Islamic Republic of Afghanistan

Ministry of Public Health

MENTAL HEALTH ACT

ARRANGEMENT OF THE BILL

Table of Contents

CHAPTER-1
General Provision

Article 1.

This Regulation in the light of the provisions of Article 10 of the constitution and provisions (1) and (3) of the Public Health of the Islamic Republic of Afghanistan to maintain the dignity of people with mental disorders is order/situation.

Purpose:

Article 2.

1. The purpose of this Bill is to promote, protect and ensure the full and equal enjoyment of human rights and fundamental freedoms by all persons with mental disabilities wherever they are, including persons being evaluated for admission into mental health facilities, and to promote respect for their inherent dignity.

2. Regulate the mental health environment in all public and/or private health and/or mental health and/or social care facilities and/or any other type of facilities where persons with mental disabilities receive or may receive health and/or mental health and/or social care services, and are or may be admitted to, or reside at, or kept in, for evaluation, care, mental health care, convalescence and/or rehabilitation, either temporarily or otherwise,

3. either with their own consent or by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence, including but not limited to Mental Health Hospitals, Public General Hospitals, Private Hospitals, Outpatient Departments, Inpatient Units, Day-care Centres, Emergency Departments, Primary Health Care Units, Private Clinics, Rehabilitation and/or Residential Centres, Half-way Houses, Community Service Facilities, Child Care Centres, Orphanages, Retirement homes, Nursing homes, Shelters for the destitute (Marastoons);

4. Set out the rights of persons with mental disabilities;

5. Regulate access to and the provision of mental health care and treatment services to the population equitably and effectively;

6. Provide for the creation of an Independent Review Mechanism within the Ministry of Public Health and the Provincial Public Health Directorates;

7. Provide for the creation of supported decision-making, facilitated decision-making, advance care planning, and decision-making ability assessments;

8. Create safeguards to protect the rights of persons admitted to mental health facilities;

Definitions of Expressions:

Article 3.
Accessibility means a precondition for persons with any disabilities to live independently and participate fully and equally in society. The notion entails the removal of environmental, legal and attitudinal barriers that prevent persons with any disabilities from fully and equally participating in society;

Advance directives are written statements in which individuals specify in detail how they wish to be treated and cared for. They can be used if at any stage individuals are seen as less capable of making decisions, and can include an appointment of proxy decision makers (persons of trust);

Advocate means a person helping to promote the interests of a person with any disabilities and who can provide moral support to that person in situations in which the person feels vulnerable;

Carer means a person familiar to a person with mental disabilities whom he or she provides care;

Children: means all people under the age of 18 years;

Council means the Mental Health Council;

Decision-making ability (also described as "mental capacity" or "competence") means the ability of a person at a particular moment to make a particular decision as judged by someone else;

Mental disorder (also described as "mental illness") is a state of mind which affects the person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person and causes dysfunction, disability, disadvantage;

Impairment means any loss or abnormality of psychological, physiological, or anatomical structure or function;

Disability means a social construct, which occurs not because of a person's impairment, but because of environmental and attitudinal barriers which exist and which prevent his or her full and equal participation in society;

Mental disabilities include mental disorder; severe dementia; significant intellectual disabilities where there is a co-morbid condition of such a severity to meet the threshold for mental disorder; underlying mental disorder as a secondary aspect to a primary problem of drug use;

Disadvantage means a lack of opportunity for a person that limits or prevents the performance of an activity or the fulfilment of a role that is normal (depending on age, social, cultural factors) for that person (e.g. discrimination and poverty);

Discrimination on the grounds of disabilities means any distinction, exclusion or restriction on the basis of disabilities which has the purpose or effect of impairing or

nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

Dysfunction means any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being (e.g. lack of work, adjustment skills, and social skills);

Emergency situation means a situation in which there is immediate and imminent danger to life and safety of the person concerned and/or others, or when a person needs control and supervision to prevent him or her causing harm to himself or others.
Equality means that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law;

Facilitated decision-making is a support used as a last resort where a person's will and preferences are not known. Here, a representative has to determine what the person would want, based on what they know about the person and on their best understanding of their wishes. Facilitated decision-making is an international human rights laws-compliant alternative to Guardianship.

Guardian is a substitute decision-maker appointed by a Court to act on behalf of an adult who is deemed by mental health professionals to lack decision-making ability in general or specific decisions;

Human Rights means rights that are said to belong to every human being in every society everywhere in the world. Human rights are predicated upon the belief that all human beings innately possess the most basic and fundamental rights, which may not be curtailed by any government;

Legal capacity means a person's standing before the law (legal standing) as well as their ability to act within the framework of the law (legal agency) on an equal basis with others without discrimination on the basis of gender or disabilities. Legal capacity does not reflect an individual's ability to make decisions but their right to make decisions, including with some support, and to have those decisions respected.

Incapacity (also described as "lack of decision-making ability" or "incompetence") means the decision-making inability of a person at a particular moment to make a particular decision as judged by someone else; Incapacity must not be presumed upon proof of mental disabilities;

Informed consent to treatment means consent obtained freely, without threat, or incentives, and after appropriate disclosure to the person of sufficient information in a manner and language understood by the person on diagnosis, purpose, method, duration, expected benefits, and side effects of prescribed treatment as well as alternative treatment methods. Informed consent can be given only by persons who have the decision-making ability to give consent to the treatment proposed;

Involuntary admission (also described as " "involuntary placement" or "compulsory confinement") means admission of a person to a health facility or continuation of

detention after an emergency admission or after a voluntary admission, where the person concerned does not have decision-making ability to consent to admission for the purposes of treatment, and that treatment of the person concerned in a mental health facility would be likely to benefit or alleviate the condition of that person to a material extent, and that failure of admission of the person would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and that no other less restrictive alternative is available;

Involuntary treatment means the provision of treatment to a person who lacks decision-making ability to consent to treatment and his or her underlying health condition is of a nature or degree amenable to or likely to benefit from treatment;

Mental health means a state of well-being in which every person realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community;

Mental health care means the care and treatment provided through mental health services;

Mental health care professionals (also described as "professionals" or "mental health care practitioners" or "mental health care providers" or "experts") means psychiatrists, psychiatric nurses, psychologists, social workers, occupational therapists, certified mental health care providers, and counsellors who have been trained to provide prescribed mental health care services;

Mental health facilities are the facilities referred to in Article 2;

Mental health service users (also described as "service users") means persons with mental disabilities who are receiving mental health care or using mental health services at a mental health facility aimed at enhancing their mental health status, and/or persons being evaluated for admission into mental health facilities;

Mental health status means the level of mental well-being of a person as affected by physical, social and psychological factors;

Multi-disciplinary care team means a team involving input from a wide range of skill sets including psychiatry, nursing, social work, clinical psychology, occupational therapy, peer support, counselling, psychotherapy, creative therapy;

Non-protesting patient means a person who does not have the decision-making ability to consent to and is not refusing the placement in a mental health facility or the treatment proposed;

Occupational therapy services are services that enable people to engage in everyday living, through occupation; to perform the occupations that foster health and well-being; and to enable a just and inclusive society so that all people may participate to their potential in the daily occupations of life;

