra* note 17.

41. For the areas in which the MI Principles recognize and protect patients' rights, see the list of MI Principle headings, *supra* note 23.

42. MI Principles 4 and 16, *supra* note 6.

43. MI Principles 16, 17 and 18, *id.*

44. MI Principles 9 and 11, *id.*

45. Uruguay ratified the U.N. Charter on December 18, 1945. 145 BRIT. & FOREIGN ST. PAPERS 805, at 832. Accordingly, Uruguay has a duty to implement U.N. standards protecting basic human rights. U.N. CHARTER arts. 2, 55 and 56.

46. The Uruguayan Constitution provides that no person can be deprived of the right to life, honor, liberty, safety, employment and property without accord to the laws established for the general welfare. URU. CONST. art. 7.

II. INVOLUNTARY COMMITMENT STANDARD

Involuntary commitment is a process by which individuals suspected of mental illness are committed to a mental health facility against their will and with state approval. Both the United Nations and Uruguay, through their respective provisions on this subject, have an involuntary commitment standard specifying the elements required before depriving a mental patient of his freedom. Defining the applicable standard is the first step in the involuntary commitment process.

The standard under the MI Principles is strict; the patient must either pose a threat of harm to himself or others, or must require admission to prevent a serious deterioration of his condition.⁴⁷ Conversely, the standard under Uruguayan law is extremely flexible: a patient may be involuntarily committed upon certification of mental illness by two physicians, and the consent of a relative and the director of the admitting facility.⁴⁸ There are varying degrees and types of mental illness, however, Uruguayan law does not distinguish between these. Therefore a patient can be committed for the mildest of mental ailments free of objective criteria.⁴⁹ The Uruguayan standard lends itself to subjective manipulation, does not provide appropriate safeguards, and fails to comply with the U.N. standard.

A. *United Nations Provisions*

1. MI Principle 16 - Involuntary Admission

MI Principle 16 provides the international standard for involuntary commitment of a mental patient⁵⁰ as follows:

47. See *infra* part II.A.

48. See *infra* part II.B.

49. As noted above, the MI Principles require a showing of danger to the patient's self or to others, or a showing that commitment is the only way to prevent serious deterioration of the patient's condition. This provides objective criteria and significantly limits the class of patients who can be involuntarily committed.

Under Uruguayan law, the standard is so flexible that it raises concerns for potential abuse on non-medical grounds. See *infra* part II.B.

50. "Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility." See MI Principles, *supra* note 6, at "Definitions."

A person may be admitted involuntarily to a mental health facility⁵¹ . . . , if, and only if, a qualified mental health practitioner⁵² authorized by law for that purpose determines, in accordance with principle 4⁵³ . . . , that that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgment 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 . . . ⁵⁴

This principle distinguishes between involuntary commitment of dangerous and non-dangerous patients. Although there are no specific labels, one situation deals with the threat of harm to the patient or others (i.e. dangerous patients), and the other with the need for treatment (i.e. non-dangerous patients).

In the case of a dangerous patient there must be "a serious likelihood of . . . imminent harm" to the patient or others due to that illness.⁵⁵ Although there is no definition of "serious likelihood" or "imminent harm" within the principles, the plain meaning of these terms prohibits arbitrary and unnecessary civil commitment that would violate an individual's fundamental right to freedom.⁵⁶

51. "Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care." *Id.*

52. "Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care." *Id.*

53. MI Principle 4 imposes certain conditions on the process of determination of mental illness. See *infra* part II.A.2.

54. MI Principle 16(1), *supra* note 6. This article's analysis of subsection (b) concentrates on the "serious deterioration" requirement. It appears to this author that not giving a mental patient "appropriate treatment that can only be given by admission to a mental health facility" generally leads to a serious deterioration of his or her condition.

55. MI Principle 16(1)(a), *id.*

56. "All human beings are born free and equal in dignity and rights." Universal Declaration of Human Rights, *supra* note 19, art. 1; "Everyone has the right to life, liberty and the security of person." *Id.* art. 3.

The involuntary admission of a mental patient does not always require a showing of dangerousness.⁵⁷ However, this alternative is limited to situations where the mental illness is severe,⁵⁸ judgment is impaired,⁵⁹ and failure to commit is likely to lead to a "serious deterioration" of the patient's mental condition.⁶⁰ It is sufficient that such admission be necessary for treatment "in accordance with the principle of the least restrictive alternative."⁶¹ In this situation, an independent practitioner should be consulted for a second opinion "where possible,"⁶² and "the involuntary admission . . . may not take place unless the second mental health practitioner concurs."⁶³

2. MI Principle 4 - Determination of Mental Illness

MI Principle 4 addresses the determination of mental illness in practice and supplements the involuntary commitment standard of MI Principle 16. MI Principle 4 does not define the legal standard of mental illness necessary for involuntary commitment. Rather, its concern is to prevent the misuse of involuntary commitment for non-medical reasons.⁶⁴

MI Principle 4 further constrains those involved in the involuntary commitment process from using subjective criteria by requiring that a determination of mental illness: (1) be made according to internationally accepted medical standards;⁶⁵ (2) not consider the patient's political, economic, or social status;⁶⁶ (3) not consider the patient's moral or political values, or reli-

57. MI Principle 16(1)(b), *supra* note 6.

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.* However, the principles do not provide guidelines nor specify any standards for defining "where possible."

