Mental Health Law of the Kyrgyz Republic and its Implementation

Available in English and Russian.

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Based in Budapest, the **Mental Disability Advocacy Center (MDAC)** is an international non-governmental organization that promotes and protects the human rights of people with mental health problems and intellectual disabilities across central and eastern Europe and central Asia. MDAC works to improve the quality of life for people with mental disabilities through litigation, research and international advocacy. MDAC has participatory status at the *Council of Europe* and is a cooperating organization of the *International Helsinki Federation for Human Rights*.

Contents

1. Introduction

This report is intended to examine the extent to which the mental health law and practice in Kyrgyz Republic complies with international standards, to provide recommendations to the Kyrgyz government. The report was prepared at the request of the Office of the President of the Kyrgyz Republic. The report examines the system of mental health care in the Kyrgyz Republic, evaluates the current laws regarding the provision of mental health services and the protection of the rights of individuals receiving mental health services. The United Nations General Assembly Resolution 46/119 "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" of 17 December 1991 (hereinafter the "**MI Principles**") is the international standard against which the system is analyzed.

Definitions

Throughout this report definitions used in the MI Principles will be used:

"Counsel" means a legal or other qualified representative;

"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental health problem (mental illness) or suspected mental illness;

"Mental health facility" means any establishment, or any unit of an establishment, whose primary function is to provide mental health care;

"User" is a person receiving mental health care, including all persons who are admitted to a mental health facility;

"Personal representative" means a person charged by law with the duty of representing a person's interests in any specified respect or of exercising specified rights on that person's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law.

2. Methodology

On January 22, 2003, Valentin Bogatyrev, Assistant to the President of the Kyrgyz Republic, sent a letter to the Mental Disability Advocacy Center (MDAC) requesting the following: That MDAC, (1) examine the system of public mental health services in the Kyrgyz Republic; (2) review the Kyrgyz National Program for Mental Health in accordance with the principles described in the World Health Organization (WHO) "World Health Report 2001: Mental Health: New Understanding, New Hope"; and (3) evaluate the current laws of the Kyrgyz Republic regarding the provision of mental health services and the protection of the rights of individuals receiving mental health services in accordance with current international standards, including the MI Principles.

In a response to that request MDAC asked lawyers from the Washington Protection and Advocacy Service (WPAS) in the USA to join the investigation and co-author this report. The authors of this report are Dr. Arman Vardanyan, Deborah A. Dorfman and Craig Awmiller.

The authors conducted a comprehensive review of **"**Law of Kyrgyz Republic On Psychiatric Care and Guaranteeing the Rights of Persons Receiving Such Care," 1999 (hereinafter "**1999 Psychiatric Care Law**"), the National Program "Mental Health of the Population of the Kyrgyz Republic in 2001-2010" and other relevant documents.[1]

The authors visited the Kyrgyz Republic in June 2003. During the visit the authors conducted in-person interviews with numerous people in the mental health system of the Kyrgyz Republic. These included**:** in patient and outpatient users of psychiatric services; psychiatrists and other clinicians; nurses and other "junior staff"; judges, defense attorneys**;** prosecutors**;** human rights advocates**;** government officials and legislators. In addition, the authors visited several inpatient mental health facilities. The authors toured and spoke with the staff and patients of the Republican Mental Health Center (hereinafter "RMHC") in Bishkek; a branch of the RMHC known as "Ward 12", located just outside Bishkek in the village of Novo-Pavlovka**,** Chim-Korgon Psychiatric Hospital and Issyk-Kul Oblast psychiatric hospital, located in the town of Karakol[2].

Although the authors met with many individuals, examined numerous documents, and toured the facilities, it would have been preferable to have more time available to review the conditions of psychiatric care. For example, the hospital at Karakol was the only hospital run by Oblast authorities that the authors visited. The authors also did not visit facilities maintained by the Kyrgyz Ministry of Social Security and Labor - several "boarding" facilities for people with severe disabilities, including intellectual disabilities. These facilities play a significant part in the Kyrgyz system of social care. Such visits were unfortunately beyond the scope of time allotted to the authors.

The results of the review show that unless serious measures are taken to meaningfully implement the 1999 Psychiatric Care Law, the mental health system in the Kyrgyz Republic will not only remain overly centralized and based on institutions, but it will continue to deteriorate. The constant growing population of the Kyrgyz Republic who are in need of mental health care has already created a situation whereby the government is unable to adequately meet even basic human needs such as food, basic health care and shelter. Without significant reform, the situation will only grow worse and the current crisis will become catastrophic at the expense of the health, safety, and human rights of individuals with mental health problems in the Kyrgyz Republic.

3. Overview of the Kyrgyz Mental Health System

The health care system in the Kyrgyz Republic is currently under transition in an effort for the government to find ways to more efficiently manage an ever-increasing demand and overly-centralized system. This effort includes mental health services, which have seen a substantial increase in demand over the past years. As part of the attempt to reform the mental health system in Kyrgyz Republic, in 1999 the government enacted the Psychiatric Care Law. In 2000, the government launched its national program "**Mental Health of the Population of the Kyrgyz Republic in 2001-2010**". Both the law and the program anticipate a shift from institutionally-based mental health care to more localized community-based care, with an emphasis on bringing mental health care to individuals in their local communities. Due to the lack of funding, implementation of the program was suspended. Tilek Meimanaliev, the First Deputy Minister of

[1] See Appendix 1 for list of documents reviewed.
[2] See Appendix 1 for list of individuals interviewed and institutions visited.

Health of the Kyrgyz Republic reported that the UK's Department for International Development (DfID) had pledged to the Kyrgyz government that DfID it would, in concert with the World Bank, work to fully fund the National Mental Health Program. Deputy Minister Meimanaliev stated that this funding had been withdrawn and therefore the national reform plan had been suspended.[3] He further expressed his uncertainty as to the reason that this funding had been withdrawn.

Despite the withdrawal of international partners, in 2001 the Ministry of Health merged the Chim-Korgon psychiatric hospital with the RMHC.[4] Later, the children's psychiatric facility in Ivanovka village was also merged the RMHC. These mergers served to further centralize the nationally funded mental health service, resulting in a concentration of funding and resources at the RMHC in Bishkek and shifting resources away from other facilities such as Chim-Korgon. The mergers have also impeded the development of community-based mental health care: the little funding that the government has allocated for mental health care has been concentrated primarily at the RMHC and has left little available for the development of community-based mental health care. All of these mental health facilities are funded, owned, and operated by the national government of the Kyrgyz Republic.[5] The RMHC provides primarily inpatient mental health care, but also provides some outpatient and partial hospitalization as well**.**

There are also a number of psychiatric facilities operated at the district and/or regional level.[6] These facilities, such as the Issyk-Kul Oblast, are funded through the Oblast budgets and are owned and operated by the State trough the district/regional administration. The facilities are administratively part of general medical hospitals and are funded through them. It was repeatedly reported to the authors that the regional hospitals tend to have fewer resources than the facilities that are funded by the national government, although the authors have been provided with neither the copies of the actual budgets for the nationally-funded facilities nor those which are locally-funded. The care provided at the local level includes both inpatient care as well as outpatient care. At the *raion* and *oblast* levels, some local governments are beginning to use a co-payment system to provide mental health care. [7] For example, according to the Medical Director of its psychiatric unit, the Issyk-Kul Region is participating in a pilot project to implement a co-payment system for mental health care. This system is not being used at the national level, although some legislators are pushing for the adoption of such a requirement.

The Kyrgyz Minister of Health explained that – in theory at least – the Kyrgyz mental health system should function on three levels: primary care provided at the *raion* level by general practitioners**;** larger intermediate care facilities staffed with psychiatrists and provided at the each *oblast* level**;** and long-term, tertiary care provided on the national level at the RMHC in Bishkek.[8] According to the Minister, the structure of this system is in keeping with the government's intention to provide mental health services in the most accessible, locally-based means possible. This, in turn, is in keeping with the recommendations of the WHO and the majority of

[3] Interview on 6 June 2003.
[4] See Decree of Ministry of Public Health of the Kyrgyz Republic, May 4, 2000, N 138 (hereinafter "Decree N 138").
[5] See Decree N 138*;* see also RMHC under the Ministry of Public Health Bylaws, Approved by the Decree N 138 of the Ministry of Public Health of May 4, 2004 (hereinafter "RMHC Bylaws").
[6] Regions are also know as "raions" and "oblasts". There are 6 regions in Kyrgyz Republic (Osh, Issuk-Kul, Batken, Jalal-Abad, Naryn, Talas and Chuiy) and 40 districts.
[7] The co-payment system is currently utilized in the regular health care system (the Government Program of the Kyrgyz Republic on the Reform of Public Health Services "MANAS").
[8] Interview on 4 June 2003.

international psychiatric authorities. As discussed below, however, and as confirmed by Dr. Valery Solozjenkin, Chief Psychiatrist at the Ministry of Health, such functionality exists in theory only.

Instead, as evidenced by the patient populations at three psychiatric facilities, large numbers of mental health patients appear not to have received any meaningful psychiatric care at either the *raion* or *oblast* level, thus causing the RMHC to become a "primary" rather than "tertiary" level facility. Dr. Solozjenkin reported that primary care physicians continue to lack a basic understanding of the causes of, and appropriate treatment for, mental illness, so these physicians do not even attempt to treat patients who have a mental illness. Rather, such patients are often sent to receive in-patient care at the RMHC. Such a transfer of responsibility and care is counter to the most common trends and recommendations regarding the proper provision of psychiatric care, in large part because such practice obviously removes the patient from his or her natural support structure.

In general the current mental health care system in the Kyrgyz Republic remains antiquated, based on large institutions and overly centralized. The attempts to bring about change have been met with strong resistance. Additional barriers are posed by inadequate funding, lack of trained mental health professionals to provide the necessary community-based mental health care, particularly in rural areas, and the lack of private pay psychiatrists. This is the case despite the government's plans in its national program "Mental Health of the Population of the Kyrgyz Republic in 2001-2010" to significantly improve the delivery of mental health services in the Kyrgyz Republic**.**

4. Analysis of Kyrgyz Mental Health Legislation

4.1. 1999 Psychiatric Care Law

The 1999 "Law of Kyrgyz Republic On Psychiatric Care and Guaranteeing the Rights of Persons Receiving Such Care" (Herinafter "**1999 Psychiatric Care Law**"), signed by the President of the Republic and enacted by the Legislative Assembly of the Kyrgyz Republic on 25 May 1999, is the current law governing most aspects of mental health care in the Kyrgyz Republic.[9] Many of the substantive provisions mirror similar legislation throughout the United States, Russia and Europe. The law largely complies with United Nation General Assembly Resolution 46/119 "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" of 17 December 1991 (the "MI Principles"). However, as discussed in detail in the following paragraphs, there are several significant elements of the legislation that either need revision or are absent from the statute.

4.1.1. Lack of a "Definitions" Section

A significant missing component of the current 1999 Psychiatric Care Law is a "definitions" section. Consequently, as was evident during the authors' visit to the Kyrgyz Republic, guidance in interpreting the Kyrgyz mental health law is sorely needed. For example, in an interview with junior psychiatrists at the RMHC in Bishkek, they reported that each psychiatrist interprets the

[9] The Law does not address forensic (criminal) mental health issues; those are addressed in the Criminal Code. Issues of civil commitment are also reflected in Civil Procedural Code.

involuntary treatment provisions of the 1999 Psychiatric Care Law differently and that they are frustrated by the lack of guidelines for interpretation.

Not only were clinicians confused about the interpretation of the involuntary commitment law, but lawyers and judges were also equally confused. For example, when during the interviews with judges at the October Court in Bishkek, there was no agreement amongst themselves as to how the Law should be interpreted.