Patient means a person who is under observation, care and/or treatment. For the purposes of this Bill the term refers to persons with mental disabilities, including those being evaluated for admission;
Person of trust means a person informally appointed by an adult mental health service user who has decision-making ability, with the duty of representing the adult's will and preferences for health and mental health care-related matters;

Psychosocial services including structured counselling, motivational enhancement, case management, care-coordination, psychotherapy and relapse prevention are helpful services in providing support, education, and guidance to persons with mental disabilities and their families;

Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

Recovery is neither a service nor a unitary outcome of services. Recovery is the deeply personal process of changing one's attitudes, feelings, perceptions, beliefs, roles, and goals in life, even with functional limitations and deep traumas;

Rehabilitation means a process designed to promote recovery, full community integration, and improved quality of life for persons whose mental disabilities seriously impairs their ability to lead meaningful lives;

Reintegration into society (also described as "social inclusion" is an outcome which can be achieved using various mental health services, as well as political action and community organizing to promote solidarity and openness to persons with mental disabilities;

Relative in relation to person means a spouse, parent, grandparent, brother, sister, child of the person or of the spouse of the person whether of the whole blood, of the half blood or by affinity;

Severe dementia means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

Significant intellectual disabilities (also described as "intellectual impairment", "developmental disabilities" or "mental retardation") means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person;

Spouse in relation to a person does not include a spouse of a person who is living separately and apart from the person;

Support is a broad term that encompasses both formal (advocates) and informal (persons of trust) support arrangements, of varying types and intensity.

Supported Decision-Making means the process in which people whose will and preferences are not obvious to others receive the help they need and want to understand the situations and choices they face, so they can make life decisions for themselves; When a person needs support to make a decision, these supports shall make sure that the person's will and preferences are respected at all times;

Treatment means an intervention (physical or psychological) on a person that, taking into account the person's social dimension, may include measures required for the purposes of safeguarding, ameliorating the condition, restoring health or relieving suffering, and improving the social dimension of a person's life, such as medications, occupational therapy services, psychosocial services, rehabilitation services; ECT; and ancillary tests and treatment. For the purposes of this Bill Emergency Treatment is not considered as treatment;

Undue influence or pressure means that the quality of the interaction between the support person and the person being supported includes signs of fear, aggression, threat, deception or manipulation;

Voluntary patient is a person who consents on his own behalf or with the support of others to admission to a mental health facility for the purpose of observation, care and treatment. The definition refers only to persons who have decision-making ability and who have genuinely consented to their admission and treatment to a mental health facility, and continue to consent to same. For the purposes of this Bill a non-protesting patient is not considered as a voluntary patient;

Voluntary treatment means the provision of treatment to a person who has decision-making ability and who genuinely consents on his or her own behalf or with the support of others;

Guiding principles:
Article 4.-
For the purposes of this Bill the following principles shall apply equally for all persons with mental disabilities, including women, children and minorities:
1. Respect for inherent dignity, "will and preferences", individual autonomy, self-determination, bodily integrity and privacy of the person
2. Non-discrimination and equality of opportunity
3. Equality for all regardless of sex or gender status
4. Respect for the evolving capacities of children
5. Accessibility
6. Full and effective participation and inclusion in the society
7. Least restrictive alternative
8. Recovery approach
9. Effective communication and the provision of information
10. Respect for diversity
11. The role of family and carers
12. Confidentiality

General provisions:
Every person who subjects, or causes to be subjected, any person with mental disabilities to the deprivation of any rights and privileges secured by the International Human Rights Laws and the Constitution and the national laws of the Islamic Republic of Afghanistan, is liable to the party injured in an action at law, suit in equity, or other proper proceedings for redress;

1. All public and private facilities and programmes designed to serve mental disabilities, including those based in the community, shall be effectively monitored by independent mechanisms;

2. Primary mental health care interventions, including a framework for supported decision-making and advocacy in the mental health system, and training on these issues for all relevant public officials at all parts of the country shall be developed according to international standards and best practice as defined by World Health Organization;

3. Outpatient voluntary treatment shall be the norm;

4. Inpatient treatment shall be a last resort, all other mental health care options having been exhausted. In all cases, length of stay shall be as short as possible;

5. Public mental health services, including community-based aftercare and rehabilitation, shall be available and provided free of charge and as close as possible to people's families and own communities, including in rural areas.

Selection of Representative:

Article 6.
1.
2.
3.

CHAPTER-2
INDEPENDENT REVIEW MECHANISM
MENTAL HEALTH COUNCILS

Article 7.
A National Mental Health Council is being established within the Ministry of Public Health and subsidiary Local Mental Health Councils are being established within the Health Directorates at the level of Provinces, to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health inpatient and community-based services, and to take all reasonable steps to protect the rights of persons receiving care and/or treatment in mental health facilities and/or in community-based services.

Article 8.-
Members of the National Mental Health Council:

1. The National Mental Health Council shall be formed of the following 11 members whom shall be appointed by the Ministry of Health:
- the head of Mental Health department, MoPH
- one representative from the curative medicines department
- one representative from the public attorney's office
- one psychiatrist
- one medical doctor with training in mental health
- one clinical psychologist or psychosocial counsellor or social worker
- one person with mental disabilities
- one family member of a person with mental disabilities
- two representatives from a human rights or women's NGO
- one lawyer from the Afghan Independent Human Rights Commission
- one representative from the Ministry of interior

Article 9.-
Functions of the National Mental Health Council:

The National Mental Health Council shall have all such powers as are necessary or expedient for the purposes of its following quasi-judicial and other functions to:
1. Review and document every case of involuntary admission and renewal order within 21 days from the date of the order;
2. Investigate any complaint about any aspect of care and treatment provided by a mental health facility and take any decisions or make any recommendations that are required within 21 days from the date of receipt;
3. Review and document all cases of voluntary admissions every 4 months;
4. Review and document all cases of involuntary admissions every 4 months;
5. Review consent given by persons of trust or representatives every 4 months;
6. Review the appeals with regard to involuntary admission and/or treatment;
7. Randomly inspect 5 inpatient and community-based mental health services every year;
8. Randomly interview patients and mental health professionals in 5 inpatient and community-based mental health services every year

9. Determine a panel of psychiatrists and/or medical doctors with training in mental health and/or trainee psychiatrists to carry out independent medical examination;
10. Supervise all mental health facilities or other premises, including in the community level, where mental health services are provided, and conduct inspections once every year;
11. Appoint facilitated-decision makers (representatives) where a person lacks decision-making ability and the person's will and preferences are not known;
12. Evaluate the community's mental health needs, services and special problems with a view to making recommendations on policy and research to the Ministry of Public Health once every year;
13. Advise on the establishment of programmes for the provision of on-going care of persons with mental disabilities
14. Advise on the establishment of programmes for the provision of on-going care and treatment of persons with mental disabilities in prisons;
15. Report annually to the Ministry of Public Health about the needs and performances of the countries' mental health system, including complaints, which report is to be tabled in the Legislative Assembly;
16. Make or arrange, with the consent of the Ministry of health and the Ministry of Finance, for developing a scheme for the granting by the Mental Health Councils of state free legal aid to involuntary patients, including at Province level;
Supervise the Local Mental Health Councils;
17. Approve and review licenses of private mental health facilities, clinics, other inpatient facilities and community-based mental health services for the care and/or treatment of persons with mental disabilities, including at Province level;
18. Review hospital licenses, including at Province level;
19. Participate in the development and approve National Mental Health Strategies and Plans;
21. Review and advice on scopes of practice and codes of ethics for practitioners.