63. *Id.*

64. In reiterating "the urgent need for principles and guarantees to prevent the misuse of psychiatry and to safeguard the rights of all individuals," the Human Rights Commission reaffirmed "its conviction that the misuse of psychiatry to detain persons in mental institutions on account of their political views or on other non-medical grounds . . . is a violation of their human rights." E.S.C. Res. 1989/40, *supra* note 13.

65. MI Principle 4(1), *supra* note 6. It is unclear from the Principles what exactly is meant by "internationally accepted medical standards."

66. MI Principle 4(2), *id.*

gious beliefs;⁶⁷ and (4) not rely solely on a history of past mental treatment or hospitalization.⁶⁸ However, there is no specific provision in the MI Principles defining who has standing to request the involuntary commitment of a patient.

B. Uruguayan Provisions

Uruguayan mental health law refers to assistance to "psychopaths."⁶⁹ Within the text of the laws there is consistent use of the words "psychological patient,"⁷⁰ "mental patient,"⁷¹ and "psychological illness."⁷² Therefore, the use of "mental," "psychological," and "psychopath" alternatively within the text of the laws suggests that they are meant to cover all cases of involuntary commitment, and not only those involving patients classified as "psychopaths."⁷³

There are three ways by which a person may be involuntarily committed in Uruguay:⁷⁴ (1) medical commitment,⁷⁵ (2) police commitment,⁷⁶ and (3) judicial commitment.⁷⁷ The provisions defining the three types of commitment apply to state and private hospitals.⁷⁸ Any person who has reached the age of legal majority has standing to request the involuntary commit-

67. MI Principle 4(3), *id.*

68. MI Principle 4(4), *id.*

69. "Asistencia a Psicópatas," Uru. Law 9.581, Aug. 8, 1936; "Patronato del Psicópata," Uru. Law 11.139, Nov. 9, 1948.

70. "[E]nfermo psíquico": Uru. Law 9.581, Aug. 8, 1936, ch. 1, arts. 1, 2; ch. 2, art. 10; ch. 4, arts. 13, 14, 15, 19, 23, 24, 26; ch. 5, arts. 32, 36.

71. "[E]nfermo mental": *Id.* ch. 1, art. 3; ch. 4, arts. 21, 22, 26, 27; ch. 5, art. 29.

72. "[E]nfermedad psíquica": *Id.* ch. 4, arts. 15, 16, 20.

73. In the United States, for instance, the terms "psychopath" and "sociopath" are lay terms that do not connote an official diagnosis. Rather, the clinical diagnosis that is closer in meaning to these two words is the "antisocial personality disorder." See DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV), at 645 (1994).

74. Involuntary commitment is also possible when a voluntary patient becomes so ill that he can no longer exercise his free will or becomes dangerous to himself or others. However, all requirements of the medical commitment procedure must be complied with, and the Inspector General of Psychopaths must be notified of such involuntary status within twenty-four hours. Uru. Law 9.581, *supra* note 69, ch. 4, art. 16.

75. *Id.* art. 13.

76. *Id.*

77. *Id.*

78. *Id.* ch. 1, art. 3.

ment of a mental patient to a psychiatric facility.⁷⁹

1. Medical Commitment

"Medical" commitment is simply another term for involuntary commitment.⁸⁰ The law specifically states that involuntary medical commitment is not punishment for criminal behavior.⁸¹ Further, it must comply with the following requirements: (a) a certificate of admission from the admitting physician;⁸² (b) a declaration signed by the patient's closest relative or legal representative setting forth his agreement and requesting admission directly to the medical director of the facility;⁸³ and, (c) a certificate of mental illness issued by two doctors, who must be independent from the patient and the admitting psychiatric facility.⁸⁴

The certificate of admission must contain the prior history of the patient, the symptomatology, and the results of the examination.⁸⁵ A clinical diagnosis is not necessary.⁸⁶

The declaration signed by the patient's closest relative or his legal representative must also set forth prior admissions to psychiatric facilities, hospitals, or private asylums.⁸⁷ The patient must be admitted within ten days of issuance of the certificate of mental illness.⁸⁸

The standard in the Uruguayan medical commitment proce-

79. *Id.* ch. 4, art. 24. A malicious request will be punished with fines or imprisonment. Specifically, imprisonment may be for one to nine years. CÓDIGO PENAL [CÓD. PEN.], tit. 11, ch. 1, art. 281 (Uru).

80. "La admisión por indicación médica, o sea involuntaria, de un enfermo psíquico, . . ." [Admission by medical recommendation, in other words involuntary, of a psychological patient, . . .]. Uru. Law 9.581, *supra* note 69, ch. 4, art. 15.

81. ". . . [S]ólo podrá ser un medio de tratamiento y nunca de privación correccional de la libertad . . ." [. . . it can only be a means of treatment and never of correctional deprivation of liberty . . .]. *Id.*

82. *Id.*

83. *Id.*

84. *Id.* It is noteworthy that the law prohibits issuance of a certificate of mental illness by a relative of: (1) the person seeking admission, (2) any of the doctors at the admitting facility, or (3) the owner or administrator of the facility, up to the fourth degree of consanguinity and second degree of affinity. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

cedure does not comply with the standard in MI Principle 16. It lacks both alternative safeguards: (1) that the patient pose a threat of harm to himself or others;⁸⁹ or (2) that the mental illness be severe and likely to lead to serious deterioration if there is no admission. Further, there is no requirement that the admission be made "in accordance with the principle of the least restrictive alternative."⁹⁰ The extent of protection afforded by Uruguayan law is that it requires one certification of mental illness and a finding of mental illness in the certificate of admission.⁹¹ This means that a patient may have a minor psychological affliction, be totally harmless to himself or others, and yet be properly committed pursuant to the Uruguayan medical commitment procedure.