An example of a term in the 1999 Psychiatric Care Law that needs a definition to avoid inconsistent interpretation is the term "emergency cases" as referenced in Article 25, "Procedures of Application and Making a Decision Regarding the Psychiatric Examination of a Person Without his/her Agreement or the Agreement of his/her Legal Representatives". There is no language in the statute to clearly define what constitutes an "emergency case". Thus, it is likely that different doctors will interpret this term differently, risking the compromise of the rights of the patient.

Synchronization of the terminology used in 1999 Psychiatric Law and in the Civil Procedural Code regarding the civil commitment is also needed. The statutes use different terms to address the same issue. Civil commitment is referred as "involuntary treatment" in 1999 Psychiatric Law and as "compulsory treatment" in the Civil Procedural Code. The use of different terms creates additional confusion among judges and lawyers, who are used to and more confident to work with the Civil Procedural Code and clinicians, who are guided exclusively by 1999 Psychiatric Law.

It is necessary to clearly to define the terms of a statute, such as the 1999 Psychiatric Care Law, in order for judges, lawyers, clinicians and others to more consistently interpret and implement the statute.

4.1.2. Involuntary Treatment/Civil Commitment

Kyrgyz law provides that an individual can be detained for involuntary inpatient mental health treatment in only limited instances and pursuant to the provisions specifically set forth in the 1999 Psychiatric Care Law. Specifically, a person may be detained for involuntary treatment if that person has been determined to be:

- a direct danger to self or others; unable to independently provide for own care needs; or
- at risk of the mental health condition worsening if no psychiatric care is received [10]

The law further stipulates that anyone detained pursuant to Article 29 must be given a psychiatric examination within 72 hours of admission to an inpatient psychiatric facility to determine whether continued hospitalization is necessary. Where it is found that such hospitalization is inappropriate, the individual must be immediately discharged.[11]

However, where continued hospitalization is deemed clinically appropriate, an application for involuntary treatment must be made within 24 hours to the local court to determine whether the

[10] Article 29, "Bases for Hospitalization in a Psychiatric In-patient Institution on In-voluntary Basis" of the 1999 Psychiatric Care Law.
[11] Article 32(1), "Examination of Persons, Placed in Psychiatric In-Patient Institutions on In-Voluntary Basis" of the 1999 Psychiatric Care Law.

individual must remain involuntarily hospitalized.[12] Within 5 days of receiving the application of the psychiatrist and the psychiatric facility for involuntary treatment, the court must decide whether continued involuntary mental health treatment is warranted.[13] Any party may appeal the court's decision within ten days of its issuance.[14]

Patients for whom an application for involuntary treatment has been filed with the court have the right to participate in the legal proceeding regarding the proposed involuntary civil commitment.[15] The court is required to ensure the participation in the legal proceedings of the prosecutor, the representative of the psychiatrist who applies to the court, and the legal representative of the patient.[16]

If the court finds that involuntary hospitalization is necessary, during the first six months of hospitalization, the need for such hospitalization "is subject to examination by the commission of psychiatrists of the psychiatric institution at least once a month.[17] At the conclusion of the first six-month period, the court reviews the need for continued hospitalization. If the court finds that further hospitalization is warranted, it may extend the order for involuntary mental health treatment.[18] The need for continued treatment is to be reviewed annually thereafter.[19]

The 1999 Psychiatric Care Law involuntary civil commitment provisions significantly parallel involuntary civil commitment laws in other jurisdictions within the Council of Europe and United States of America. However, there are a number of important provisions missing from this part of the 1999 Psychiatric Care Law or in need of clarification including:

4.1.2.i) Lack of Clear and Specific Provisions Providing for the Right to Counsel in Civil Commitment Proceedings

International law and standards require that a patient be provided with legal counsel to represent them in involuntary civil commitment proceedings, regardless of whether the individual can afford to pay for the attorney.[20]

The provisions addressing judicial review of involuntary commitment applications in the 1999 Psychiatric Care Law are vague and do not provide specific guidance as to the procedures for such a review. An important component that is missing is whether there is a *right* to counsel in such proceedings.[21] For example, Article 34, "Consideration of the application on hospitalization on in-voluntary basis" of the 1999 Psychiatric Care Law refers only to the patient's legal representative, stating that such a representative should be allowed to "participate" but does not define who pays for the lawyer or representative to participate.

[12] Article 32(2); *see also* Article 33, "Reference to the Court on the Subject of Hospitalization on In-Voluntary Basis" of the 1999 Psychiatric Care Law.
[13] Article 34(1), "Consideration of the Application on Hospitalization on In-voluntary Basis" of the 1999 Psychiatric Care Law.
[14] *Ibid*
[15] Article 34(2) of the 1999 Psychiatric Care Law.
[16] Article 34(3) of the 1999 Psychiatric Care Law.
[17] Article 36(1), "Prolongation of Hospitalization on In-voluntary Basis" of the 1999 Psychiatric Care Law.
[18] Article 36(2), "Prolongation of hospitalization on In-voluntary basis" of the 1999 Psychiatric Care Law.
[19] Article 36(3), "Prolongation of hospitalization on In-voluntary basis" of the 1999 Psychiatric Care Law
[20] Principle 18(1) of the "MI Principles".
[21] The "right" to counsel (attorney) means that an attorney shall be provided to represent the individual in the involuntary commitment proceedings. Where the individual cannot afford to pay for such representation, it will be provided free of charge to that individual.

The list of patients' rights in Article 5 of the 1999 Psychiatric Care Law also states that a patient has the right to "assistance of a lawyer, legal representative or other persons in accordance with procedure set by the legislation of the Kyrgyz Republic." The mandatory language of this provision appears to confer a right to counsel. However, the law does not specifically provide for a procedure for appointing counsel in involuntary civil commitment proceedings.

Similarly Article 7(3), "Representative Office of Rights and Legal Interests of Citizens who Receive Psychiatric Care," of the 1999 Psychiatric Care Law also refers to the right to a lawyer, stating that the "[p]rotection of rights and legal interests of the citizen receiving psychiatric care may be implemented by the lawyer. Invitation procedure of the lawyer and payment for his/her services are provided by the legislation of Kyrgyz Republic."[22]

Article 5 of the 1999 Psychiatric Care Law seems to provide for a right to counsel. However, the law is silent as to whether such counsel shall paid for by the State for those who cannot afford to pay for representation, or whether the law merely allows for counsel if the individual and/or their family have the money. Similarly, Article 7 of the 1999 Psychiatric Care Law and Article 40 of the Constitution, while more specifically addressing the issue of payment of the lawyer for indigent persons, still do not clearly address the issue. More specific language must be added to the statutes.[23]

The right to an attorney is essential to ensure that the rights of the patient are protected in the involuntary civil commitment process. It is not enough to have legislation that allows an individual to instruct an attorney to represent them, as many are simply unable to pay for an attorney.[24] The law should be modified to clearly state that an individual who is subject to the involuntary commitment process has a right to representation by an attorney and if they cannot afford it, an attorney will be provided to them free of charge.

4.1.2.ii) Lack of Clear Procedures for Judicial Review of Involuntary Civil Commitment Applications

The 1999 Psychiatric Care Law lacks any clear procedures guiding the judicial review of involuntary civil commitment applications. Accepted world-wide legal and psychiatric standards require that before an individual can be subject to involuntary civil commitment beyond the first

[22] Article 40 of the Constitution of the Kyrgyz Republic states that "[e]very citizen in the Kyrgyz Republic shall be provided qualified legal assistance and defense of the rights and freedoms guaranteed by the Constitution."

[23] It should be noted that even if the language of the statute, as it currently exists, were to be interpreted to confer a right to counsel, paid for by the State, this right is not being implemented. As discussed more below, the involuntary treatment procedures are virtually never used. Moreover, local attorneys informed MDAC there are no free legal services provided by the State in such cases, as the only free (extremely limited) legal services provided are for criminal cases. (The Legal Aid Society lawyers provides representation only in criminal cases). Furthermore, it was reported by Nurlan Sudykov of the Association of Lawyers of the Kyrgyz Republic, that there is little interest in the legal community in providing *pro bono* (unpaid) representation to people with mental disabilities.

[24] See "Kyrgyz Republic: Country Reports on Human Rights Practices – 1999", United States Department of State, Bureau of Democracy, Human Rights, and Labor, February 23, 2000 discussing the impoverished conditions of the Kyrgyz Republic and its people.

initial 72 hours, he or she is entitled judicial review, representation by counsel, and procedural safeguards[25].

At a minimum, these safeguards must include:

- the right to counsel
- the right to have the assistance of an interpreter if necessary
- the right to request and produce evidence at any hearing
- an independent mental health report and/or any other reports or admissible evidence
- the right to copies of the patient's records, reports, and other documents relied upon to support the hospital's application for civil commitment, unless such information is demonstrated to be likely to cause the individual serious harm if her or she were to see it
- the right to request the presence of others at the hearing upon the request of the legal representative of the patient.
- the right to decide whether the court hearing should be in any way made public, absent a showing that such a decision would cause harm to the patient or others;
- the right to attend and participate in any court hearing regarding the patient; and
- the right to a written decision by the court articulating the reasons specifically for the court's decision whether or not to grant the application for civil commitment.[26] The World Psychiatric Association referred to this issue in a Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill (hereinafter "**WPA Statement of 1989**")[27].

The current Kyrgyz law should be modified to include specific language regarding the procedures to be followed and the rights of the individual for whom involuntary commitment is sought. Without such language setting forth these minimal procedures and rights, the entire judicial review of involuntary commitment is at serious risk of being rendered meaningless. Without clear procedures and rights there would be no way to ensure that a patient would receive true procedural fair trial protections during the involuntary treatment hearing process. Additionally, lack of clear guidelines also increases the risk that judges, lawyers, and clinicians will inconsistently interpret the statute, further risking the compromise of the patient's rights.

4.1.2.iii) Infrequent Ongoing Judicial Review of Civil Commitment Beyond Six Months

International law requires that civil commitment orders be reviewed by a court on a regular basis at fixed intervals (for example at least every 180 days).[28] In the Kyrgyz Republic, the 1999 Psychiatric Care Law allows only for annual judicial review of civil commitment beyond the initial commitment order and first six months of review of the necessity for continuing commitment. Without a right of the patient to apply to the court between the automatic annual reviews, there is a serious risk that the person could be detained well beyond the time necessary due to judicial review.

[25] See Principles 16,17, 18 of the "MI Principles". See also World Psychiatric Association's Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill (adopted by WPA General Assembly in Athens, 17 October, 1989) (hereinafter "**WPA Statement of 1989**").
[26] Principle 18 of the "MI Principles".
[27] Adopted by WPA General Assembly in Athens, 17 October, 1989.
[28] *See* WPA Statement of 1989.

4.1.3. Lack of Provisions Mandating the Reporting and Investigation of Allegations of Patient Abuse and/or Neglect

All patients have a right to be protected from harm, including, but not limited to, abuse by other patients and staff.[29] Despite this clearly articulated right, individuals with mental disabilities are among the most vulnerable to physical and sexual abuse, particularly those individuals who are institutionalized. The heightened vulnerability of people with mental health problems requires that the staff take affirmative measures to protect patients from harm from themselves and others. A key component in ensuring such protection is the requirement that all staff working at a facility be mandated to report and investigate any allegations of patient abuse and neglect.

The 1999 Psychiatric Care Law lacks any provisions mandating the reporting and investigation of alleged patient abuse and/or neglect at psychiatric facilities. The Law should be amended to include mandatory reporting and investigation of alleged patient abuse and neglect provisions. Reporting and investigating allegations of patient abuse and neglect is a key element in ensuring that abusive and/or negligent staff will be identified and disciplined or have their employment terminated, as is appropriate. These requirements also serve to stop and prevent patient abuse and neglect.