Article 10.
LOCAL MENTAL HEALTH COUNCILS

Article 11.-
Members of the Local Mental Health Councils:
Each Local Mental Health Council shall be formed of the following 9 members whom shall be appointed by the Ministry of Health:

- one person from the provincial public attorney's office
- one psychiatrist or medical doctor with training in mental health
- one clinical psychologist or psychosocial counsellor or social worker
- one person with mental disabilities
- one family member of a person with mental disabilities
- one representative from a human rights or women's NGO
- two lawyers from the Afghan Independent Human Rights Commission
- one MH Focal Point from an NGO implementing services in the Province

Article 12.-
Functions of the Local Mental Health Councils:

1. The Local Mental Health Councils shall have all such powers as are necessary or expedient for the purposes of the quasi-judicial and other functions referred to under numbers 1-14 in Article 8.

2. The Local Mental Health Councils shall report annually by catchment area and service area to the National Mental Health Council on the needs and performances of the Province's' mental health system, including complaints.

Article.13-

1. The National Mental Health Council shall meet within the Ministry of Public Health and the Local Mental Health Councils shall meet within the Provincial Public Health Directorates once every three months.

2. The Ministry of Public Health shall appoint a member of each Mental Health Council to be the chairperson of that Council.

3. Three members including the Chairperson or one of the Deputy Chairpersons, at any meeting of any of the Mental Health Councils shall constitute a quorum.

Conflict of interest:
Article 14:

No conflict of interest shall exist between the members' posts inside the National and Local Councils and any other professional commitments they may have, especially with regard to the members from the medical community who, in addition to their membership in the National and Local Councils, may be responsible for one of the mental health facilities whose inspection the Council undertakes.

CHAPTER-3

RIGHTS OF PERSONS WITH MENTAL DISABILITIES AND RIGHTS OF FAMILIES

RIGHTS OF PERSONS WITH MENTAL DISABILITIES

Article 15:

1. **Right to the enjoyment of the highest attainable standard of physical and mental health, and rehabilitation:**

2. Persons in health and mental health facilities shall be ensured their right to:
a. Receive treatment of the same quality and standards as other individuals;

b. Receive treatment which addresses holistically their needs through a multidisciplinary care plan approach;
c. Receive treatment in the least restrictive environment and in the least restrictive manner;
d. Aftercare and rehabilitation services when possible in the community so as to facilitate their social inclusion;
e. Be adequately informed about their condition;
f. Actively participate in the formulation of their treatment plan;
g. Give free and informed consent before any treatment is provided and such consent shall be recorded in the patient's medical file;
h. Confidentiality of all information about themselves, their disorder and treatment in whatever form stored, which information must not be revealed to third parties without their consent;
i. Access to their clinical records;
j. Full respect of their dignity;
k . Protection from cruel, inhuman and degrading treatment, punishment, exploitation, violence and abuse;

Article 16.
Right to an adequate standard of living and social protection:
Persons in health and mental health facilities shall be ensured their right to:
a) a safe and hygienic environment, including adequate, sufficient and quality food and clothing when they cannot provide their own;
b) Access to appropriate social services and protection programmes as well as State financial assistance and other financial-related supports.

Article 17.
Equal recognition before the law:

a) Persons with mental disabilities shall have the right to equal recognition as persons before the law, and the right to exercise legal capacity on an equal basis with others in all aspects of life, and the right to access to support to exercise legal capacity;
b) The existence of mental disabilities must not be the sole criterion to justify the deprivation of legal capacity;
c) Persons who are able to fully function and participate in society without posing a threat to another constitutionally protected value must not be deprived of their legal capacity solely on grounds of mental disability; in every individual case, the specific interest that is purported to be protected by this deprivation shall be identified.
d) Deprivation of legal capacity can be ordered only by the Courts;
e) In legal capacity cases the Court must not solely be based on expert opinions but shall have direct visual contact with the person with mental disabilities and the opportunity to question him or her.

Article 18.
Right to liberty and security of the person:

1. Deprivation of legal capacity must not be a ground to deprive a person with mental disabilities of his or her liberty by admitting him or her to a mental health facility on an involuntary basis;

Persons involuntarily admitted to a mental health facility, including those who have been deprived of their legal capacity, shall:
a) Have the right to pursue independently a legal review to challenge their admission;
b) Be ensured freedom from arbitrary involuntary admission to mental health facilities;
c) Be entitled to all guarantees afforded to persons with other disabilities or to persons without disabilities, including access to legal mechanisms of protection and complaints, and regular monitoring of the mental health facilities by the AIHRC.

Article 19.
Social inclusion:

1. Persons with mental disabilities shall have the right to exercise all civil, political, economic, social and cultural rights with choices equal to others, including but not limited to the right to live in the community, the right to have access to a range of in-home, residential and other community support services, the right to employment and integration at work, and the right to education.
2. Effective and appropriate measures shall be taken to facilitate full enjoyment by persons with mental disabilities of their civil, political, economic, social and cultural rights and their full inclusion and participation in the community.

Article 20.
Protection from discrimination:

Persons with mental disabilities shall enjoy equal opportunities and protection from discrimination. The Afghan Independent Human Rights Commission shall take appropriate action against anyone who discriminates, or exploits a person by reason of his or her mental disability, and shall make recommendations to competent authorities to further promote the social inclusion of persons with mental disabilities.

CHAPTER-4

RIGHTS OF FAMILIES OF PERSONS WITH MENTAL DISABILITIES

RIGHTS OF FAMILY:
Article 21.
Family is recognized as an equal partner with mental health care professionals, and the supportive role of families in the life of their relative with mental disabilities is fully recognized equally;

Rights of participation:
Article 22:
Relatives and carers shall have the right to participate actively in the formulation and implementation of the patient's treatment plan, including for the continuity of care and rehabilitation after discharge;

Rights of Decision making:

Article 23:
Mental health professionals shall provide relatives and carers with the necessary information required for the accomplishment of their supportive role in the patient's life and recovery, and the best knowledge and information to support the patient to make decisions;

Right of Complain:
Article 24:
Relatives, carers and representatives have the right to submit complaints to the Council and the Afghan Independent Human Rights Commission regarding cruel, inhuman and degrading treatment or punishment, and/or exploitation, violence and abuse of the patient in mental health facilities.

CHAPTER-5
ALTERNATIVES TO COERCION

Article 25. – Persons of trust:
Adults with mental disabilities who have decision-making ability and are capable of understanding the meaning of authorities and the consequences of giving authorities to a person of trust may appoint a person of trust of their own choice to consent to mental health care they wanted when well but which they later refuse, because for example a health problem or other conditions have affected their decision-making ability.