Objective criteria, such as a showing of dangerousness or significant deterioration of the patient's condition, are necessary to prevent potential misuse of this procedure. Moreover, these objective criteria provide only basic protection, since the very nature of psychiatric diagnosis calls for an inescapable degree of subjective interpretation.

2. Emergency Police Commitment

Emergency police commitment is another gateway for the medical commitment procedure.⁹² The law authorizes this type of commitment only where the mental illness is such that it endangers the "public order."⁹³ This type of commitment is limited to a twenty-four hour observation period.⁹⁴

The law provides two standards for emergency police commitment: (1) a doctor's opinion that the patient is "dangerous to himself or others;"⁹⁵ or, (2) that as a consequence of the mental

89. MI Principle 16(1)(a), *supra* note 6.

90. MI Principle 16(1)(b), *id.*

91. Uru. Law 9,581, *supra* note 69, ch. 4, art. 15.

92. *Id.* art. 20.

93. *Id.*

94. *Id.*

95. *Id.* A separate provision for the emergency commitment of indigent mental patients allows for a speedy admission in case of dangerousness. *Id.* art. 21. It is noteworthy that the law contains a separate provision for indigents; however, discussion of the socio-economic dynamics behind this distinction is beyond the scope of this article. For comments and discussion of the situation of indigent mental patients, see Sylvia Cousin, *El Exilio de los Enfermos Mentales Pobres*, Revista

illness, there is "imminent danger"⁹⁶ to the peace, public morals, security or property."⁹⁷ Both of these alternative standards are subject to the requirements of medical commitment if the observation period is to last more than one day.⁹⁸

The emergency police commitment is somewhat similar to the threat-of-harm standard in MI Principle 16. However, it fails to comply with the MI Principle by permitting the temporary waiver of a formal determination of mental illness.⁹⁹ Even when a physician opines that the patient is "dangerous to himself or others," emergency police commitment resembles an arrest for disorderly conduct more than it resembles proper commitment of a mental patient.

3. Judicial Commitment Upon Determination of Incompetence

The patient's relatives and the Public Ministry may request a judicial determination of incompetence due to mental illness.¹⁰⁰ The Public Ministry is always a party to such proceedings,¹⁰¹ and the court may not enter a finding of incompetence without first hearing the Public Ministry's position in the matter.¹⁰² The judge must personally question the person who is allegedly mentally incompetent and must obtain the diagnosis of two or more mental health practitioners of the court's choosing.¹⁰³ Further, if the judge deems it appropriate, he may appoint a temporary legal guardian of the person and property

IELSUR, No. 1 (1987), at 44.

96. The law does not give a definition of imminent danger. However, the plain meaning of the words suggests danger that will most certainly occur if the police do not detain the potential patient immediately.

97. Uru. Law 9.581, *supra* note 69, ch. 4, art. 20.

98. *Id.*

99. *Id.*

100. "Podrán provocar la declaración de incapacidad y nombramiento de curador al incapaz, cualquiera de sus parientes y el Ministerio Público" [Any of the patient's relatives and the Public Ministry may obtain the declaration of incompetence and the appointment of a guardian]. CÓDIGO CIVIL [CÓD. CIV.] tit. 11, ch. 1, art. 433 (Uru.).

101. "En estos procesos, desde su iniciación, intervendrá necesariamente el Ministerio Público" [The Public Ministry will necessarily intervene in these proceedings from the beginning]. CÓDIGO GENERAL DEL PROCESO, Law 15.982, bk. 2, tit. 6, ch. 3, art. 445.3 (Uru.).

102. *Id.* art. 447.3.

103. CÓD. CIV., tit. 11, ch. 1, art. 435 (Uru.).

of the alleged mental incompetent.¹⁰⁴

The standard for judicial commitment is that there must be a medical evaluation and report.¹⁰⁵ The report must contain detailed information about the results of any prior psychiatric reports and their effects in the application of the law.¹⁰⁶ In addition, the medical report must specifically set forth the following:

- (1) diagnosis of the illness;¹⁰⁷ (2) prognosis of the illness;¹⁰⁸
- (3) characteristic manifestations of the alleged incompetent's present condition;¹⁰⁹ (4) consequences of these manifestations on the alleged incompetent's social behavior and on the administration of his property;¹¹⁰ and (5) adequate course of treatment to ensure the alleged incompetent's best possible condition in the future.¹¹¹

In cases of emergency, the judicial authority may waive the medical evaluation and report requirement.¹¹² However, the law does not specify whether this waiver is temporary or permanent.

The judicial commitment procedure addresses important issues. Initially, there is concern that a diagnosis be made¹¹³

104. *Id.* art. 436.

105. Uru. Law 9.581, *supra* note 69, ch. 4, art. 23. As previously noted, this requirement is also present in the medical commitment context. *Id.* art. 15.