4.1.4. Lack of Judicial Review or Right to Counsel for Individuals Incompetent to Make Care Decisions

When an individual is deemed to lack the capacity to make care decisions**,** such as children and individuals with intellectual[30] or other cognitive disabilities, a legal representative should be appointed to make such decisions. However, such a decision-maker should only be appointed after there has been a "fair hearing by an independent and impartial tribunal".[31] UN Resolution 46/119 also requires that "[s]pecial care be given within the purposes of these Principles and within the context of domestic law to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.**"**

There are simply no provisions in the 1999 Psychiatric Care Law for judicial review or a right to an attorney for individuals who are incompetent to make their own care decisions. Rather, Article 7(2) of the 1999 Psychiatric Care Law states that such decisions shall be made by the individual's "legal representative". This person is defined as "parents, adoptive parents, guardians" and where these individuals are absent the "administration of psychiatric institution or psycho-neurological institution for social security and special training."

The Law should be modified to include specific language providing that the appointment of a legal representative for persons deemed incompetent to make care decisions should be done pursuant to judicial review with legal representation of the alleged incapacitated person or minor by an attorney. Furthermore, the law should be modified to ensure that such an individual has the right to judicial review and legal representation in cases where the issue is involuntary treatment or intrusive procedures such as electro-convulsive therapy (ECT) and other similar procedures and treatments. Such review and legal representation are essential in order to protect the human

[29] Principle 8 of the "MI Principles".
[30] Also known as developmental or learning disabilities.
[31] Principle 1(6) of the "MI Principles".

rights of these patients. Further safeguards are required for irreversible procedures such as sterilization or psychosurgery.

4.2. Criminal Code of Kyrgyz Republic

The Kyrgyz Criminal Code addresses issues of forensic mental health. Specifically, it sets forth procedures for assessment and evaluation of criminal defendants who have mental illnesses to determine whether or not the mental illness was the cause, either in full or in part, for the crime which they were accused of committing and whether the individual should be committed to a mental health facility instead of being sentenced to prison.

4.2.1 No Provision for Individuals Who Are Incompetent to Stand Trial in Forensic Mental Health Cases

It does not appear that the Kyrgyz Criminal Code includes provisions to deal with criminal defendants who are incompetent to stand trial.[32] Thus, every criminal defendant with a mental illness and/or intellectual disability stands trial, regardless of his or her competency to do so. This is inconsistent with accepted legal standards in jurisdictions in other parts of the world. In the United States, for example, it is unconstitutional for a court to allow a criminal defendant to proceed to trial when it has been determined by a court following psychiatric examination, that the individual is incompetent to stand trial (*e.g.*, unable to understand the charges brought against him or her or unable to assist in his or her defense).[33] In such circumstances, American courts will order an individual deemed incompetent to stand trial to participate either in inpatient or outpatient "competency restoration" treatment for a specified period of time, usually 90 or 180 days, to see if they can be restored to competency. If after the period of competency restoration treatment, the individual becomes competent to stand trial, the proceedings continue. However, if the individual is still not restored to competency, the charges are dropped and civil commitment proceedings are usually initiated to detain the patient for inpatient mental health care.

It is important to revise the Kyrgyz Criminal Code to include similar provisions so that the rights of individuals who are incompetent to stand trial are protected.

5. Implementation of the 1999 Psychiatric Care Law

Although the substance of the 1999 Psychiatric Care Law largely corresponds to international standards, there are significant problems with the actual implementation of the law. As discussed more fully below, the law has often been inconsistently implemented and in some cases virtually never implemented. When laws, such as the 1999 Psychiatric Care Law, are not implemented correctly or simply not implemented, they become merely illusory. In order to make the current mental health legislation meaningful, it must be fully and properly implemented. The UN Resolution 46/119 of 1991 mandates that, "[s]tates should implement [the principles of the

[32] This issue was raised with the Judges of the October Court in Bishkek. The judges told MDAC that there are no provisions with dealing with incompetency to stand trial.
[33] *See, Jackson v. Indiana*, 406 U.S. 715 (1972).

resolution] through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically." [34]

5.1. Lack of Adequate Funding to Implement the Law

Article 17, "Funding of Psychiatric Care" of the 1999 Psychiatric Care Law states: "Funding of institutions and person providing psychiatric care is implemented from the state budget, the fund of compulsory medical insurance and other sources not forbidden by the legislation of Kyrgyz Republic in amounts necessary for the guaranteed level and high quality of psychiatric care".

International standards also mandate that psychiatric facilities have sufficient resources to provide the required standards of care. Principle 14(1)(a)-(d) of the UN Resolution 46/119 of 1991 states that "[a] mental health facility shall have access to the same level of resources as any other health establishment and in particular:

(a) qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
(b) [d]iagnostic and therapeutic equipment for the patient;
(c) appropriate professional care;
(d) adequate, regular and comprehensive treatment, including supplies of medication."

The Kyrgyz Republic is not in compliance with international law and standards or with its own laws with regard to the provision of resources for mental health facilities. Despite the mandate for funding under Article 17 of the 1999 Psychiatric Law, and other relevant international standards, during the research of this report, the "lack of sufficient funding" was the single most commonly cited reason for the failure to implement the 1999 Psychiatric Care Law. Virtually everyone interviewed informed of a severe lack of funding by the government as a significant cause for the lack of implementation of the law.

As discussed more fully below, the lack of funding has adversely affected the conditions of care for individuals in need of mental health treatment, in both the community as well as in institutions. In some cases, the conditions of care have been so poor that the inadequate conditions have caused the patients to suffer serious and irreparable harm. A lack of funding is no justification in international law for inhuman or degrading treatment and conditions.

5.2. Patients' Rights

Article 5 of the 1999 Psychiatric Care Law sets out the rights of individuals with mental health problems with regard to the conditions of care while at a mental health facility. These rights include, but are not limited to:

- the right to respectful and human treatment
- the right to information about illnesses
- the right to psychiatric care in conditions limiting their freedom to the least extent possible and if possible, at home
- the right to all types of care based upon what is medically necessary for the individual patient
- the right to psychiatric care in "conditions satisfying basic sanitary-hygiene requirements

[34] Article 23(1) of the "MI Principles".

- Similarly, international legal and psychiatric standards also require the guarantee of such patients' rights.[35]

The Kyrgyz Republic is not in compliance with its own mental health laws regarding patients' rights or with worldwide standards and requirements. In touring some psychiatric facilities such as "Ward 12" of RMHC, Chim-Korgon, and the RMHC, the authors found that the conditions of care were significantly below accepted world standards. The conditions also violated the Kyrgyz Republic's own legal standards and seriously violate the most basic human rights of the patients.

It should also be noted that not only are the provisions of the 1999 Psychiatric Care Law regarding patients' rights not being implemented, but in some cases they are being blatantly disregarded with deliberate indifference. This is evidenced by the continuing failure and refusal by the Ministry of Health to take steps to ameliorate the grossly inadequate conditions of care and squalor imposed upon the patients residing on Ward 12. Local advocacy groups including the Youth Human Rights Group have repeatedly informed the Ministry of Health about the situation and have asked the Ministry to address these unacceptable living conditions.[36]

On June 19, 2003 MDAC sent a letter of concern to the First Deputy of the Ministry of Health respectfully asking that immediate action be taken to improve the situation. The Ministry of Health has not responded, and the situation remains the same in January 2004.

In another example, during a visit to the **"**Labor Colony**"** at Chim-Korgon psychiatric hospital, the authors learned that the female patients have been repeatedly subjected to sexual and physical abuse by the male patients with whom they are forced to reside. This problem was immediately brought to the attention of the medical director of Chim-Korgon psychiatric hospital as well as his staff and requested that the situation be ameliorated immediately. In addition, the concerns regarding the safety of the female patients were brought to the First Deputy of the Ministry of Health, Mr. Meimanaliev, and other government and RMHC officials, during the visit. It was promised that the female patients would be moved to the main campus of the Chim-Korgon psychiatric hospital no later than June 10, 2003. Despite the promises of the Ministry of Health, as of the date of this report the situation has not been addressed and the female patients at the Labor Colony continue to suffer and are at serious risk of suffering harm in the future.

5.3. Forced Labor

The law and constitution of the Kyrgyz Republic specifically forbid anyone or any entity from imposing forced and uncompensated labor upon anyone, including patients at mental health facilities.[37] Further, international standards also forbid forced labor and require that any work performed by mental health patients be fairly compensated. Principle 13(3) of UN Resolution 46/119 of 1991 states, that "[i]n no circumstances shall a patient be subject to forced labor" and

[35] *See* Principles 11, 12,13 of the "MI Principles". See also WPA Statement of 1989.
[36] See the NGO's monitoring report of 2002.
[37] Article 28 of the Constitution of the Kyrgyz Republic (*as amended* 1998) and Article 37, "Rights and responsibilities of patients staying in the psychiatric in-patient institution," of the 1999 Psychiatric Care Law (2) (requiring "remuneration equal to other citizens for work according to its quantity and quality, if the patient participates in productive work"). The only exception to this prohibition is "in cases of war, natural disaster, epidemic, or in other extraordinary circumstances, as well as in accordance with execution of punishment per order of court." Article 28(3) of the Constitution of the Kyrgyz Republic (*as amended* 1998).

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

The practice regarding forced labor at the psychiatric facilities in the Kyrgyz Republic are not in compliance with the laws and constitution of the Kyrgyz Republic and international standards. During the on-site reviews of RMHC and Chim-Korgon psychiatric hospital, both the patients and staff informed the authors of this report that patients were required to do work to improve the hospital, but were not compensated for this work. For example, at the RMHC, the deputy medical director stated that the patients are compelled do unpaid work as a form of "labor therapy". Similarly at Chim-Korgon psychiatric hospital, the patients perform unpaid work.

The most egregious example of forced unpaid labor that we observed was at the so called "Labor Colony", a ward at the Chim-Korgon psychiatric hospital. At the "Labor Colony" patients are required to do work such as growing vegetables and other crops, as well as other types of labor, while residing at the hospital. Although these patients spend all day, almost every day doing work to benefit the hospital, they receive no payment.

5.4. Involuntary Treatment/Civil Commitment

5.4.1. Adults

As previously discussed, the involuntary treatment provisions of the Kyrgyz mental health law restrict involuntary commitment to only those patients who have been deemed a danger to themselves or others, gravely disabled, and/or a risk of exacerbating their psychiatric symptoms pursuant to a court order.[38] Moreover, international legal and psychiatric standards recognize the substantial infringement upon human rights imposed by involuntary mental health treatment and that specific criteria and legal safeguards are necessary when imposing mental health treatment under compulsion.[39]

Despite these clear legal requirements, the research for this report revealed that the involuntary treatment procedures were virtually never implemented. For example, the judges at the October District Court of Bishkek, reported that since the enactment of the 1999 Psychiatric Care Law, they were only aware of 5 cases brought by the administration of the RMHC in Bishkek, the facility with 700 beds. The judges further reported that families often have a family member admitted to a psychiatric facility for mental health treatment. In such cases these admissions are considered "voluntary"[40] and thus, the involuntary treatment court procedures are not invoked.