Awareness program:
Article 26.-

The Ministry of Public Health shall provide awareness raising and education around advance planning so that persons with mental disabilities are empowered to put advance directives in place and/or to appoint persons of trust.

Article 27.- Advocacy:

Persons with mental disabilities shall have the right to a range of advocacy supports, such as citizen advocacy, peer advocacy and self-advocacy equally available in both as inpatient settings and within the community.

CHAPTER -6
DECISION-MAKING

DECISION-MAKING ABILITY
Article 28.-

a) Every person shall be deemed to have decision-making ability to make decisions for and by themselves, with assistance if needed;
b) The presence of a mental disability or a person's behaviour, personality or appearance must not be the overall determining factor of a person's decision-making ability;

Article 29.
Decision-making ability assessment:
1. Assessment of a person's decision-making ability shall be conducted by a range of mental health professionals, including psychiatrists, psychiatric nurses, psychologists, and social workers, in consultation with the treating clinician. A minimum of three disciplines shall be involved in any assessment and a person who is familiar to the person (relative, carer or person of trust).

2. In assessing decision-making ability or a status of 'in need of protection' a multi-disciplinary team shall recognize the inalienability of legal capacity of persons with mental disabilities and apply a decision-specific test, to identify:
a) the person's ability to understand the information to make a decision and use the information in order to make a decision;
b) the person's wishes and goals;
c) the decisions a person needs and wants to make;
d) the person's will and preferences;
e) what supports are necessary for the person to exercise the right to make his or her own decisions.

Article 30.
Assessing a person's decision-making ability to make decisions about his or her treatment:

1. For the purposes of assessing a person's decision-making ability to make decisions about his or her treatment it shall be ensured that the person has been given:
(a) an explanation of the proposed treatment including—(i) the purpose of the treatment; and (ii) the type, method and likely duration of the treatment; and
(b) an explanation of the advantages and disadvantages of the treatment including information about the associated discomfort, risks and common or expected side effects; and an explanation of any beneficial alternative treatment that are available, including any information about the advantages and disadvantages of these alternatives;
(c) answers to any relevant questions that the person has asked;
(d) any other relevant information that is likely to help the person in his or her decision-making; and
(e) in the case of proposed treatment, a statement of rights relevant to his or her situation.

2. Information shall be explained in a way that takes account the abilities, communication capabilities and language of the person.

FACILITATED DECISION-MAKING

Article 31.

1. In situations where persons may need support to express their will and preferences they shall be provided with the support they need but cannot be required to accept support against their will;

2. Support shall respect the rights and the will and preferences of the person, shall be free of conflict of interest and undue influence, and must never amount to substitute-decision making.

3. Access to such support shall be provided to prevent abuse and ensure its appropriateness to meet individual rights, including the right to take risks and make mistakes.

Health Care
Article 32.
Health and social care professionals assessing a person's decision-making ability shall record in detail in the person's medical file every step they have taken to reach their conclusion, including the steps to determine a person's decision-making assistance requirements and the reasonable accommodation provided to the person in need of support;

Legal capacity:
Article 33.-
Any assessment of decision-making ability must be informed by the principles of autonomy, self-determination and "will and preferences" and focus on assessing what supports is necessary to ensure that persons can exercise their legal capacity.

Facilitated Decision Making:
Article 34.
Supports that help someone to make a decision shall be made as easy as possible for people to use. This shall ensure that other people making decisions for a person (representatives) are a last resort, rather than the first option.

1. Persons who have been assessed as lacking the ability to make a decision in relation to admission and treatment shall fall within the definition of "involuntary patients".
2. Where a person's will and preferences cannot be understood, and the person has not previously expressed his or her will and preferences through advance directives or through a person of trust, a representative shall determine what the person would want based on what they know about the person and on their best understanding of his or her wishes.
3. The representative shall make a decision for someone else only when the following have been attempted before facilitated decision-making can apply:

A. the representative shall have made the best effort to communicate with the person, through all possible means, including unconventional or alternative communication;
B. the representative shall have made every effort to understand the person's will and preferences;

C. if there is no existing support network for the person who could help with the decision, one should have been created if possible;

D. Every effort shall have been made to provide information in a manner that the person can understand and all means of support (including advocacy) shall have been provided in order to help the person to make a decision.

4. Representatives shall be appointed by the Council and monitored by the Council every four (4) months. on a regular basis.
5. Persons who are assessed as lacking decision-making ability to make decisions about their treatment shall enjoy their right to seek review of the assessment of decision-making ability by a differently composed multidisciplinary team, their right to periodic review of their admission by the Council and the AIHRC, and their right to challenge the appointment of the representative in the Courts
6.

CHAPTER 7

DETERMINATION OF MENTAL DISORDER

DETERMINAION OF MENTAL DISORDER:
Article 35.
Any determination of mental disorder shall be made in accordance with internationally accepted medical standards.

1. Determination of mental disorder must never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.
2. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, must never be a determining factor in diagnosing mental disorder.
3. A background of past hospitalization of a person must not of itself justify any present or future determination of mental disorder.

VIOLENCE RISK ASSESSMENT

Article 36.

1) To facilitate uniformity at nation-wide level, identification of cases in which people pose a violence risk and determination of the steps necessary to protect individual and or/public safety shall be done with the use of the internationally recognised violence risk assessment instrument HCR-20.

2) Violence risk assessment shall be practiced by a multidisciplinary team involved in assessing a person's dangerousness for admission, including psychologists, psychiatrists, nurses, social workers, occupational and rehabilitation therapists.

3) Detailed official guidelines shall be adopted by the Ministry of Public Health to guide professionals in their assessment of violence risk in every individual case, and data collection mechanisms shall be set up so that these standards can be monitored and measured over time.

CHAPTER- 8

VOLUNTARY ADMISSION AND TREATMENT

Voluntary Admission
Article 37.
A person may be admitted voluntarily to a mental health facility only if he or she has the capacity to make such a decision and has consented to his or her admission and continues to consent.

1. Only persons who in accordance with the provisions stipulated in Articles 25-33 of the present Bill have been assessed as having the ability to make a decision in relation to admission and treatment with or without support shall fall within the definition of "voluntary patient".

2. without prejudice to any other rights under this Bill, a voluntary patient:
(*a*) must not be admitted unless he or she consents in writing to admission;
(*b*) is given treatment only with his or her informed consent;
(*c*) must not be secluded or restrained unless he or she consents in writing;
(*d*) can discharge himself or herself at any time, even against medical advice, unless the criteria for their admission as involuntary patients apply ;
(*e*) shall have a multidisciplinary individual care plan formulated in consultation with himself or herself and finalised within 7 days from admission; and
(*f*) shall give written informed consent prior to any significant changes in the care plan;
(*g*) is given information about complaint mechanisms;
(*h*) must not be said to be a voluntary patient in circumstances where a surrogate has consented to the treatment on their behalf;
(*i*) shall have the right to refuse or to stop treatment, regardless of the outcome for the person of that decision or how wise that decision appears to others;
(*j*) is allowed to meet and instruct a lawyer
(k) shall have the right to set out their wishes in the form of advance directives and through persons of trust in the event of future incapacity

Individual health care plans:
Article 38:
An individual mental health care plan shall be drawn up for every voluntary patient in consultation with the patient. The plan shall involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, etc. The plan shall address the individual steps taken to activate the recovery approach while the patient is in the mental health facility and shall include discharge planning.