106. The language in Law 9.581 is not entirely clear: "Cuando se trate de enfermos psíquicos ingresados por orden judicial, deberá igualmente acreditarse su envío, mediante un informe médico ordenado por la autoridad que dispone su ingreso, en el cual se indique con detalle preciso, los resultados del informe psiquiátrico a que han sido sometidos con anterioridad por uno o diversos médicos, a los efectos de las disposiciones judiciales aplicadas" [In cases dealing with mental patients admitted by judicial order, their admission should likewise be accredited, through a medical report ordered by the authority mandating the admission, which should indicate with precise detail, the results of the psychiatric report that have been previously submitted by one or more physicians, for the purposes of the applied judicial dispositions]. *Id.* art. 23. ("Judicial dispositions" are equivalent to judicial rulings in common law countries).

107. Uru. Law 15.982, *supra* note 101, art. 441.

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. Uru. Law 9.581, *supra* note 69, ch. 4, art. 23.

113. Uru. Law 15.982, *supra* note 101, art. 441.

and the best course of treatment defined¹¹⁴ for the alleged mental incompetent. There is also concern with the alleged incompetent person's safety¹¹⁵ and the safety and comfort of others.¹¹⁶ Finally, there is the underlying concern with the administration of the alleged incompetent's property.¹¹⁷ In this respect, some court decisions have required a clear and convincing showing of mental incompetence before ruling that a patient be deprived of his constitutional right¹¹⁸ to liberty and property.¹¹⁹ However, judicial commitment fails to comply with MI Principle 16 in that it does not require the need for treatment "in accordance with the principle of the least restrictive alternative," nor a showing of dangerousness as alternative prerequisites to commitment. In effect, judicial commitment leans toward a more flexible standard by allowing for a judicial waiver of the medical evaluation and report requirement, which does not exist under the MI Principles.

The Uruguayan medical commitment, emergency police commitment, and judicial commitment also fail to comply with MI Principle 4. Uruguayan law does not define the role of the

114. *Id.*

115. The court will take the necessary steps to ensure the alleged incompetent's personal protection. *Id.* art. 442. The alleged incompetent will not be deprived of his personal liberty except in cases where he might hurt himself . . . Cód. Crv., tit. 11, ch. 1, art. 447 (Uru).

116. The alleged incompetent will not be deprived of his personal liberty except in cases where he might . . . cause danger or notable discomfort to others. *Id.*

117. A guardian is appointed to someone who cannot look after himself nor his business. *Id.* art. 431. The court may, at its discretion, appoint a guardian of the property of the alleged incompetent. *Id.* art. 436. Income from the incompetent's property shall be spent on rehabilitative treatment. *Id.* art. 448.

118. "Los habitantes de la República tienen derecho a ser protegidos en el goce de su vida, honor, libertad, seguridad, trabajo y propiedad." [The inhabitants of the republic have a right to be protected in the enjoyment of their life, honor, liberty, security, employment, and property]. URU. CONST. art. 7.

119. See 1989-XX Jurisprudencia Sistematizada [hereinafter J.S.], Incapacidad: Configuración de la Incapacidad, Case Summary No. 382 (holding that the fact that the alleged incompetent was 63 years old, a widow, and with very little education, did not substantiate allegations that she presented a chronic psychotic condition, requiring her to be declared incompetent to manage her income); 1988-XIX J.S., Incapacidad: Causa para la declaración de incapacidad, Case Summary No. 380 (holding that mental illness that does not affect the person's ability to handle himself or his estate, is insufficient to declare the person incompetent); see generally, 1986-XVII J.S., Incapacidad, Case Summary No. 451 (holding that instituting an action to declare a person incompetent does not carry with it the presumption that the person is, in fact, incompetent).

patient's political, economic, or social status,¹²⁰ nor his moral, political, or religious values¹²¹ in the determination of mental illness. These practical deterrents are very important in preventing subjective manipulation of the commitment procedure. The potential for abuse of the existing Uruguayan standard underscores the importance of adopting the MI Principles, which provide objective criteria and specific protection against commitment on non-medical grounds.

III. INVOLUNTARY COMMITMENT PROCESS

The involuntary commitment process involves the application of the involuntary commitment standard. Ideally, it outlines the necessary steps to safeguard a patient's right to due process. The MI Principles afford significant protection to this fundamental right. They specify the patient's right to prompt review by a review body independent of the committing body, to appointment of counsel, to attendance at any hearing, and to copies of all documents.¹²² Uruguayan law provides for different review bodies and for certain review procedures.¹²³ However, these procedures are entirely discretionary and do not include the safeguards required by the MI Principles.

A. *United Nations Provisions*

1. MI Principle 16 - Involuntary Admission

The involuntary commitment process is initially set out by MI Principle 16 as follows:

Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment *pending review of the admission or retention by the review body*.¹²⁴

This provision refers to a review of all involuntary commit-

120. MI Principle 4(2), *supra* note 6.

121. MI Principle 4(3), *supra* note 6.

122. *See infra* part III.A.

123. *See infra* part III.B.

124. MI Principle 16(2), *supra* note 6 (emphasis added).

ments as a matter of course. This is consistent with the International Covenant on Civil and Political Rights' provision that "anyone who is deprived of his liberty . . . shall be entitled to take proceedings before a court" ¹²⁵

MI Principle 16 further provides that:

The grounds for the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body ¹²⁶

Although there is no definition of "without delay" or "promptly," the plain meaning of these words transmits a sense of urgency and immediacy. The review body must be notified as soon as possible so that a hearing is not delayed unnecessarily.