[38] *See* Articles 28 & 29 of the 1999 Psychiatric Care Law; *see also* Article 18(3) of the Constitution of the Kyrgyz Republic (as Amended October 21, 1998)("[n]o one may be subjected to arrest or detention except on the basis of law").
[39] *See* WPA Statement 1989; *see also* Principles 15, 16, 17, and 18 of the "MI Principles".
[40] Pursuant to Article 4, "Voluntary Referral for Psychiatric Care" of the mental health law of the Kyrgyz Republic, "voluntary" mental health care "is provided upon voluntary referral of the person or with his/her permission except in cases provided by the present Law [sic]." Similarly, under Article 28(4), "Basis for hospitalization in a psychiatric in-patient institution" voluntary inpatient care is specifically based upon the request or agreement of the patient alone.

The psychiatrists and administrators at the RMHC stated that they rarely utilize the involuntary commitment court procedures as most of their patients were "voluntary" as a result of family admitting a relative to the hospital. Similarly, the staff at the Issyk-Kul Oblast reported that they have never used the involuntary treatment process, as all of their patients are "voluntary" as a result of their families admitting them for treatment. The mental health service users reported that if their families commit them to a mental health facility, they must stay there regardless of what they want and without judicial review.

- *In a representative example, a patient on the female rehabilitative unit of the Chim-Korgon psychiatric hospital had been admitted to the hospital by her family. She had been there as a "voluntary" patient for 10 years without any judicial review or court order mandating that be subjected to inpatient mental health care and was only there as a result of her family's wishes.*

This practice directly conflicts with Article 28 of the 1999 Psychiatric Care Law which limits "voluntary" hospitalization "upon his/her [*e.g.*, the patient's] request or with his/her agreement" and with Article 4(2) of the 1999 Psychiatric Care Law.

5.4.2. Minors 15 Years Old and Older

MDAC also found that the provisions of the Kyrgyz mental health law regarding involuntary mental health treatment for children 15 years or older are not implemented. In the Law, children 15 years and older are entitled to the same due process procedures for involuntary mental health treatment as adults.[41]

The laws requiring judicial review of applications for involuntary treatment and a court order imposing involuntary mental health inpatient treatment of a child over the age of fifteen are not implemented. During the visit to the RMHC in Bishkek and Chim-Korgon, MDAC researchers observed a number of children fifteen years old or older, who were housed with adult patients. According to the staff, the children's families had admitted them to the hospital on a "voluntary" basis. However, the admission was based on what the family wanted, not the child's wishes or needs. The staff at Chim-Korgon also said that some of the children aged fifteen or older were orphans who were no longer permitted to stay at the state-operated orphanages. These children were therefore placed at Chim-Korgon for lack of any alternative, even where the child did not have a mental health problem.

- *In a representative example, a 16-year-old child was on a female rehabilitative ward at the Chim-Korgon psychiatric hospital, who had been at an orphanage until the age of 14. Since she was too old to remain at the orphanage, she was placed at Chim-Korgon when she turned 14 and has been at Chim-Korgon ever since that time. She is considered a "voluntary" patient and has not had her case reviewed through the involuntary commitment process.*

[41] This issue is regulated by the Article 28(4) of the 1999 Psychiatric Care Law, "[a] minor *under* the age of 15 is placed in the psychiatric in-patient institution upon request or with the agreement of his/her parents or another legal representative."(*emphasis added*); Article 31, "Examination of the minors, those recognized as incapable, placed in a psychiatric institution upon request or with agreement of their legal representative"; and Article 4(2), "Voluntary referral for psychiatric care." ("[a] minor up to the age of 15 and a person recognized as incapable in accordance with procedures established by the law is provided psychiatric care upon the request or with the agreement of their legal representatives in accordance with procedures specified by the present Law").

- *In another representative example, a 15-year-old orphan with a severe intellectual disability on the acute ward of the Chim-Korgon had been admitted to the hospital 30 days prior to MDAC's visit. Before being admitted to the Chim-Korgon psychiatric hospital, she lived in a state-operated orphanage. She was no longer allowed to stay at the orphanage because she was too old.*

5.5. Discharge of "Voluntary Patients"

Related to the problem of failing to implement the law regarding involuntary commitment is the failure to implement the law regarding the discharge of "voluntary patients" from psychiatric hospitals. Article 40(2), "Discharge from a psychiatric in-patient institution" of the 1999 Psychiatric Care Law, states that a "voluntary" patient can be discharged from an in-patient psychiatric facility upon his or her request, the request of his or her legal representative, or the decision of the individual's treating physician. Additionally, Article 40(1) of the 1999 Psychiatric Care Law mandates that a patient for whom there has been a clinical determination that there is no longer a need for inpatient mental health treatment should be discharged. Similarly, international standards require that a patient who is admitted to a psychiatric facility on a "voluntary" basis be discharged from the facility upon his or her request, unless he or she would constitute a danger to themselves or others and/or is gravely disabled.[42] Particularly, Principle 15(3) of the "MI Principles": "[e]very patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as involuntary patient, […] and he or she shall be informed of that right".

Discharge of voluntary patients from psychiatric facilities in the Kyrgyz Republic is not in conformance with the Kyrgyz law and international laws and standards. Doctors and staff at the RMHC in Bishkek, the Chim-Korgon psychiatric hospital, and the Issyk-Kul Oblast repeatedly reports that patients are often admitted to the hospital on a "voluntary" basis by their families. The patient cannot be discharged from the hospital, regardless of their clinical appropriateness for hospitalization agrees to the discharge. If the family refuses to take the patient back home, the patient remains indefinitely in the hospital. Patients who are orphans or who have lost ties to their family are also often compelled to stay at the hospital, regardless of their clinical needs, until they die because they have no where to go in the community. The psychiatrists and hospital staff reported that it was a particular problem for patients coming from rural areas who were far from their families.

- *In a representative example, in the female rehabilitative ward at Chim-Korgon psychiatric hospital, MDAC researchers met a 28-year old patient who had no parents. She was placed at Chim-Korgon when she was 14 years old because she was too old to remain at the orphanage. As her doctor confirmed, she had no mental illness or mental disability, but she has remained at Chim-Korgon for the past 14 years. She would like to be discharged to the*

[42] In cases where a "voluntary" patient wishes to be discharged from the hospital and his or her doctor believes that he or she is a danger to themselves or others or is gravely disabled, the patient should be detained pursuant to the involuntary commitment procedures, including judicial review. Article 40(5) of the 1999 Psychiatric Care Law mandates that "[t]he patient placed in psychiatric in-patient institution voluntarily, may be refused discharge, if bases for hospitalization on in-voluntary basis will be identified by the commission of psychiatrists of psychiatric institution, as set out in article 29 of the present Law. In that case the issues of his or her stay in the psychiatric in-patient institution, prolongation of hospitalization and discharge from in-patient institution are settled in accordance with the procedure, set out in articles 32-36 and item 3 and article 40 of the present Law".

community. Her doctor informed MDAC that since she is an orphan and has no family, she must stay in the hospital indefinitely.

Psychiatrists also reported that families often use psychiatric commitment inappropriately to resolve family disputes. If there is a family dispute a person would often be placed at a psychiatric hospital and abandoned for the rest of their lives. The psychiatrists further stated that women were particularly vulnerable to indefinite commitment in psychiatric hospitals because of their family's refusal to allow them to return home. They also reported that men often have their wives committed to psychiatric facilities as a result of problems such as a domestic dispute, the man's unemployment and his resulting inability to take care of his wife, and/or other related marital difficulties. Mr. Bogatyrev stated that the psychiatric hospitals have been beginning to fill up with victims of domestic violence, mostly abused women and children.

- *In a representative example, during the visit to the acute female ward of the Chim-Korgon psychiatric hospital, MDAC researchers met a female patient who had trained as a nurse. Following a dispute with her sister, the sister placed the patient at the Chim-Korgon psychiatric hospital. Her family will not take her home, although she is doing well, according to the staff. Therefore, she must remain at the hospital. In order to make the time pass while she is waiting for her family to allow her to come home, she helps the nursing staff at the hospital by doing things such as cleaning the ward.*

- *In another representative example, at Chim-Korgon psychiatric hospital MDAC researchers met a woman who was admitted to the hospital by her family. She and her family came from a rural area far from the hospital. Since her admission to the hospital nine months ago, she has lost all contact with them and now must stay at Chim-Korgon indefinitely, as her family has not allowed her to return home and she has lost ties with them.*

5.6. Restraint

The Kyrgyz mental health law requires that "[m]easures of physical restraint and isolation at the in-voluntary hospitalization and stay in the psychiatric in-patient institution [are] applied only in those cases, forms and for the period of time, when, by the opinion of the psychiatrist, it is impossible to prevent actions of the hospitalized person presenting direct danger for him or her and other persons by other methods, and [restraints] are implemented under constant control of medical personnel".[43] There is no clear guidance on the forms of restraint to be used. However, the law requires that "[a]ll persons having mental disorders and receiving psychiatric care have rights for respectful and human treatment excluding humiliation of human dignity",[44] which is clearly applicable to the restraint forms.

The forms of restraint that MDAC witnessed in psychiatric facilities of the Kyrgyz Republic were disrespectful and inhumane. Patients are sometimes restrained to their beds for some days. According to the chief psychiatrist of one ward at Chim-Korgon psychiatric hospital, such patients occasionally urinated and defecated while still in their bed, thereby soiling the mattress. In order to prevent the further waste of such scant resources such as mattresses, these patients had not been supplied with a new mattress and had therefore been restrained directly to their iron bedstead, in order that they could expel waste into a bedpan placed on the floor. When MDAC researchers discussed this occurrence with the head psychiatrist of the ward, she tearfully

[43] Article 30 (2) Measures of guaranteeing the safety in the provision of 1999 Psychiatric Care Law.
[44] Article 5 Rights of persons having mental disorders of 1999 Psychiatric Care Law.

explained that she knew that this was "wrong" but that she did not know what else to do. She did not have enough staff to appropriately supervise patients and therefore had to resort to restraining patients for long periods of time. Such restraints appeared to be most frequently applied to patients with senile dementia and intellectual disabilities.[45]

- *In a representative example, a 14 year old, female patient with an intellectual disability had been admitted from an orphanage to Chim-Korgon approximately one month before the MDAC visit. According to staff, this young woman had been restrained – tied by her wrists and ankles to her bed – continuously until the day of the MDAC visit. According to staff, such measures were necessary because she would bite others and herself. No specialized psychological program was utilized to assist this young woman from engaging in such behavior, nor were any of the other patients with intellectual disabilities benefiting from any specialized program.*

5.7. Failure to Establish an Independent Agency to Investigate and Monitor Allegations of Patient Abuse, Neglect, and other Rights Violations

The 1999 Psychiatric Care Law mandates that an entity be established to protect and enforce the rights of patients receiving psychiatric care. Article 38, "Service of protection of rights of patients placed in psychiatric in-patient institutions," of the 1999 Psychiatric Care Law requires that "[t[he State creates service of protection for persons that are in psychiatric in-patient institutions independent from the agencies of health protection. Representatives of the service protect rights of patients who are in psychiatric in-patient institutions, receive their complaints and applications, which they solve with the administration of the given psychiatric institution or, depending on their nature, send them to the representative and executive power authorities, the prosecutor or the court".

Such independent agencies are consistent with international standards and laws. Principle 22 of UN Principles also requires that "[s]tates shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient."

The requirement in the 1999 Psychiatric Care Law to establish an entity to protect and advocate on behalf of patients with mental disabilities regarding their psychiatric care has not been implemented. There is currently no entity established and authorized to carry out such duties. The provisions of the 1999 Psychiatric Care Law that allows for patients to bring complaints regarding their care to the courts for resolution are meaningless in practice. It is highly unlikely that such individuals will be able to retain an attorney to help them pursue their complaints and there is no agency established to provide such assistance. The lack of such an entity is one of the reasons that notwithstanding the legal procedure, by which patients receiving psychiatric care

[45] The Kyrgyz mental health law also requires that a record be kept on the types of restraints and the time of the application of these restrictive measures in the patient's medical record for each instance of seclusion and/or restraint or other restrictive intervention. It is highly unlikely that cases as one described above are properly recorded. However, if so, then it brings the broader issue of professional competency and ethical standards, which are not covered in this report.

may bring complaints against the entity providing the psychiatric care and its staff,[46] such complaints are not regularly voiced or addressed.