1. The right to refuse treatment by voluntary patients may be overridden only in emergency life-threatening situations and in line with the doctrine of necessity. The use of ECT, psychosurgery and depot neuroleptics shall be absolutely prohibited in such emergency situations, and the safeguards referred to in Article 92 subsections 1, 6, 7, 10, 12, 13, 14, 15, 16, 17 shall always apply.

2. The Director of the facility shall ensure that voluntary patients are not abused, are not subject to coercion, and are not admitted under the threat of involuntary admission.

3. Voluntary patients shall have the right to leave the mental health facility at any time unless the criteria referred to in Article 61 for their continuation of admission as involuntary patients apply.

4. Mental health facilities are required to provide detailed information to the Council on every occasion a voluntary patient is prevented from leaving the mental health facility.

Article 39.-
Where the Council has concerns about the adequacy of the consent process in respect of any voluntary patient in relation to either admission or treatment, and/or the period of stay, and/or any voluntary patient's complaint or allegation of rights violations, it shall have the case referred to the AIHRC.

Article 40.
Where the Afghan Independent Human Rights Commission has concerns about the adequacy of the consent process in respect of any voluntary patient in relation to admission or treatment, and/or any violations of voluntary patients' rights, it shall have the case brought to the administrative courts and/or prosecute officials.

CHAPTER-9

INVOLUNTARY ADMISSION AND TREATMENT

Emergency admission for observation:
Article 41-
Any person who, satisfied from personal observations or information received, reasonably believes that a person with mental disorder is acting in a manner likely to endanger that person's own safety or the safety of others, may cause that person to be admitted for observation to a mental health facility.

1. A person apprehended under subarticle 54 (1) must be released if a consultant psychiatrist on the staff of the mental health facility who has examined the person to be admitted does not issue a certificate in which he states that:
i. he has examined the person on the date set out; and
ii. based on the actual behaviour of the person there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons and that the threshold of dangerousness required for a person to be hospitalised is met.

2. In emergency situations, the medical assessment referred to in subarticle 54 (2) shall suffice for the purpose of involuntary admission for observation.

Duration of admission for observation:
Article 42:
A person admitted under article 54 may be detained for 72 hours after the date of admission for observation, and be discharged at the end of the 72 hour period unless the threshold of dangerousness required for a person to be hospitalised is still being met or the criteria for involuntary admission referred to in Article 61 are met.

Admission beyond the 72 hour period:
Article 43:
Unless the person has previously consented to voluntary admission, for involuntary admissions beyond the 72 hour period the provisions and safeguards for involuntary patients shall apply.

Evaluation:
Article 44:
During the 72 hour observation period a second consultant psychiatrist on the staff of the mental health facility shall:

1. Assess whether the person suffers from a mental disorder the severity of which presents a significant risk of serious danger to life or safety of the person or others; and

2. Assess the decision-making ability of the person and the supports he or she may need in accordance with the provisions stipulated in articles 25-33 of the present Bill.

Provision of information:
Article 45:

Upon admission the person under observation or his/her representative if the person has been assessed as lacking decision-making ability shall be informed by the staff of the mental health facility that he or she is being admitted as an emergency for observation for 72 hours.

Treatment in emergency situations:
Article 46:
Involuntary admission of a person to a mental health facility as an emergency must not be construed as authorising treatment without his or her consent if the person has the decision-making ability to make treatment choices.
1. No standard treatment shall be given in emergency situations unless it is emergency treatment with no therapeutic purpose but meant solely to target the serious presenting symptoms and prevent life-threatening situations.
2. Standard treatment for mental disorder can be provided only after renewal of admission in accordance with the provisions referred to in Articles 67-68, and only in accordance with the provisions and safeguards referred to in Articles 77-87 and Article 90.
3. The use of ECT, psychosurgery and depot neuroleptics is absolutely prohibited in emergency situations.
4. Emergency treatment may be administered only for a short period of time which must not be longer than 72 hours.
5. Such emergency treatment may only be continued beyond 72 hours if:
a. the person gives his or her full and free informed consent in writing to the continuation of administration of emergency medications, or the will and preferences of the person and are ascertained through the use of an advance directive or by means of a person of trust; or
b. where the person lacks the decision-making ability to give consent or is unwilling to give such consent and no advance directive or person of trust can ascertain the will and preferences of the person, the continuation of administration of such emergency medications is authorised:
- by one consultant psychiatrist on the staff of the mental health facility, and
- by another independent consultant psychiatrist following referral of the matter to him or her by the Council, and
- With the agreement of a multidisciplinary team on the staff of the mental health facility.

Emergency Treatment:
Article 47-
In any case of emergency treatment the safeguards referred to in Article 92 subsections 1, 6, 7, 10, 12, 13, 14, 15, 16, 17 shall apply.

1. The Ministry of Public Health in consultation with the Afghan Independent Human Rights Commission shall develop special adequate training for Judicial and Police Officers, health and mental health professionals, and staff working in jail, juvenile centres and any other place where persons with mental disabilities may be placed or detained on their equality duties both in terms of professional and personal attitude and approach to know how to deal with

persons with mental disabilities, including in emergency situations, in accordance with the provisions of the present Bill and International Human Rights Treaties ratified by the Islamic Republic of Afghanistan.

2. Upon admission every patient shall be provided a list with names and telephone numbers of the members of the Independent Bar Association who undertake pro bono it means free, without money: it's a worldwidely used legal term cases, as well as a list of contact details of approved NGOs that provide free legal assistance and representation.
3. A brochure about the Afghanistan Independent Human Rights Commission (AIHRC) and its complaints process and resource centres and telephone numbers, including information about the role of the Councils, and patient's right to challenge admission and/or treatment to the Courts. A leaflet containing information on the rights and freedoms contained in this Bill in simple and accessible language in Dari and Pashto shall be delivered to every patient on admission. Persons facing difficulties to understand written information shall receive appropriate assistance by the staff of the mental health facility.
4. Specific arrangements, including the provision of pens and paper, shall exist to enable persons lodge formal complaints.
5. The Ministry of Public Health in consultation with the Afghanistan Independent Human Rights Commission shall cause to be prepared and delivered in every mental health facility the information material referred to in this Article.

CHAPTER -10

INVOLUNTARY ADMISSION

Criteria for involuntary admission:
Article 48:
A person may be involuntarily admitted for observation to a mental health facility pursuant to an application under article 62, or continue to be involuntarily detained after an emergency admission or after a voluntary admission, on the grounds that he or she does not have decision-making ability to consent to admission, and that treatment of the person concerned in a mental health facility would be likely to benefit or alleviate the condition of that person to a material extent, and that failure of admission of the person to a mental health facility would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission.