2. MI Principle 17 - Review Body

MI Principle 17 provides for a review body ¹²⁷ which "shall be a judicial or other . . . impartial body established by domestic law." ¹²⁸ Further, it shall perform its review functions with the aid of one or more mental health practitioners. ¹²⁹ The review body shall review cases of involuntary commitment *as soon as possible after admission*, ¹³⁰ and *periodically thereafter*. ¹³¹ Every patient admitted involuntarily may apply to the review body for release or change to voluntary status, at regular intervals as specified by domestic law. ¹³²

125. International Covenant on Civil and Political Rights, *adopted* Dec. 19, 1966, art. 9, § 4, 999 U.N.T.S. 171.

126. MI Principle 16(2), *supra* note 6.

127. "The review body' means the body established in accordance with principle 17 to review the involuntary admission or retention of a patient in a mental health facility." See MI Principles, *supra* note 6, at "Definitions."

128. MI Principle 17(1), *id.*

129. *Id.*

130. MI Principle 17(2), *id.*

131. MI Principle 17(3), *id.* (emphasis added).

132. MI Principle 17(4), *id.*

3. MI Principle 18 - Procedural Safeguards

To ensure proper procedure, the patient is "entitled to choose and appoint a counsel to represent the patient as such."¹³³ If the patient lacks financial means, counsel shall be made available at no cost.¹³⁴ The patient has a right to receive copies of his records,¹³⁵ and may present at any hearing an independent mental health report and any other relevant evidence.¹³⁶ The patient has the right to "attend, participate and be heard personally in any hearing."¹³⁷ The review body must express the decision resulting from the hearing and the reasons for such decision in writing,¹³⁸ and it must give a copy to the patient and to the patient's counsel.¹³⁹

MI Principle 18 does not address the practical implications of instituting these safeguards. For instance, it does not describe what the hearing process must be like, nor does it specify who is to bear the cost of legal representation or the cost of reproducing documents in cases of indigent patients (i.e. the State or a relative). This is probably due to the differences among countries and their legal systems; a procedure that will work well in one country may be impractical in another. However, MI Principle 23 specifically directs States to "implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically."¹⁴⁰

Moreover, the MI Principles establishing the review body and procedural safeguards refer to procedures in accordance with "domestic law."¹⁴¹ Accordingly, it is up to the individual States to determine the best course of action regarding implementation as they incorporate the MI Principles into their domestic law.

133. MI Principle 18(1), *id.*

134. *Id.*

135. MI Principle 18(4), *id.*

136. MI Principle 18(3), *id.*

137. MI Principle 18(5), *id.*

138. MI Principle 18(8), *id.*

139. *Id.*

140. MI Principle 23(1), *id.*

141. MI Principle 17(1), (2), and (3); and MI Principle 18(4), *id.*

B. Uruguayan Provisions

Uruguayan law designates three review bodies to monitor the involuntary commitment of mental patients: (1) Inspector General of Psychopaths (IGP),¹⁴² (2) Honorary Consulting Commission on the Assistance to Psychopaths (HCCAP),¹⁴³ and (3) judicial courts.¹⁴⁴

1. Office of the Inspector General of Psychopaths (IGP)

The IGP's office supervises the assistance given to mental patients in private and public facilities.¹⁴⁵ The IGP's duties include creating a general registry of all mental patients in the country,¹⁴⁶ visiting and inspecting private and public mental health facilities at least every three months and at any time he deems proper,¹⁴⁷ sending warnings and proposing sanctions against the directors of facilities who violate the mental health laws pursuant to the resolutions of the HCCAP,¹⁴⁸ and notifying the judicial courts of any cases of improper involuntary commitment.¹⁴⁹ In addition, the law requires that the IGP be notified of any medical or emergency commitment within twenty-four hours of admission.¹⁵⁰ The physician-director of the facility must forward a summary of all documents required for the medical commitment of a patient as well as the reasons for admission within three days of the date of admission.¹⁵¹ In the case of an emergency admission, the physician-director of the admitting facility must include a certificate setting forth the reasons for emergency status.¹⁵²

142. "Inspector General de Psicópatas." Uru. Law 9.581, *supra* note 69, ch. 6, art. 38. Note the IGP office was vacant from the early 1970's to October 1993. See *infra* text accompanying note 223.

143. "Comisión Honoraria Asesora de la Asistencia a Psicópatas." Uru. Law 9.581, *supra* note 69, ch. 7, art. 42.

144. *Id.* ch. 6, art. 41.

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.* ch. 4, arts. 15, 17.

151. *Id.* art. 17.

152. *Id.*

The IGP may, at its discretion and without prior notice, visit the inpatient facilities to confirm all information given on any involuntary patient in the investigation of any allegations of improper admission.¹⁵³

2. Honorary Consulting Commission on the Assistance of Psychopaths (HCCAP)

The HCCAP is made up of the following members: the IGP as consulting member,¹⁵⁴ a representative of the Psychiatric Society,¹⁵⁵ a Professor of Legal Medicine from the Faculty of Laws,¹⁵⁶ a Professor of Psychiatry from the Faculty of Medicine,¹⁵⁷ the consulting attorney on mental health legislation from the Ministry of Public Health,¹⁵⁸ and the State Attorney.¹⁵⁹

The duties of the HCCAP include: (1) proposing sanctions against physicians or directors of facilities who fail to comply with the Law of Assistance to Psychopaths;¹⁶⁰ (2) hearing all allegations of non-compliance reported by the IGP;¹⁶¹ (3) hearing all cases where the legal representative, guardian or relatives of a patient arrange for his discharge and there are different criteria with respect to the discharge;¹⁶² (4) giving opinions about all matters presented to it for review by the Ministry of Public Health and the IGP;¹⁶³ and, (5) formulating new projects to better assist psychopaths.¹⁶⁴

3. Judicial Courts

Upon notification by the IGP, the judicial court having legal jurisdiction over the facility may address allegations of any im-

153. *Id.* art. 18.