5.8. Failure to Supervise the Implementation of the Kyrgyz Mental Health Law

Pursuant to Article 46, "Control and Public Prosecutors' Supervision of Provision of Psychiatric Care" of the 1999 Psychiatric Care Law, the general prosecutor of the Kyrgyz Republic is charged with the duty of supervising compliance of the psychiatric laws.[47]

This does not happen in practice. During the visit to Kyrgyz Republic, MDAC researchers met with the Chief Prosecutor at the Department on Supervision and Compliance on Human Rights Requirements, Mr Amir Shagivaliev and one of his colleagues. During the interview, Mr. Shagivaliev reported that he and his staff do not spend much time dealing with enforcing compliance with the mental health laws or other human rights laws for individuals with mental disabilities. The reason that he gave for devoting so little time to these matters is that his office is understaffed (he reports that he only has six prosecutors and one inspector) and therefore, his capacity to address these issues is limited. When the authors asked him if he had ever been to the Chim-Korgon psychiatric hospital, he stated that although he had been once, over ten years ago.

5.9. Criminal Prosecution of People with Mental Health Problems

Care givers who commit crimes against people with mental disabilities are subject under Kyrgyz law to criminal penalties, as well as being liable for administrative and civil penalties.[48] However, such individuals are rarely held responsible for their actions, criminally or otherwise. The chief prosecutor, Mr. Shagivaliev, explained that this is because of a lack of adequate staffing at the prosecutor's office to handle these cases. Furthermore, he stated that in order to successfully prosecute these cases it is necessary to have a quick response in order to prevent important evidence of the crime from being hidden. Since the patients have virtually no way of contacting the police or the prosecutor, it is almost impossible for the police and the prosecutor's office to respond in a timely fashion. Consequently, crimes against patients committed to psychiatric facilities in the Kyrgyz Republic go mostly unpunished and, therefore, abusive staff members are allowed to continue to work with the patients and there are few deterrents to such behavior.

6. Implementation of the Criminal Code

6.1. Delays in Completing Forensic Assessments

MDAC received a number of complaints regarding the inadequate implementation of the requirement under the Criminal Code that criminal defendants with mental illness ordered to

[46] *See* Article 47, "Procedure and terms of appeal," and Article 48, "Procedure of complaints consideration in the court," and Article 49, "The procedure of complaints by the higher body (by higher official)" of the 1999 Psychiatric Care Law.
[47] Article 46(3) of the 1999 Psychiatric Care Law.
[48] *See* Article 50, "Amenability for the violation of the present Law" of the 1999 Psychiatric Care Law.

under go a mental health assessment. Specifically, it was reported that these evaluations are not done in a timely manner. The chief prosecutor, Mr Amir Shagivaliev, stated that the Criminal Code requires that such assessments are completed within 30 days of a court order. Despite this requirement, these evaluations, he reported, often take up to 6 months. This is due, at least partially, to the fact that there are not enough qualified forensic mental health evaluators and these evaluations are only available in the south of the country at the psychiatric hospital in Kyzyl-Djar and more recently at Chim-Korgon. Interviews with judges at the October Court and the lawyers at the Legal Aid Society and Dr. Rosa Raimbekova (former medical director of the RMHC) also confirmed that the delays in completing forensic evaluations.

6.2. Failure to Ensure Independent Assessments for Criminal Defendants

As discussed above, the Kyrgyz Criminal Code allows a court to order a forensic evaluation of a criminal defendant to determine whether the individual's psychiatric condition influenced the defendant's actions as they related to the alleged crime. State employed evaluators conduct these evaluations. If, after the evaluation has been completed, the defendant disagrees with the outcome of the evaluation, the defendant can either ask for a second opinion to be rendered by a panel of state appointed evaluators. Alternatively, the defendant may retain an independent expert to conduct an independent forensic evaluation of the defendant to offer to the court in support of the criminal defendant's case.

Although a criminal defendant is entitled under the law to a second opinion or an independent evaluation in defending his or her case, it was reported to MDAC that defence attorneys virtually never seek these independent evaluations and second opinions. Specifically, legal aid attorneys told MDAC that they have never retained an independent expert because they have no money to do so.[49] Thus, without proper funding for independent experts, this right becomes illusory.

7. Conditions of Care

7.1. International and National Standards

A number of documents by various intergovernmental institutions and organizations have created a *de facto* body of generally recognized set of basic international standards regarding the provision of mental health care and treatment. These documents include statements of ethics in the field of psychiatry, reports and recommendations by international health care organizations specific to the provision of mental health care, and various declarations, covenants, and conventions which describe and define certain fundamental, widely-recognized, human rights.[50]

[49] The lawyers at the Legal Aid Society also stated that they very rarely seek a second opinion from the panel of state appointed evaluators, although they did not explain why they do not ask for a second opinion.

[50] Such key documents include, but are not limited to, the "International Covenant on Civil and Political Rights" (adopted into force by the General Assembly of the United Nations on 23 March, 1976), the "International Covenant on Economic, Social and Cultural Rights" (adopted into force by the General Assembly of the of United Nations on 3 January, 1976), the "Convention on the Elimination of All Forms of Discrimination Against Women" (adopted by the United Nations General Assembly into force on 3 September 1981) the United Nations General Assembly Resolution 46/119 on the "Protection of Persons with Mental Illness and the Improvement of Mental Health Care," (adopted by the General Assembly of the United Nations on 17 December 1991), the World Psychiatric Association's "Statement and Viewpoints on

Within the Kyrgyz Republic itself, the 1999 Psychiatric Care Law is the single most significant text in regard to the establishment of minimum standards of mental health care. As already discussed, this law was enacted with the specific intention of ensuring a minimum standard of care and treatment for citizens of the Kyrgyz Republic who have a mental illness.

For the purposes of this report, the aggregate international standards set forth in the various documents discussed above will be used as criteria against which the present condition of mental health service in the Kyrgyz Republic shall be measured. While these documents should naturally be read in their entirety, certain sections of these documents are of particular relevance. These excerpted sections are attached, *verbatim*, as Appendix 1 to this report.

7.2. Overall Findings Regarding Standards of Care

7.2.1. Excessive centralization

The majority of psychiatric services in the Kyrgyz Republic remain concentrated within the general area of Bishkek, and particularly beneath the umbrella of the RHMC. Such heavy centralization is contrary to international standards regarding appropriate mental health care provision in the most integrated and accessible community setting. It is disturbing that "Decree N 138", was enacted fairly recently by the Ministry of Health, a legal provision which has further centralized the mental health system.

7.2.2. Inadequate level of out patient care

MDAC observed only three instances of out-patient care. Such care was provided on two out-patient wards at the RMHC and through informal follow-up visits conducted by the staff of the hospital at Karakol. It is clear that the majority of health care practitioners in the Kyrgyz Republic continue to assume that in-patient care is the preferred means of psychiatric treatment. This too is at odds with current international standards.

7.2.3. Inadequate types of medication

As described more fully below, the lack of appropriate medication is endemic throughout the entirety of the Kyrgyz mental health system. This is certainly true concerning the older medications currently listed on the government-approved formulary; and it is also true in regard to other medications widely used in other countries. For example, none of the psychiatrists interviewed were able to provide their patients with fluoxetine, one of the most common and efficacious anti-depressants available, and some psychiatrists had never heard of this medication. This is unfortunate, considering that the exclusive patent on fluoxetine has expired and much

the Rights and Legal Safeguards of the Mentally Ill" (adopted by the World Psychiatric General Assembly in Athens, Greece, 17 October, 1989), the World Psychiatric Association's "Declaration of Hawaii" (adopted by the World Psychiatric Association in Vienna, Austria, on 10 July, 1983), the World Health Organization's "Round table on mental health: Report to the Secretariat" of 19 May, 2001, the World Health Organization's "Mental Health: Responding to the Call to Action, Report to the Secretariat" of 11 April 2002, and the World Health Organization's "The World Health Report 2001, Mental Health: New Understanding, New Hope".

more inexpensive, "generic", forms of this drug are now widely available. While a medication similar to that of atypical anti-psychotic clozapine was said to be in occasional use, psychiatrists seemed unable to procure other atypical anti-psychotics such as respiradone or olanzapine, which do not cause the potentially lethal side effects associated with clozapine. Again, this highlights the pressing need to increase not only the availability of the older generation drugs listed on the government formulary, but to also expand the formulary to include more safe and efficacious drugs that are widely available in more developed counties.

It is curious to note that procurement of supplies of non-formulary drugs is apparently almost exclusively exercised by the RHMC in Bishkek. This may well again be another effect of excessive centralization of resources.

7.2.4. Failure to appropriately fund the mental health system

The mental health system in the Kyrgyz Republic is so short of funds that it cannot ensure that people in its care receive even a minimal amount of human necessities such as food, clothing, and appropriate medication. Therefore, if measured by these rudimentary standards alone, the Kyrgyz mental health system falls well below the international standard of care – and it shall inevitably continue to do so until funding levels are dramatically increased.

MDAC was told throughout our visit that this chronic state of under-funding remains the single greatest obstacle to providing appropriate mental health care. Every effort should immediately be made by people of the Kyrgyz Republic and by the international community to increase the funding to an appropriate level.

However, such under-funding cannot be used as an all-purpose excuse for failures to find more innovative and cost-effective measures of providing care. Dr. Sutybek Nazarculov, General Director of the RMHC in Bishkek, acknowledged that operating large psychiatric hospitals such as the RMHC is not necessarily the most cost-effective means of providing good mental health care. Given the widespread poverty in the country, mental health care practitioners are faced with an emergent and particularly critical situation. They bear the responsibility of devising and implementing an appropriate remedy in the most cost-effective and exigent means possible.

Moreover, MDAC cannot conclude that the lack of funding serves as a justification for the various human rights violations observed by, or reported to, the authors at the psychiatric facilities. In many instances, additional safeguards that would provide more safe and humane conditions for the patients would require little or no monetary investment. However, MDAC researchers noted a general and disturbing lack of interest on the part of several authorities within the Kyrgyz mental health system to implement such crucial safeguards. Such additional, relatively inexpensive and easily implemented safeguards will be discussed in more detail below in regard to conditions at individual psychiatric facilities.

Finally, it appears that the funding currently available within the mental health system is not distributed equitably. For example, the off-campus branches of the RMHC at Chim-Korgon and the "Ward 12" vocational program in the village of Novo-Pavlovka both showed signs of physical dilapidation, shortages of basic supplies, and significant treatment failures far worse than those observed by the authors at the main campus of the RMHC. Again, this suggests an inequitable concentration of funding not only within the RMHC and its branches, but also within the main campus of the RMHC in Bishkek. Likewise, the conditions observed at Chim-Korgon and at "Ward 12" were much worse than the conditions observed at the oblast-level hospital in Karakol.

This too would suggest that funds are not equitably distributed throughout the whole of the Kyrgyz mental health system.

7.2.5. Individual Psychiatric Facilities

All four psychiatric facilities visited by MDAC violate basic international standards regarding the conditions of care. There are, however, marked differences in regard to the degree and number of these violations among the four facilities.