Application for involuntary admission:
Article 49:
1. An application for recommendation that the person be so admitted may be made to the mental health facility by any of the following: a person's relative or person of trust or representative-guardian ("the applicant").

2. The following persons shall be disqualified for making an application:

a) persons under the age of 18 years, and
b) medical doctors who work in the mental health facility concerned.

3. Any person who, for the purposes of or in relation to an application, makes any statement which is to his or her knowledge false or misleading in any material particular shall be guilty of an offence.

Involuntary admission for observation:
Article 50:
Except for patients continuing to be involuntarily detained after an emergency admission or after a voluntary admission, an initial assessment shall be made by two medical doctors on the staff of the mental health facility, one of whom must be a consultant psychiatrist, within a maximum of 24 hours from each other. In the case of a discrepancy between the two assessments, a third independent assessment by a psychiatrist on the staff of the facility shall be carried out and then the majority recommendation shall prevail.

Article 51:
1. If based on the certifications of the medical doctors referred to in Article 63 the person concerned fulfils the criteria referred to in Article 61, he or she may be involuntarily detained to the mental health facility for a period of observation not exceeding 72 hours from the issuance of the second's medical doctor certificate referred to Article 63.
2. A Director or a person who has authority to admit persons to a mental health facility must not admit a person as an involuntary patient if in the opinion of the two medical doctors who assessed the person it has been ascertained that he or she has the decision-making ability to consent to admission.

Observation – Evaluation:
Article 52:
During the 72 hour observation period a second consultant psychiatrist and a multidisciplinary team on the staff of the mental health facility shall thoroughly assess the decision-making ability of the person and the supports he or she may need in accordance with the provisions stipulated in articles 27-46 of the present Bill.

Provision of information:
Article 53:
During the 72 hour observation period the person admitted shall be informed in writing and orally by the staff of the mental health facility that he or she:
a) is being admitted as an involuntary patient for 72 hours,
b) shall be given a general description of the proposed treatment,
c) beyond the 72 hour maximum period his or her admission shall be formally reviewed by the Council,
d) shall have the right to complain to the Council and the Independent Human Rights Commission.
e) shall have the right to appeal against admission, renewal and/or treatment orders to the Council and the courts
f) shall be given written information and oral explanations about his or her rights during admission and about complaints mechanisms.

Admission order:
Article 54:

1. Where within the period of 72 hours and based on the decision-making ability assessment findings and the support needs of the person, and the written certifications of a multidisciplinary team including at least one consultant psychiatrist, one trainee psychiatrist and one clinical psychologist

- That the person does not have decision-making ability to consent to admission for the purposes of treatment,
- and that treatment of the person concerned in a mental health facility would be likely to benefit or alleviate the condition of that person to a material extent, and that failure of admission of the person to a mental health facility would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission,
-and that there are no other less restrictive alternatives, the Head of the mental health facility shall issue an admission order for a period not exceeding 21 days.

2. Not later than 24 hours thereafter the Head of the mental health facility shall send a copy of the admission order together with the decision-making ability assessment findings and the support needs of the person, the written certifications of the three members on the staff of the mental health facility and a detailed care plan to the Council, and give notice in writing of the making of the admission order to the person concerned and the purposes of the admission.

Review of admission order by the Council:
Article 55:

1. Following the receipt of a copy of the admission order and related documents, the Council shall review the documents, as soon as possible, interview the patient, and make a decision within 21 days of the making of the admission order. If the Council is satisfied that the proper procedures have been followed and that the person concerned does not have decision-making ability to consent to admission for the purposes of treatment, and that treatment of the person concerned in a mental health facility would be likely to benefit or alleviate the condition of that person to a material extent, and that failure of admission of the person to a mental health facility would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and that no other less restrictive way would achieve the best possible outcome for the person, the Council shall affirm the admission order and shall notify in writing the person concerned and the Head of the mental health facility. If it is not satisfied, it shall revoke the admission order and direct that the person be discharged.

2. An affirmed admission order by the Council shall authorise the admission of the person concerned and shall remain in force for a period of 21 days from the date of the making of the admission order.

Renewal order:
Article 56:

1. The period of 21 days may be further extended for a period not exceeding 3 months by order made by the Head of the mental health facility on the basis of written certifications of a multidisciplinary team including a consultant psychiatrist, one medical doctor, one clinical psychologist and the Head of the mental health facility,

and only on the grounds that the person concerned continues to lack decision-making ability to consent to admission for the purposes of treatment.

2. Not later than 24 hours thereafter a copy of the renewal order giving specific reasons for the extension and any modification on the care plan shall be submitted to the Council, and notice in writing of the making of the renewal order shall be given to the person concerned.

Review of renewal order by the Council:
Article 57:

1. Following the receipt of a copy of the renewal order by the Council, the Council shall as soon as possible review the documents and interview the person concerned.

2. Before affirming any renewal order the Council shall investigate, through an independent review of the person by a mental health professional from the panel of independent mental health professionals determined by the Council, whether the criteria for involuntary admission are still operative and whether there was any failure by any mental health professional in not attaining the desired outcomes as a result of not abiding by the multidisciplinary care plan submitted by the team.

3. In those cases where the Council is satisfied that the necessity for the extension results from a failure of any mental health professional, who is not abiding to the submitted multidisciplinary care plan, the Council shall make any recommendations it deems necessary and take such actions against any mental health professional as provided by or under this Bill.

4. In any case, the Council shall make a decision within 21 days from making of the renewal order. If the Council is satisfied that the criteria for involuntary admission referred to in Article are still operative, it shall affirm the renewal order and notify in writing the person concerned and the Director of the mental health facility. If it is not satisfied, it shall revoke the admission order and direct that the person shall be discharged.

5. An affirmed renewal order by the Council shall authorise the extended admission of the person concerned for 3 months and shall remain in force for a period of 3 months from the date of the renewal order.

6. Further extension of involuntary admission beyond the extension granted by the Council for a period of 3 months must not be possible unless after an independent review by two independent mental health professionals from the panel of independent mental health professionals determined by the Council it has been certified that the person concerned continues to meet the criteria for involuntary admission referred to in Article 61.

7. In any case, any such recommendation for extension of involuntary admission beyond 3 months must not be executed without prior consultation with and approval by the Council and the AIHRC .

CHAPTER-11

ADMISSION OF NON-PROTESTING PATIENTS

Admission of involuntary patient:
Article 58:
Where a person does not have the decision-making ability to consent to and is not refusing the admission to a mental health facility or the treatment proposed, shall be regarded as an involuntary and not as a voluntary patient.

1. Prior to admitting persons who do not have the decision-making ability to consent to and are not refusing the placement in a mental health facility or the treatment proposed, and who do not pose a risk either to themselves or to others but require treatment in an inpatient setting, all steps towards supported decision-making referred to in Chapter V must be exhausted.

2. Any admission and treatment of non-protesting patients shall be carefully and regularly reviewed by the Council and the same safeguards shall be provided as those applicable to involuntary admission and involuntary treatment under this Bill.