154. "[M]iembro asesor," *id.*, ch. 7, art. 43.

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*, ch. 6, art. 41(E).

161. *Id.*, ch. 7, art. 44(A).

162. *Id.*, art. 44(B).

163. *Id.*, art. 44(C).

164. *Id.*, art. 44(D).

proper involuntary admission.¹⁶⁵ Thereupon, the court will determine each party's responsibility and impose appropriate sanctions designated by the Penal Code.¹⁶⁶

The IGP, HCCAP, and the judicial courts as review bodies fail to meet the requirements of MI Principles 16, 17, and 18, because the law does not require that they review each admission as a matter of course. Although the IGP must be notified of all involuntary admissions, it is within his discretion to review the circumstances in any given case. If he does determine that there was an improper commitment, he may report the case to the HCCAP or to the judicial courts. Moreover, the legal provisions defining the role of the IGP, the HCCAP and the judicial courts do not provide the minimally acceptable rights of patients under current U.N. standards, such as the right to appointment of counsel¹⁶⁷ and the right to be present at any hearing.¹⁶⁸

The creation of a general registry of all mental patients in the country is a crucial starting point, since it lists the cases to be reviewed. However, review hearings need to be a mandatory part of the involuntary commitment process, along with acknowledgement of the rights of patients at such hearings. This will protect the patients' right to due process and will enable the review bodies to detect improper admissions at their inception.

IV. SECLUSION AND RESTRAINT

Once a patient has been involuntarily committed, the use of seclusion and restraint is yet another way to deprive him of the most basic form of freedom: corporal mobility. The MI Principles provide strict limitations on the use of seclusion and restraint.¹⁶⁹ The patient must pose a threat of immediate or imminent harm to himself or others,¹⁷⁰ the procedures must be officially approved by each facility,¹⁷¹ the staff must notify the

165. *Id.*, ch. 4, art. 18.

166. *Id.*, ch. 4, art. 18. The Penal Code provides that "Whosoever shall, in any manner, deprive another of his personal freedom, will be punished with one to nine years of imprisonment (emphasis added)." C  D. PEN., tit. 11, ch. 1, art 281 (Uru.).

167. MI Principle 18(1), *supra* note 6.

168. MI Principle 18(5), *id.*

169. See *infra* part IV.A.

170. MI Principle 11(11), *supra* note 6.

171. *Id.*

patient's personal representative,¹⁷² and qualified staff must provide regular supervision.¹⁷³ By contrast, Uruguayan law has a broad standard. This standard allows the use of seclusion and restraint when "necessary for treatment" or in "exceptional circumstances."¹⁷⁴ Accordingly, Uruguay needs more specific limitations to comply with the MI Principles.

A. United Nations Provisions

1. MI Principle 11 - Consent to Treatment

Under MI Principle 11, physical restraint or involuntary seclusion of a patient may only be used when it is necessary to prevent "immediate or imminent harm to the patient or others,"¹⁷⁵ and must be implemented in accordance with the "officially approved procedures" of the facility.¹⁷⁶ The MI Principles do not offer specific standards to guide facilities in setting out these procedures, nor do they define "officially approved." However, they provide a general framework within which to operate. This framework observes the patient's right "to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others."¹⁷⁷

172. *Id.*

173. *Id.*

174. *See infra* part IV.B.

175. MI Principle 11(11), *supra* note 6.

176. *Id.*

177. MI Principle 9(1), *id.* The remaining provisions of MI Principle 9 are as follows:

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Id.

Further, the use of seclusion and restraint must be documented in the patient's medical record¹⁷⁸ and a personal representative must be given prompt notice of the use of such procedures.¹⁷⁹ Finally, a patient in seclusion and restraint is entitled to humane living conditions¹⁸⁰ and regular supervision by qualified staff members.¹⁸¹

B. Uruguayan Provisions

Uruguayan law contains two separate provisions that address the issue of seclusion and restraint.¹⁸² They are both substantially similar in terms of content; however, one regulates private residences¹⁸³ and the other regulates mental health facilities.¹⁸⁴

1. Regulations in Private Residences

"[I]mposition of measures [that are] restrictive of [the patient's] liberty" in a private residence is only allowed when necessary for treatment¹⁸⁵ or due to the patient's anti-social reactions.¹⁸⁶ However, the law does not provide a definition of "anti-social reactions." In these cases, the physician must notify the IGP of the use of these measures within twenty-four hours.¹⁸⁷ The IGP may visit the residence to document the patient's condition at any time.¹⁸⁸ The physician must provide

178. MI Principle 11(11), *id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. Uru. Law 9.581, *supra* note 69, ch. 3, art. 11, and "Establecimientos Psiquiátricos: Se Establecen Condiciones Para los Particulares," Presidential Decree of Apr. 29, 1939.