7.2.5(c) RMHC in Bishkek

Built in 1956, the RMHC is a large psychiatric hospital located in Bishkek and generally regarded among the Kyrgyz psychiatric community as the premier mental health facility in the country. As mentioned previously, the Minister of Health reported that the RMHC functions as a "tertiary" level facility, providing care to patients who have previously been unsuccessfully treated at the raion and oblast level psychiatric facilities.

Due to its centralized location in the capital, the staff and patients of the RMHC benefit from a close association with the Kyrgyz Institute of Psychiatry and Neurology, headed by Dr. Valeri Solozjenkin, Chief Psychiatrist for the Ministry of Health of the Kyrgyz Republic. This university-affiliated institute provides professional training and certification to students of psychiatry. Due to this proximity to and collaboration with this group of young and motivated medical students – many of whom expressed a desire to remain informed of the most current international standards in the practice of psychiatry – the staff and patients of the RMHC enjoy a resource unlike any other found in the Kyrgyz Republic.

The RHMC currently serves an average of 700 patients. Patients are dispersed throughout the hospital according to the following designations: males who have been deemed by RMHC staff to be in an "acute" stage of "psychosis"; females who have been deemed to be in an "acute" stage of "psychosis"; patients who according to RMHC staff suffer from various "neuroses" and "psycho-somatic" disorders; individuals who are being assessed for participation in the military; males who, according to RHMC staff, have "lost connections with their families" (these males are concentrated at "Ward 12," which is discussed more fully below); one ward that provides adult outpatient treatment; and one ward that provides outpatient treatment for children.

Each ward visited by the authors at RMHC was overcrowded. Rooms on the wards each contained approximately 14 to 16 beds, allowing little room for patient movement, no guarantee of privacy, and no room for personal belongings. Staff on each of the wards reported to the authors that each ward was operating well beyond its designated capacity.[51]

RMHC staff, including Dr. Nazarculov, reported to the authors that the hospital could not guarantee that its patients would receive adequate amounts of food,[52] medicine, clothing, bed

[51] Principle 13 of the "MI Principles" mandates that "[e]very patient in a mental health facility shall, in particular, have the right to full respect for his or her…(b) Privacy;…"

52 Article 11(2) of the "International Covenant on Economic, Social and Cultural Rights" (adopted into force by the General Assembly of the of United Nations on 3 January, 1976), The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international cooperation, the measures, including specific programs, which are

linens, blankets, or mattresses. Other staff members stated that most of the improvements to the physical structure of the hospital, such as paint for walls, had to be provided by the staff themselves. Several staff members told the authors that, on occasion, the shortage of mattresses is so acute that patients must sometimes sleep on bare, rusted bedsteads. In regard to basic hygiene issues, the staff on two wards reported that patients were bathed approximately every ten days. One ward had no working toilets.[53]

Staff also reported that there were insufficient numbers of staff members to provide adequate treatment and ensure patient safety. Due to this chronic shortfall, certain higher functioning patients provide both supervision and care to patients who are in a more acute stage of their mental illness.[54]

In regard to the provision of medication, staff reported that due to the inconsistency of the medication supply, medications must be administered on a "triage" basis. According to the RMHC triage system, patients who are the most acute and most recently admitted to the hospital are the most likely to receive medication. Staff acknowledged that, on occasion, medication shortages are such that some patients who should be provided with medications do not receive any medication at all for an extended period of time. This erratic administration of psychotropic medication is less than optimal, and perhaps even dangerous.

On an "acute" male ward and an "acute" female ward, each of the several patients interviewed reported that they were receiving the same psychotropic regimen of *Haloperidol* and *Cyclodol*.[55]

The authors noted that several individuals who appeared to have intellectual disabilities were interspersed among the general patient population. Staff acknowledged that although patients with intellectual disabilities are sometime admitted to the RMHC, no specific treatment program has been developed that would be congruent to these patients' level of intellectual functioning.

All of the patients interviewed regarding psychotropic medications stated that they were receiving the same regimen. Even patients with intellectual disabilities are treated in a manner indistinguishable from the rest of the adult psychiatric population. The treatment provided to patients at the RMHC is therefore not individualized.

Further, except for those patients who reside on the "neurotic" ward, no patient at the RHMC receives any form of psychotherapy. This appears to be further indication of a lack of appropriately individualized services at the RMHC.[56]

When examined in its entirety, it is obvious that the RMHC is hardly the type of small, intensive, in-patient psychiatric facility as envisioned and recommended by the WHO "World Health

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needed: (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources; (b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of would food supplies in relation to need."

[53] Interviews with RMHC staff, June 4 2003.

[54] Principle 14 (1) of the "MI Principles" requires that psychiatric facilities shall have, *inter alia*, "[q]ualified medical and other appropriate professional staff in sufficient numbers".

[55] Interviews in Ward 9 and Ward 10 of RMHC 4 July 2003.

[56] Principle 9 (2) of the "MI Principles" requires, that "[t]he 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".

Report 2001", where patients are treated for as short a time as possible and then returned to the community. This was also acknowledged by Dr. Solozjenkin, who stated to MDAC that many of the patients admitted to the RMHC could more successfully and appropriately be treated in the community through out-patient services.

Evidently, the RHMC – far from being a "tertiary" level facility – functions instead as a "primary" level facility located at a great distance from many of the patients' homes. Rather than providing the type of care as consistent with international standards, the RMHC continues to function as it was no doubt originally designed: that is, as a large, custodial-style, institution. Given these limitations, the RMHC is also obviously struggling – and failing – to fulfill even this more restricted function. Even a "custodial" mental health facility should reasonably be expected to provide its patients with at least a appropriate-level amount of medication and staff supervision, as well as an adequate amount of food, clothing, privacy, bed linens, and mattresses. By the reports of its own staff members – who were aggrieved by the conditions at their hospital – this is not occurring at the RMHC.

7.2.5(d) Chim-Korgon Psychiatric Hospital

According the staff at the RHMC in Bishkek, patients are transferred to the RHMC Branch Facility in the village of Chim-Korgon, located 85 kilometers to east if they do not show significant improvement within three months of their admission to the RHMC in Bishkek. Several patients interviewed by MDAC had been at the RMHC in Bishkek for much more than three months. Other patients at the RHMC in Chim-Korgon stated that they had been admitted directly to the facility in Chim-Korgon and had not been treated in Bishkek. Such a general process of transfer appears to be at least more or less in place. Staff members at the RHMC also reported that patients who have been abandoned by their families are transferred to Chim-Korgon. This too appeared to be generally accurate. Many patients at Chim-Korgon, often from distant rural areas, confirmed that they had been placed at the facility as a result of having been abandoned by their family: further evidence of the excessive centralization of the Kyrgyz mental health system.

The Director of the RHMC Branch at Chim-Korgon, Dr. Janubek Agybekov, stated that 500 patients currently reside at Chim-Korgon. Dr. Agybekov explained that the hospital had originally been constructed to house 850 patients, but that the wards that would provide space for the additional 350 beds are presently uninhabitable. Several staff members at Chim-Korgon, including Dr. Agybekov, reported that more patients would be housed at Chim-Korgon when the construction of a new building – financed through a grant from the Islamic Development Bank – was completed. Staff members of Chim-Korgon took MDAC researchers to this new building. As reported by Dr. Agybekov, and as noted by MDAC, this building was not yet habitable and was not being used to house patients.[57]

As for staffing levels, Dr. Agybekov stated that although the hospital was supposed to employ 550 staff members, only 300 staff members were employed at the facility. In order to compensate for this shortage, some staff members worked continuously for two days, without rest.[58]

[57] A "Comprehensive Development Framework/National Poverty Reduction Strategy" website posted by the government of the Kyrgyz Republic at http://cdf.gov.kg/en/donors/techhelp_idb.htm states that the construction of this new building, funded for 140,000 USD by the Islamic Development Bank, has been "completed".
[58] See Principle 14 (1) of the "MI Principles".

Dr. Agybekov also stated that: 1) the problems at Chim-Korgon were "too numerous" to describe in detail; 2) that he was certain the authors of the report would be aware of these problems by the end of their tour of the facility; 3) that the hospital at Chim-Korgon was chronically under-funded; and that 4) such under-funding was symptomatic of general under-funding of mental health facilities in the Kyrgyz Republic.

The facility at Chim-Korgon serves three general populations: "acute" adult psychiatric patients, geriatric patients, and patients who have been sent to the hospital as a result of a forensic assessment. The facility also contains a "Labor Colony" (described in greater detail below) that reportedly provides patients with "vocational therapy." Including the "Labor Colony," the authors visited wards representing each of these population groups.

As stated above, although many of the patients at Chim-Korgon have been transferred from the RHMC in Bishkek, the mental health practitioners at Chim-Korgon are unable to offer these patients any form of therapy that was not already available at the RHMC in Bishkek. As in Bishkek, patients at Chim-Korgon recited received *haloperidol* and *cyclodol* as the principle and perhaps singular form of pharmacological treatment. Staff and patients at Chim-Korgon were more even more expressive regarding frequent shortages of medication than their counterparts in Bishkek. Staff members stated that they frequently could not provide patients with either appropriate neuroleptics or the appropriate "correctives" for side effects. Further, one patient stated that he felt like killing himself because he was being administered *haloperidol* without any "corrective". In regard to this particular patient, staff confirmed that they were currently unable to provide him with the appropriate medication to counteract the side-effects he was experiencing.

The amount of suffering experienced by individual patients who are unable to receive appropriate psychotropic medication is troubling. The situation is illustrative of a failure of the Kyrgyz mental health system on a more systemic level. Rather than a "tertiary" level facility, as described by the Minister of Health, the hospital at Chim-Korgon - which, it must be remembered, is considered to be a branch of the RMHC - should more appropriately be considered, in many cases, a "terminal" level facility. Given that many of the patients there have already exhausted all available forms of treatment - and given that a number have been also been abandoned by their families - a large number of residents at Chim-Korgon are likely to remain there until they die. According to one staff member at Chim-Korgon, the maximum length of stay for a patient was supposedly up to seven years. For those non-geriatric patients who have not yet responded to treatment and who have no family, this would seem to be a conservative estimate.

In order to determine if Chim-Korgon was indeed fulfilling such a "terminal" and hopelessly "custodial" capacity, staff members were repeatedly asked if they had access to *any* form of treatment not available at the RMHC in Bishkek. The staff reported that, to the contrary, certain drugs were occasionally available at the RMHC in Bishkek that were never available in Chim-Korgon. The staff members at Chim-Korgon did not elaborate on which classes of drugs, or specific medications, were available at the RMHC in Bishkek that were not available to them. Certainly, the heavy reliance upon *haloperidol* was evident among the patient population at Chim-Korgon. Perhaps as to be expected, several patients appeared to be suffering from extrapyramidal symptoms commonly associated with *haloperidol* class medications.[59]

Without a reasonable opportunity to provide some of their patients with the possibility of discharge – and with such severely restricted access to common pharmacological treatment

[59] Principle 8 (2) of UN Resolution 46/119 of 1991, "Every person shall be protected from harm, including unjustified medication, causing mental distress or physical discomfort"

options – the staff members at Chim-Korgon therefore serve an even more limited custodial function the staff at the RMHC in Bishkek. Unfortunately, they also appear to possess even less material capacity to fulfill this role than the staff in Bishkek.

For example, while both patients and staff at the RHMC in Bishkek complained of a lack of sufficient nutrition, three patients at Chim-Korgon appeared to be actively suffering from the effects of prolonged malnutrition, as evidenced by reduced muscle mass, protruding bones, dry, pale skin, and general emaciation. While such malnutrition could be the result of any number of associated diseases—rather than of a lack of food *per se*—this certainly would be congruent with the statements of staff and patients regarding a chronic lack of food. In the event that the emaciation we observed was due to a medical condition rather than a lack of food, one must therefore question the adequacy of general medical care at Chim-Korgon.