Involuntary admission of children:
Article 59:
1. Without prejudice to the provisions relating to involuntary admission of adults, an involuntary admission of a minor is only permissible if a specialist who has clinical experience in working with minors with mental health problems certifies that community based alternatives are not available or are unlikely to be effective or have been tried and failed or are unsafe, and the Council approves such admission.

2. Admission of children in adult wards is prohibited.

Parent-child bonding:
Article 60:
When a minor or a parent with dependent minors is admitted to a mental health facility, the admitting facility shall grant flexible visiting hours to minimise the effects of parent-child separation, unless the responsible specialist in consultation with the other members of the multidisciplinary team, believe that such separation is in the best interests of the minor.

CHAPTER-12

TREATMENT
IN CASE OF INVOLUNTARY ADMISSION

Individual health care plans:
Article 61:

1. An individual mental health care plan shall be drawn up for every involuntary patient in consultation with the patient. The plan shall involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, etc, shall address the individual steps taken to activate the recovery approach while the mental health service user is in the mental health facility, and shall include a discharge planning.

2. Regular reviews of a patient's health status and any medication prescribed shall be ensured through the. Council

Consent to treatment:
Article 62:
The admission of a person to a mental health facility on an involuntary basis must not be construed as authorising treatment without that person's consent.

1. Assessment of the decision-making ability to make decisions about treatment shall be conducted in accordance with the provisions referred to in Chapter V.

2. It shall be the duty of the mental health professionals of the mental health facility admitting the patient to obtain informed consent to treatment of the patient himself or herself.

3. Involuntary treatment can be given only in exceptionally limited circumstances and only to persons who lack the decision-making ability to consent to treatment and where the treatment proposed would be likely to benefit or alleviate the condition of those persons to a material extent.

Decision making ability:
Article 63:

1. Every person who has the decision-making ability to make decisions about his or her treatment, whether admitted voluntarily or involuntarily, shall have the right to refuse or stop treatment.
2. The right to refuse treatment may only be overridden in very limited circumstances and in line with the doctrine of necessity (to prevent life-threatening situations). In such cases only emergency treatment shall be allowed, and the safeguards referred to in Article 92 subsections 1, 6, 7, 10, 12, 13, 14, 15, 16, 17 shall apply.

Mental Disabilities:
Article 64:
Where a person with mental disabilities, even if subject to a measure of protection [i.e.
, facilitated-decision making, guardianship], is in fact capable of giving a free and informed consent to a given intervention in the health field, the intervention may only be carried out with his or her consent.

Treatment of persons who do not have decision-making ability about treatment:
Article 65:

Persons with mental disabilities, who are assessed as lacking decision-making ability to make decisions about their treatment, including non-protesting patients, shall enjoy their right to periodic review of their admission and treatment by the Council and the AIHRC.

RELEASE FROM INVOLUNTARY ADMISSION

Article 66:
If an involuntarily admitted person regains decision-making ability and the criteria for involuntary admission and treatment cease to exist either during the period of involuntary admission or at the end of the approved involuntary treatment period, as the case may be, the Head of the mental health facility shall immediately release the person from the involuntary admission order and inform the Council about this decision.

On release from the involuntary admission order the person concerned shall attain all the rights related to a voluntary patient and may continue to be admitted and/or treated only with his or her consent.

CHAPTER-13

SPECIAL PROCEDURES

SPECIAL PROCEDURES:
Article 65.
Electroconvulsive therapy (ECT) is a recognised form of mental health care for certain cases. Care shall be taken that ECT fits into the patient's mental health care plan, and its administration shall be accompanied by appropriate safeguards as follows:
1. ECT shall always be administered in a modified form (i.e. with anaesthetic and muscle relaxants).

2. ECT shall always be administered out of the view of other patients, by staff members who have been specifically trained in administering ECT.

3. Recourse to ECT shall be recorded in detail in a specific register.

4. ECT shall always be administered based on the free and informed consent of the patient based on full, accurate and comprehensible information about his or her condition and the mental health care proposed.

5. ECT must not be administered to children.

Means of restraint (mechanical restraint, chemical restraint, seclusion):
Article 66:

When restraint of violent persons is necessary for some occasions the following shall apply:

1. Patients shall be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse of patients by staff or between patients constitutes a minimum requirement;

2. Staff in mental health facilities shall be trained in both non-physical and manual control techniques vis-à-vis violent patients. The possession of such skills shall enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff;

3. Resort to instruments of mechanical restraint, such as soft restrains and/or padded leather straps, or seclusion shall only apply very rarely be justified and must always be expressly ordered by a medical doctor after an individual assessment;

4. Patients must not be mechanically restrained in view of other patients. Patients under restraint shall be adequately dressed, and able to eat and drink autonomously and to attend natural functions;

5. Police handcuffs, metal chains, net- and cage-beds, locking devices, rope or cord, rubber bands and sheets are degrading and must not be used;

6. Use of restraint must never have a therapeutic justification;
7. Trained staff shall be continuously present and monitor whenever patients are subjected to restraints;

8. Mechanical restraint and or seclusion must never be imposed onto minors below 16 years of age, pregnant or breastfeeding women;

9. If recourse is had to mechanical restraint and seclusion, the maximum duration should ordinarily not exceed 6 hours; In the extremely rare cases where restraint is considered to be the only available measure to handle continuously dangerous behaviour prolongation of mechanical restraint or seclusion more than six hours, shall require a further review by two psychiatrists who shall both agree on the decision to continue the use of mechanical restraint or seclusion. The same procedure applies if the use of mechanical restraint or seclusion of the same person is repeated within 24 hours after previous use was terminated. Mechanical restraint and seclusion must not exceed 24 hours under any circumstances.

10. Only, well established and short acting drugs shall be used if recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers. The clinical need for chemical restraint must be reassessed every 6 hours. After 72 hours, prolongation of chemical restraint requires further review by two consultant psychiatrists who must both agree on the decision to continue the use of chemical restraint. The side-effects that medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.

11. Persons who have decision-making ability and who are subjected to mechanical restraint or seclusion must never be medicated without consent, except in emergency situations in order to save the life of the person concerned.

12. Means of restraint or their prolonged application must never be applied, as a punishment for perceived misbehaviour or as a means to bring a change of behaviour, or as a means of convenience for the staff, or due to lack of staff.

13. Once means of restraint have been removed, it is essential that a debriefing of the person take place. For the medical doctor or the psychiatrist, this shall provide an opportunity to explain the rationale behind the measure, and thus reduce the psychological trauma of the experience as well as restore the doctor-mental health service user relationship. For the patient, such a debriefing is an occasion to explain his or her emotions prior to the restraint, which may improve both the mental health service user's own and the staff's understanding of his or her behaviour.

14. A full record of the debriefing shall be retained by the staff for audit and disclosure purposes;

15. A specific register shall be available to record all instances of recourses to means of restraint. This shall be in addition to the records contained within the mental health

service user's personal medical file. The entries in the register shall include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered it; and an account of any injuries sustained by person with mental disabilities or staff. Patients shall be entitled to attach comments to the register, and be informed of this. At their request, patients shall receive a copy of the full entry.