183. Uru. Law 9.581, *supra* note 69, ch. 3, art. 11.

184. Presidential Decree of Apr. 29, 1939, *supra* note 182.

185. This "necessary for treatment" standard gives excessive deference to the physician's professional judgment.

186. Uru. Law 9.581, *supra* note 69, ch. 3, art. 11. "[L]a imposición de medidas restrictivas de la libertad, exigidas por la necesidad del tratamiento o por sus reacciones antisociales . . ." [The imposition of measures restrictive of liberty, demanded by the need for treatment or by his antisocial reactions].

187. *Id.*

188. *Id.*, ch. 6, art. 41(C). The IGP has the power to issue warnings and propose sanctions against violators of these provisions. *Id.*, art. 41(E).

a certificate setting forth the patient's symptomatology¹⁸⁹ and the results of the physical and psychological examination.¹⁹⁰ He need not establish a clinical diagnosis.¹⁹¹ The physician must inform the IGP once every two months of the patient's progress,¹⁹² and must immediately notify the IGP upon the patient's recovery or death.¹⁹³

2. Regulations in Mental Health Facilities

The Presidential Decree of April 29, 1939 establishes the conditions for the use of restraints in all psychiatric facilities in Uruguay.¹⁹⁴ This decree contains an express prohibition against the use of "mechanical restraint devices"¹⁹⁵ in the regular treatment of institutionalized mental patients.¹⁹⁶ However, psychiatrists may authorize the use of these devices in "exceptional" cases.¹⁹⁷ Although there is no definition of "exceptional," this provision should be read in context¹⁹⁸ with the requirements set forth in the regulations for private residences,¹⁹⁹ since both provisions regulate the use of seclusion and restraint.

Uruguayan regulations on the use of measures restrictive of a patient's liberty stand in violation of MI Principle 11. Uruguayan law allows the use of these measures when "necessary for treatment,"²⁰⁰ or when warranted due to "exceptional circumstances."²⁰¹ These standards are too vague and have a sig-

189. *Id.*, ch. 3, art. 11.

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. Presidential Decree of Apr. 29, 1939, *supra* note 182.

195. "[M]edios de contención mecánicos," *id.*, art. 4.

196. *Id.*

197. *Id.*

198. The Presidential Decree of Apr. 29, 1939, has the following preamble:

"Atento a que el artículo 7o de la ley número 9.581 de 8 de Agosto de 1936, que organiza la asistencia de psicópatas, establece que el Ministerio de Salud Pública fijará las condiciones que deben reunir los establecimientos particulares." [Inasmuch as article 7 of law number 9.581 of August 8, 1936, which organizes the aid to psychopaths, establishes that the Ministry of Public Health shall set the uniform conditions for the particular facilities.] *Id.* This cross-reference indicates that the decree is complementary to Uru. Law 9.581.

199. See Regulations in Private Residences, *supra* part IV.B.1.

200. Uru. Law 9.581, *supra* note 69.

201. Presidential Decree of Apr. 29, 1939, *supra* note 182, art. 4.

nificant potential for subjective manipulation. Conversely, the MI Principles allow the use of restrictive measures only when necessary to prevent *immediate* or *imminent* harm to the patient or others.²⁰² Uruguay's adoption of this harm requirement will significantly limit the use of these measures and help prevent their misuse for non-medical purposes.

V. MENTAL DISABILITY RIGHTS INTERNATIONAL PRELIMINARY FINDINGS

In November 1993, the MDRI Review Team²⁰³ arrived in Montevideo, Uruguay, to begin its survey of conditions and practices in the Uruguayan Mental Health System.²⁰⁴ Uruguay's total population is approximately three million.²⁰⁵ Of these three million, there are approximately 2,000 inpatients housed by the public mental health system.²⁰⁶ Public inpatient beds are distributed among two big "Colonias" located ninety kilometers outside of Montevideo,²⁰⁷ and two psychiatric hospitals in Montevideo.²⁰⁸ Colonia Santin Carlos Rossi and Colonia Etchepare house a total population of approximately 1,300 patients.²⁰⁹ Musto and Vilardebo Hospitals house a total population of approximately 650 patients.²¹⁰ Over a two week period, MDRI visited all four public facilities, as well as one private psychiatric hospital, one institution for males with mental retardation, and two community mental health facilities.²¹¹ MDRI team members spoke to hospital administrators, clinicians, government agency directors, attorneys, and the patients themselves.²¹²

202. MI Principle 11, *supra* note 6.

203. The MDRI Review Team consisted of Eric Rosenthal, Director, MDRI; Professor Elizabeth Iglesias, University of Miami School of Law; Dr. Humberto Martínez, Executive Director, South Bronx Mental Health Council, Inc.; Leonard S. Rubenstein, Executive Director, Bazelon Center for Mental Health Law; and, Clarence J. Sundram, Chairman, New York State Commission on Quality of Care for the Mentally Disabled. MDRI Preliminary Report, *supra* note 35.

204. Telephone Interview with Eric Rosenthal, *supra* note 33.

205. MDRI Preliminary Report, *supra* note 35, at 9.

206. *Id.* at 16.

207. *Id.* at 13.

208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.* at 1.

212. *Id.* at 1.