The use of "quarantine rooms" raises another concern in regard to the level of general medical care. On one ward, according to staff, very sick patients are moved into a "quarantine room." This "quarantine room" is a small room separated from the rest of the ward by a wooden door. When asked what sort of illnesses would cause an individual to be moved into the "quarantine room", staff replied that "any patient" suffering from "any kind" of communicable disease was moved into the "quarantine room." When asked if this meant that patients who were suffering from both common colds and diarrhea were therefore placed in the same small room together, staff did not respond.

Other serious shortcomings were observed in regard to simple custodial care. Each ward visited by MDAC was overcrowded, with up to 16 beds placed within one room. These wards are unable to provide patients with an even minimal degree of movement and privacy. While each patient observed by MDAC had been recently provided with a fresh supply of bed linen, a number of patients stated their belief that this bed linen had been distributed in anticipation of our visit, given that these linens had only been procured within the last two weeks. Before that time, the bed linen had been, according to Dr. Agybekov, in a serious state of disrepair. When asked why the bed linen had not previously been available, and how he had recently managed to finally procure a sufficient amount, Dr. Agybekov declined to answer, and instead stated, "That's my secret." Many staff also spoke to us about a shortage of mattresses, complicated by the fact that patients are sometimes restrained to their beds for several days on end and that as a result of urination and defecation the mattress is destroyed.[60]

The sanitary conditions throughout the hospital are poor, particularly given that the facility did not appear to have a working sewer system. Rather, in small, fetid rooms, patients squat over holes in the floor in order to relieve themselves. One blind, elderly patient was noted to be leaving the toilet area with both feces and urine on his clothing. Several other patients smelled of urine. Staff stated that they rarely had the opportunity to assist patients with physical disability to bathe. Obviously, such failure to provide patients, including people with physical disabilities, with basic hygienic care while they stay in a psychiatric institution is a violation of these patients' right to be free from inhuman or degrading treatment.[61]

The physical structure of the hospital showed signs of serious neglect throughout. Many windows had been broken and holes had been broken in the floors and walls. The glass from these broken windows could obviously be used as a weapon by either suicidal or aggressive

[60] See section on restraint above.
[61] Article 7 of International Covenant on Civil and Political Rights states that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

patients. The lighting throughout the hospital was also poor. Some sections of the wards were lit by only one small, dim bulb.

"Vocational programs" – in the loosest possible sense of the phrase – are occasionally offered to those patients who are permitted to leave the wards. One patient explained that he was a mechanic and that as such he was allowed to leave the ward in order to repair staff members' vehicles. Male patients with sufficient privileges are also allowed to work in a grain mill located on the hospital grounds. This grain mill is connected to a bakery that provides bread and pasta to the patients. (A staff member overseeing the work at the bakery stated that if it were not for the grain mill and bakery, the patients would starve.) A sewing center has been constructed which is intended to provide vocational opportunities for female patients: yet because no fabric is presently available, no vocational activities are currently being offered to female patients. Although all of the patients interviewed stated that they enjoyed the opportunity to work – particularly to alleviate boredom – none were being paid for the work.[62]

In addition, some patients reported that they were allowed to supplement their usual diet of bread and pasta by working in the vegetable fields that surround the hospital grounds. These patients stated that they were grateful for this opportunity. Again, such activity was said to at least break up the boredom commonly experienced on the wards –and by harvesting these vegetables, the patients were able to supplement their otherwise meager diets. Such harvesting, however, remains problematic. Bearing in mind the chronic food shortage at Chim-Korgon, this "opportunity" soon resembles a form of forced labor: if a patient wishes to have a diet that consists of anything substantially more than bread, pasta, or tea, he or she must work for this food. It is disturbing that patients must comply with treatment, or directions, in order to earn sufficient privileges that in turn allow them to have a slightly more varied diet. Some patients at Chim-Korgon are unable to earn such privileges due to a continued unstable psychiatric or behavioral condition.

No newspapers, radios, televisions, or telephones were available for the use of patients. Furthermore, even those patients who were allowed to leave the wards after having earned enough "privileges" told MDAC that they were not allowed to enter the nearby village. Aside from their own company, rare visits from family members, and conversations with hospital staff, patients have no other occasion for social interaction.

When considered as a whole, the conditions at the main campus of the Chim-Korgon hospital can be considered to be in violation of practically every basic principle outlined by the Principle 13 of the MI Principles.[63]

Additionally, no educational facilities programs are being provided to the several young adults who reside at Chim-Korgon.[64]

7.2.5(e) The "Labor Colony" at Chim-Korgon

Approximately one kilometer from the main campus of the Chim-Korgon hospital, down a narrow dirt road, surrounded by trees and in the middle of a field, stands a group of buildings that is collectively known by Chim-Korgon staff and patients as the "Labor Colony." The compound

[62] Principle 13 (4) of the "MI Principles" rights and conditions in mental health facilities.
"The labor of a patient in a mental health facility shall not be exploited."
[63] Principle 13 of the "MI Principles": rights and conditions in mental health facilities
[64] Principle 13 (2b) of the "MI Principles": the environment and living conditions in mental health facilities shall include facilities for education.

includes a bathhouse and a single, barracks-style ward for approximately 30 male and female patients.

According to the psychiatrist appointed to oversee the "Labor Colony," patients who have demonstrated particularly good behavior and whose psychosis is in remission are allowed to move from the main campus of Chim-Korgon and to the Labor Colony. While at the "Labor Colony" patients are expected to participate in harvesting vegetables and grains from the nearby fields. According to the psychiatrist, patients living at the Labor Colony also have greater freedoms than those living on the main campus. When asked about the precise nature of these "freedoms", MDAC researchers were told that patients at the Labor Colony could "come and go as they pleased." This, however, did not appear to include entrance into the village of Chim-Korgon itself. Rather, the Colony psychiatrist seemed to be referring to the fact that patients were allowed to either work in the fields or to remain in the barracks, as they wished. This psychiatrist explained that if a patient once again became psychotic – to the degree that he or she was unable to participate in vocational therapy – the patient was returned to the main campus.

These careful, clinical distinctions made by the this psychiatrist in regard to appropriate candidacy for residence at the "Labor Colony" soon appeared to be quite illusory once MDAC spoke with patients themselves. One young, apparently floridly psychotic woman begged to be returned to the main campus because the "gods in her head were trying to kill her again." She stated that since coming to live at the "Labor Colony" she had not been receiving any medications. She stated that she "did nothing all day but lie in bed." Several young women with intellectual disabilities seemed to be no more or less capable of participation in the Labor Colony vocational program than any of the other young women with intellectual disabilities whom MDAC met on the main campus.

MDAC asked the psychiatrist about the young woman who felt that the gods in her head were trying to kill her about how her symptoms comported with his criteria for determining patient readiness to participate in the programming at the "Labor Colony". The chief psychiatrist of the Colony stated that he was aware of her delusions and that this particular young woman had been determined to be "entirely resistant to treatment." He declined to elaborate upon how her presence could possibly comport with his previous description that an absence of significant psychosis was a requirement to participate in programming. When asked if perhaps the young woman was not exercising one of her greater "freedoms" by requesting to return to the main campus of the hospital, the psychiatrist replied that such a return would not be permitted. He declined to give reasons. Such evasiveness, or uncertainty, on the part of the Colony's chief psychiatrist further brings into question whether or not the therapeutic nature of the vocational program at the Labor Colony was clinically meaningful in any way.

This young, psychotic woman lived in one of the two rooms that had been designated for the use of female patients. These two rooms were located at located at the back of the barracks, with no alternative exit except through the front of the barracks. To exit the barracks, the female patients had to pass in front of the rooms designated for the use of male patients. Staff offices were also at the front of the barracks. The rooms for female patients were therefore directly next to rooms designated for male patients. As at the main campus, the barracks was poorly lit, with a single bulb in the central hallway. Male patients were observed to have free passage into the rooms of female patients.

When interviewed privately, a number of female patients stated that they had been victims of severe abuse while living at the Labor Colony. They described how male patients beat and raped them in the same-sex toilet area of the barracks, in the nearby bathhouse, in the fields, and in their

own rooms. They reported that those women who were more willing to engage in sexual acts were granted even more "privileges." They reported that male patients often took away food from them. They also stated that some of the male patients were "sexual perverts." When MDAC asked the chief psychiatrist if some of the male patients at the Labor Colony had been committed to Chim-Korgon due to a previous sex offence, the head psychiatrist stated that this was true for "one or two" of the male patients at the Labor Colony.

It is true that some patients with psychosis may have delusions. However, the quantity, nature and detail of the allegations MDAC received left the researchers in no doubt of the credibility of these women's testimony. Such credibility is further heightened by the fact that several of the female patients argued among themselves as to whether or not they should reveal to the authors the "truth" about their living conditions. At least one female patient was displeased that MDAC had been told about the rapes and sexual assaults. This woman concluded that as outsiders, MDAC would recommend the closure of the Labor Colony and she would be moved back to the main campus of Chim-Korgon, where she "would be hungry again". She said that she would prefer to "put up with" the sexual assaults and rapes that were occurring at the Labor Colony in exchange for having greater access to food. Such careful weighing of how the disclosure of the sexual assaults and rapes would effect any recommendations made by this report, gave further credence to the impression that the issue of sexual assaults and rapes was one that the female patients at the Labor Colony commonly dealt with.

One young woman was noted to be barefoot. When asked if she had any shoes, she stated that she and another patient shared a pair of shoes, and at the moment the other patient was wearing them. Other patients described a similar lack of clothing. One young woman explained that she and another patient shared a bathrobe and a dress: when she was wearing the robe, the other woman wore the dress, and *vice versa*.

None of the patients participating in the Labor Colony vocational program received remuneration for their work. Like the patients at the main campus, the residents of the Labor Colony explained that they were at least able to supplement their diets by working in the fields.

The general physical conditions of the barracks were as equally squalid as the main campus.

One staff member was observed shouting at a male patient who was attempting to talk to us. The staff member sternly directed the patient to return to his room. The patient was visibly frightened by the staff member and quickly obeyed the commands given to him.

The conditions at the Labor Colony were in violation of not only international standards of psychiatric care, but of several basic international human rights standards as well. Many of these violations could be avoided by implementing inexpensive or free safeguards. For example, if men and women are to be housed together at the Labor Colony, staff offices should be located between male and female rooms in order to provide at least a minimal degree of protection for the female patients. As discussed above, staff offices are currently at the front of the barracks and therefore provide no buffer between male and female patients. Such a measure would require no additional funds. Additionally, several of the female staff members at the Labor Colony reported that they themselves were afraid of the male patients, as many particularly aggressive males had been placed at the Labor Colony. A re-distribution of the patient population between the Labor Colony and the main campus at Chim-Korgon could well reduce the likelihood of further sexual

abuses from occurring at the Labor Colony without any additional expenditure.[65] Likewise, the enforcement of a policy strictly forbidding the occurrence of sexual assaults and rapes – as well as patient abuse in general – would cost nothing, and yet would be of enormous benefit to the patients.

The fact that the Labor Colony is so dimly lit increases its potential for abuse, as the staff cannot appropriately supervise or protect patients whom they cannot see. An inexpensive investment of additional light bulbs would be low cost. Administrators at Chim-Korgon stated that it would be unlikely for them to secure sufficient funds to buy additional light bulbs.