16. Every instance of restraint shall be the subject of a detailed policy spelling out, in particular: the means of restraints that may be used, under which circumstances they may be applied, types of cases in which they may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the supervision required; the action to be taken once the measure terminated; staff training in control techniques and in person with mental disabilities' rights; complaints policy; debriefing; and biannual reporting to the AIHRC;

17. The use of restraints shall be subjected to the oversight of the AIHRC.

Medical or scientific experimentation:
Article 67:

Experimentation is prohibited if potentially harmful or dangerous to the person. In any case an approval from the Council, the AIHRC and Department of Health & Substance Abuse of the Ministry of Public Health shall be always required.

a) Medical interventions, such as psychosurgery, may be performed only if the patient has personally given informed consent in writing to the performance of psychosurgery for himself or herself and an approval has been obtained from the Department of Health & Substance Abuse of the Ministry of Public Health to perform the surgery.
b) Psychosurgery for involuntarily admitted persons is prohibited.

Sterilization of men or women and forced abortion:
Article 68:
Sterilization of men or women and forced abortion, when such sterilization is non-therapeutic, and when such abortion is non-therapeutic for the mother or the foetus are prohibited.

CHAPTER -14

PERSONS CONCERNED IN CRIMINAL PROCEEDINGS

Article-69:
Psychiatric evaluation:

Where in the course of any proceedings on the charge of a criminal offence the question of the decision-making ability of the accused, whether at the time of the offence or of the proceedings arises, the court requests independent specialist opinion, forensic psychiatrists and/or medical doctors with additional training in forensic psychiatry in designated mental health facilities shall:

1. Conduct Court-ordered evaluations and risk assessments for individuals in court or community settings.
2. Conduct Court-ordered forensic evaluations of pre-trial or adjudicated defendants.
3. Conduct Court-, community-, and hospital-based evaluations for competency to stand trial and criminal responsibility.
4. Conduct forensic consultations.
5. Conduct forensic risk assessments.
6. Provide direct short-term services to individual with mental disabilities who become involved with the courts or criminal justice.

Certification of illness:
Article 70:
In any case, and before making any certification any of the above physicians shall assess:
1) The condition of the person in accordance with internationally accepted medical standards;

2) the decision-making ability of the person and the supports he or she may need in accordance with the provisions stipulated in Articles 25-33 of the present Bill; and

3) Whether the condition of the person poses a risk of danger to life or safety of the person and/or others with the use of the internationally recognised violence risk assessment instrument HCR-20.

Rights of forensic patients:
Article 71:

During forensic psychiatric assessment and/or acute inpatient short-term treatment, forensic patients are ensured the same rights and safeguards with other patients;

Forensic care principles:
Article 72:

1) When forensic patients lack decision-making ability to make mental health care decisions, their treatment without consent shall be justified on the same basis with civil patients who lack decision-making ability to make decisions about their treatment.
2) When forensic patients lack decision-making ability to consent to treatment, involuntary treatment shall be authorised. If they regain decision-making ability, treatment may continue only with their consent.

3) In the case of those found unfit to stand trial, who cannot be sent to prison, their involuntary treatment shall be lawful even if they retained decision-making ability, on the following conditions: they have been shown, on reliable evidence, to have committed the acts or omissions necessary to constitute a serious offence; they have a mental disorder that contributed significantly to that conduct, and an effective treatment can be offered that could reasonably be expected to reduce the risk of recurrence.

4) Serious criminal offenders who were found to lack decision-making ability to consent to treatment shall receive involuntary treatment. If they regain decision-making ability and refuse treatment, however, they shall continue their sentence without mental health care. At the end of their sentence, if decision-making ability was not regained, their involuntary treatment shall continue as civil patients.

Forensic Psychiatric Commissions:
Article 73:
1. A Forensic Psychiatric Commission is being established by the Ministry of Public Health in each mental health department of general hospitals or forensic units of mental health hospitals.

2. Eligibility for appointment and/or reappointment, terms of office, allowances, meetings and regulations for proceedings and delegation of functions of the members of the Forensic Psychiatric Commissions, shall be determined in a Ministerial Decree subject to the provisions of this Bill.

Function of the Forensic Psychiatric Commissions:
Article 74:

1. The functions of the Forensic Psychiatric Commissions are:
(a) to provide forensic psychiatric services to the courts and to give expert forensic psychiatric evidence;
(b) to support research respecting the diagnosis, treatment and care of forensic psychiatric cases, and
(c) to undertake educational programs respecting the diagnosis, treatment and care of forensic psychiatric cases;
(d) to perform other duties, responsibilities, research and educational programs respecting forensic psychiatry;

2. Any other functions shall be conferred by the Ministry of Justice in consultation with the Ministry of Public Health.

A person who, for whatever reason is in prison and develops a mental disorder whilst in prison and cannot be adequately assessed in prison, shall have the right to be transferred for evaluation to a mental health facility with the approval of the person responsible for the management of such prison.

CHAPTER-15
Miscellaneous Directives

Article 75:
Supports that help someone to make a decision shall be made as easy as possible for people to use. This shall ensure that other people making decisions for a person (representatives) are a last resort, rather than the first option.

Article 76:
Persons who have been assessed as lacking the ability to make a decision in relation to admission and treatment shall fall within the definition of "involuntary patients".

Article 77:
Persons who are assessed as lacking decision-making ability to make decisions about their treatment shall enjoy their right to seek review of the assessment of decision-making ability by a differently composed multidisciplinary team, their right to periodic review of their admission by the Council and the AIHRC, and their right to challenge the appointment of the representative in the Courts

Commented [Mw1]: Repetition in previous pages

Article 78:
Psychosurgery, sterilisation, implantation of hormonal or other invasive devices to modify sexual and, or emotional and, or behavioural changes arising from mental disabilities must not be carried out on minors.

Article 79:
Every facility purporting to provide mental health services shall be duly regulated by the Ministry of Public Health and shall abide by all the conditions specified in such licence.

Article 80:
Every mental health facility shall draw up operational guidelines in furtherance of the provisions of this Bill and a written patient care management protocol supported by adequate resources to ensure that effective and efficient care is provided and the risk of institutionalisation is minimised.

CHAPTER-16
CORECTIONAL SENTENCES

Offences and penalties:
Article 81:

First time: written notice
Second time: warning
Third time: Any person who is found guilty of an offense under this Bill is liable on conviction to a fine of 2000-3000 Afghani and/or to ……..months imprisonment or to both such fine and such imprisonment.

Definition of offences:
Article 82:
1. Any person who neglects, abuses or treats a person with mental disabilities in any degrading manner or allows the person with mental disabilities to be treated in that manner, is guilty of an offence.

2. Any person who breaches any of the provisions of this Bill is guilty of an offence.

Area for implementation:
Article 83:
This bile is equally implemented on people who have mental Health problems in any geographically location in Afghanistan.

Code of practice:
Article 84:
The Ministry of Public Health shall support the development of a code of practice providing details on the implementation of this Bill.

Article 85:
The provision in (16 CHAPTERS) and season (85) of this Act after the Council of Ministers and signed by the Head of State Ministry of Justice and published in the official gazette is really apply.