A. Involuntary Commitment

Institution authorities reported that the great majority of patients are admitted through medical certification.²¹³ Approximately ten to fifteen percent of patients are admitted by judicial order;²¹⁴ only one to two percent are admitted voluntarily.²¹⁵

The team reported that in practice, there appears to be little or no attention to the mental health law.²¹⁶ Many patients do not have a diagnosis in their chart, nor an explanation of why they were committed in the first place.²¹⁷ Patient records do not contain individualized treatment plans nor any medical notes reflecting physical examination or psychiatric assessment.²¹⁸ Hospital authorities explained that large portions of the inpatient population have no psychiatric diagnosis because they are not mentally ill.²¹⁹ They further reported that between one third and two thirds of the total inpatient population need not be committed but are held because they have nowhere else to go.²²⁰ These people are usually disabled, elderly, socially outcast, or homeless;²²¹ these individuals are known as "social patients."²²²

These findings illustrate precisely what the MI Principles seek to avoid: the use of psychiatry for non-medical purposes. Although the homelessness problem is a legitimate concern, it should not be the exclusive burden of the Uruguayan mental health system. Moreover, housing "social patients" in public mental institutions is detrimental to patients who really need treatment, since it exhausts the resources and quality of care they would otherwise receive. Implementation of the MI Principles will be an important first step in taking this burden away from the mental health system, and in making the local communities cope with the homelessness problem through more appro-

213. *Id.* at 21.

214. *Id.*

215. *Id.*

216. *Id.* at ix.

217. *Id.* at 32.

218. *Id.*

219. *Id.* at vii.

220. *Id.* at 16.

221. *Id.* at 17-18.

222. *Id.* at 16.

priate channels.

B. Review Body

Until recently, the IGP and HCCAP review body safeguards were purely theoretical, since the IGP office was vacant from the early 1970's to October 1993,²²³ and the HCCAP is not presently functioning.²²⁴ The IGP's first major project is to update all information contained in the psychiatric register.²²⁵

Another of the IGP's concerns is to verify that all psychiatric hospitals have telephones available to patients.²²⁶ This will facilitate patient access to the IGP office for complaints or problems. The IGP also "intends to review every psychiatric commitment in the country of more than sixty days."²²⁷ However, as of December 1993, review of commitment practices was limited to a telephone call to the psychiatric facility to verify that the patient was there and to ask about the patient's well-being.²²⁸ "If the director [of the facility] states that the patient is present and still mentally ill, the review is complete."²²⁹

As for the judicial courts, attorneys from the Judicial Information Service reported that the majority of judicial commitments result from a judge's determination that an individual is incompetent to stand trial.²³⁰ These attorneys further reported that despite the requirement of a medical examination, the decision to commit a person is strictly within the judge's discretion.²³¹ These findings underscore the need for objective standards to prevent subjective use of involuntary commitment for non-medical purposes.²³²

223. *Id.* at 23. Interestingly, the IGP office was filled one month before the visit by the MDRI team. *Id.*

224. Interview by Eric Rosenthal, Director of MDRI, with Antonio Aguirre Ariel, Inspector General of Psychopaths, Montevideo, Uruguay (Dec. 6, 1993).

225. MDRI Preliminary Report, *supra* note 35, at 23-24. See also text accompanying note 146.

226. *Id.* at 24.

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.* at 25.

231. *Id.*

232. For instance, one of these non-medical purposes involves the "social patients" phenomenon. See *supra* text accompanying notes 220-222.

C. Seclusion and Restraint

The MDRI team did not find any misuse of seclusion or restraints at the facilities.²³³ This is surprising in light of the generality of the standard previously discussed.²³⁴ However, the MDRI team also reports that they "found no evidence of internal controls for quality assurance regarding psychiatric treatment, . . . and . . . no internal mechanism for accident or incident reporting."²³⁵ The reader should note that in the absence of any incident reports, these findings are limited to the length of time and scope of the MDRI Team's visit.

VI. CONCLUSION

Uruguay enacted laws regulating involuntary commitment and the use of seclusion and restraint long before the United Nations adopted the MI Principles.²³⁶ To its credit, Uruguay anticipated the need for laws in this area. However, these laws are now outdated. The Uruguayan provisions that set forth: (1) the involuntarily commitment standard, (2) the involuntary commitment process, and (3) the use of seclusion and restraint in the treatment of mental patients are too broad and subject to misuse for non-medical purposes. Adoption of the MI Principles will renovate Uruguay's mental health system by providing more objective standards and affording protection consistent with its constitution.²³⁷ Adoption of these principles will also signal Uruguay's compliance with its treaty obligations in the international community.²³⁸

The practical value of the MI Principles will be fully appreciated once they are adopted and implemented. They contain objective legal standards and practical limitations specifically

233. *Id.* at 46.

234. *See supra* part IV.B.

235. *Id.* at 39.

236. Uru. Law 9.581, *supra* note 69, and Presidential Decree of Apr. 29, 1939, *supra* note 182.

237. The Uruguayan Constitution provides that no person can be deprived of the right to life, honor, liberty, safety, employment and property without accord to the laws established for the general welfare. URU. CONST. art. 7.

238. *See* U.N. Charter provisions, *supra* notes 18-21, and accompanying text.

designed to prevent misuse of psychiatry for non-medical purposes. In Uruguay, the importance of adopting these objective standards and practical limitations is highlighted by the "social patient" phenomenon. Moreover, the combined force of domestic and international scrutiny during the implementation process will yield more results than domestic pressure alone.²³⁹ Once Uruguay incorporates these principles into its domestic law, it will, once again, be in the vanguard of novel legal developments, this time by being one of the first countries to implement the MI Principles.

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239. Indeed, this author would argue that there is already evidence of the effectiveness of international pressure in this context. For instance, the IGP office was filled one month before MDRI's visit, following approximately twenty years of vacancy.

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