7.2.5(f) Rehabilitation Unit ("Ward 12")

Like the facility at Chim-Korgon, Rehabilitation Unit # 12, commonly known as "Ward 12", is another branch of the RMHC. Another barracks-style ward, it is located in the village of Novo-Pavlovka, on the outskirts of Bishkek, and provides accommodation to approximately 30 male patients. According to staff members, the patients at Ward 12 have either been "abandoned" by their families or in some other way have lost all other social connections. As at Chim-Korgon, the emphasis at "Ward 12" is entirely upon providing custodial care rather than psychiatric treatment. As at Chim-Korgon, the staff lack the material resources for provide even this limited level of care.

Both staff and patients told MDAC of the insufficient amounts of food and clothing at Ward 12. Many of the patients stated that they were always hungry and that in the winter they were very cold. Staff members stated that, for the most part, patients survive on a few crusts of bread and water. Patients pointed out that they also receive "compote" – a type of grain mash – and tea occasionally. A few fruit trees grow on the grounds, from which patients are able to gather apples. One patient mentioned that one of the local farmers sometimes gave the patients a cucumber. Another patient reported that they are sometimes taken to the cornfields. Patients reported that in winter they were provided with no fruits or vegetables whatsoever. At no time in the year were they provided with meat, or fish, or any protein of any kind. One patient stated that on occasion, gifts of food arrived from relatives, but that the patients devoured these gifts so quickly that they then vomited.

Ironically, a sign posted on a wall outside the ward states that the patients are "not to be fed." Rather purposelessly, considering the general shortage of food at Ward 12, this sign then proceeds to describe all the particular types of food that the public should not give to the patients.

Ward 12's electrical system works only intermittently. A coal stove provides the only heat for the ward. Many of the windows are broken and shards of glass are scattered on the floor, easily accessible to the patients. Water for bathing and drinking has to be carried from a rusted pump in the yard. Several exposed pipes protrude from the walls, upon which suicidal patients could attempt to hang themselves. The single toilet, at the time of MDAC's visit, was overflowing with human waste and could not be used. The ward smelled of feces throughout. Several of the patients had no mattresses and so had to lie directly on their iron bedsteads. Bed linens and blankets were in short supply. The patients' clothing was threadbare. Patient rooms were crowded with beds, allowing for little room for movement and no privacy.

[6565] As described by the female staff, these "exceptionally aggressive" male patients, are provided with the greatest level of freedom of all the patients at Chim-Korgon, as they reside at the "Labor Colony," where they are allowed to "come and go as they please."

Two large bathtubs, unconnected to any plumbing system, sat unused in one room. According the staff, these bathtubs had been the gifts of "an American."

The patients stated that they were given newspapers on occasion, but that they had no television, radio, or telephone.

In regard to psychiatric care, both the patients and staff reported that they were unable to procure sufficient amounts of medications. Each patient interviewed stated that he had been prescribed both *haloperidol* and *cyclodol*. None of the patients interviewed knew their mental health diagnosis. One patient stated, "All I know is that the doctor says I've got the worst possible illness." Another patient stated, "I'm not sure" and another, when asked why he was at Ward 12, just shrugged. According to the staff, a psychiatrist visited the ward three times a week, on a part-time basis.

Several of the patients reported that they were originally from rural areas and that they would like to return to their homes, but did not know when this might occur.

The staff stated that the ward had been last inspected and visited by the General Director of the RHMC a year and a half before our visit.

Despite these dire conditions, the staff members of Ward 12 – who are underpaid and largely forgotten by the authorities in the Kyrgyz mental health system – expressed a great deal of sympathy of the patients in their care. These staff members should be commended for their commitment to providing all the possible care that their capacity allows.

7.2.5(g) Issyk-Kul Oblast Hospital in Karakol

The standards of care observed by MDAC at the Issyk-Kul Oblast hospital in Karakol came as a very pleasant surprise. This small, essentially rural, 30-person hospital, at a considerable distance from the capital, was the single most well maintained facility that MDAC visited. Credit for this must be given to the supervisors and staff members of the Karakol hospital, all of whom are seemed committed to providing their patients with the best care possible.

Rooms that at Chim-Korgon would have contained 16 beds contained a maximum of four at the Karakol hospital. Each patient had a table next to his or her bed as a place to store personal belongings. Each patient was well clothed. Each had sufficient and clean bed linen, blankets, and a mattress. The male patients were appropriately separated from the female patients and were being adequately supervised. Patients had the opportunity to socialize in a common area, which included a working television set. Staff members spoke to patients in a respectful manner. When asked if the staff experienced difficulty in properly feeding the patients, it was explained that because the patients at the Karakol hospital were still within a reasonable distance of their families, families were able to supply the majority of the food for the patients. Staff reported, however, that they would have difficulty providing the patients with an adequate level of nutrition if the patients were forced to rely exclusively upon the food provided to them by the hospital.

In terms of psychiatric care, the Karakol hospital was largely fulfilling the function for which it was designed. Staff reported that if a patient admitted to their care did not improve within 25 days, he or she was to be transferred to Chim-Korgon hospital, but that, for the year of 2003, they had only been required to send 5 patients, out of an approximate 200, to Chim-Korgon. Staff

members were demonstrably and deservedly proud that they had been so successful in providing care that ensured that, in the majority of instances at least, individuals with a mental illness were able to continue to live in their own community. Staff reported that they also functioned as an informal out patient clinic. That is, when an individual was discharged from the Karakol hospital, a staff member would often follow-up with the patient to ensure that he or she was still following the recommended treatment. It could well be that this aggressive form of community case management on the part of the Karakol staff – rather than the prescription of medications – is largely responsible for the hospital's low transfer rate to Chim-Korgon.

Of great concern to the staff members was the inconsistent availability of appropriate medication. Staff reported that they were unable to procure sufficient amounts of the anti-depressants, anti-anxiety agents, neuroleptics, and anti-convulsants listed in the government-approved formulary and therefore supposedly guaranteed to anyone in need of them. The staff also reported that on occasion the RHMC in Bishkek was able to procure medications, such as serotonin re-uptake inhibitors and atypical anti-psychotics, through donations from humanitarian aid organizations. Staff recalled that a small shipment of serotonin re-uptake inhibitors had been sent to Karakol on one occasion, but that the supply had been so limited that they were unable to determine either the short or long term efficacy of this drug.

MDAC asked Dr. Nazarculov of the RMHC why a small, rural hospital such as the one in Karakol should be able to ensure conditions that were in some ways far superior to the conditions at the RMHC. Dr. Nazarculov stated that the local hospital in Karakol was a "special project" and that it received additional funds not necessarily available to either other rural hospitals or the RMHC itself. Dr. Nazarculov stated that because of this inequity in funding, the hospital at Karakol was not particularly representative of the oblast level psychiatric facilities in the Kyrgyz Republic.

8. Recommendations

8.1. Immediate Cessation of Human Rights Violations

Every effort must be immediately taken in order to end the violations of basic human rights within the Kyrgyz mental health system. Patients must be provided with adequate food, medicine, and general medical care. Immediate steps must be taken in order to end the sexual exploitation of women in the Chim-Korgon Labor Colony.

8.2. Development of an Independent Service to Protect Human Rights of Psychiatric In-Patients

It is imperative that the government designate and facilitate the development of an independent service to protect human rights of psychiatric in-patients as it is obliged to do by the Article 38 of the 1999 Psychiatric Care Law. Such service should provide advocacy, monitoring, and investigation of allegations of patient abuse, neglect and other rights violations. The agency should be staffed with advocates and attorneys trained with a background and genuine interest in mental health or mental health law. The purpose of the agency would *not* be to provide medical or any clinical advice, but rather to provide advocacy and, if necessary, legal representation to individuals with mental disabilities in issues related to their disabilities. Such an agency should have the authority to take any action, including legal action as allowed by law, on behalf of an

individual with a mental disability in an attempt to resolve any issues related to his or her disability.

This independent service should also have the authority to conduct full investigations into any allegations – or into probable cause beliefs – that an individual or a group of individuals with mental disabilities had been or were abused, neglected, or had suffered any violation of rights. This authority should include, but not be limited to: reasonable access to individuals with mental disabilities, including those living in institutions; the capacity to meet privately and confidentially with such individuals; reasonable access to facilities providing mental health treatment, including but not limited to state-operated and locally-operated psychiatric hospitals; access to patient records with the appropriate consent for release of information; access to patient records in the event that the patient is incompetent to consent to a release of said records and there is probable cause to believe that said individual has been abused or neglected or is likely suffer from abuse or neglect in the future.

Such an agency could operate as part of Ombudsman Office of the Kyrgyz Republic. Adequate funding by the government should also be made available to support this entity.

8.3. Training on Mental Health Law and Procedure (Civil Commitment)

The failure to implement this part of the 1999 Psychiatric Care Law appears to be largely the product of a widespread and serious lack of knowledge and understanding of the involuntary commitment procedures among clinicians, lawyers, and judges. For example, when MDAC interviewed the staff at the Issyk-kul Oblast Hospital in Karakol, we inquired as to whether they were familiar with the involuntary treatment provisions of the current mental health law of the Kyrgyz Republic. Although the staff members responded by saying that they were aware of the law and its requirements, it became clear upon further discussion that they had confused civil commitment with mental health commitments through the criminal law. The law to which they were referring was actually the provision for forensic mental health commitments under Kyrgyz law.

Similarly, during an interview with psychiatry students at the RMHC, they reported to MDAC that each psychiatrist interprets the law for involuntary treatment differently. These students also expressed their frustration at the lack of clear guidelines as to when to invoke the involuntary treatment application procedures.

The lack of understanding of the law was also evident during MDAC's meeting with judges in the October Court. During our meeting with the Court, we discussed both forensic and civil commitments. When we discussed civil commitments and the legal requirements for this process, the judges began to argue amongst themselves as to what the law required.

During an interview with MDAC, Dr. Solozhenkin, Chief Psychiatrist for the Ministry of Health of the Kyrgyz Republic, also stated that judges in the Kyrgyz Republic have been generally unwilling to participate in the involuntary commitment process.

As discussed above, the pervasive failure to utilize the court procedures before admitting an individual violates the Kyrgyz mental health law and violates the rights of affected individuals with mental health problems.

Extensive and comprehensive training should be provided to mental health clinicians, hospital staff, lawyers, and judges regarding the Kyrgyz mental health law, with a particular focus on the specific provisions of the involuntary treatment procedures under the Kyrgyz mental health law. Such training should be provided through the auspices of a qualified, independent, national or international NGO with expertise in the area of mental health law and the provision of advocacy for people with mental disabilities.

8.4. Training on Forensic (Criminal) Mental Health Law and Procedure

During interviews with judges at the October Court and lawyers at the Legal Aid Society it also became apparent that these professionals lacked an adequate understanding of the relevant forensic mental health law. For example, when MDAC inquired as to the timeframes by which forensic assessments needed to be completed, the judges gave conflicting answers and then began to debate amongst themselves. One judge said that the assessments were to be completed within three months of the order for the assessment. Another judge stated that the assessment was to take no less than three months, but the actual amount of the time for the assessment was the psychiatrist's decision. Similarly, the Legal Aid attorneys stated that they simply did not know what the time frames were for the completion of such an assessment.

Mr Amir Shagivaliev, prosecutor of the Kyrgyz Republic, was the only individual we spoke to who stated correctly how long the assessments were to take. Training for judges, lawyers, and clinicians regarding the legal requirements for forensic mental health assessments is necessary. Again, this training could be provided by either a qualified national or international NGO, or through the collaboration of such entities.

8.5. Monitoring of Involuntary Treatment Procedures

Formal monitoring should be conducted by an independent, qualified, designated NGO with expertise in the area of mental health law – or by a group of similarly qualified NGOs, working collaboratively – regarding the implementation of the involuntary mental health treatment procedures. The purpose of the monitoring would be to determine if the law is better implemented in some areas of the country than others; the reasons for any failure of implementation; barriers to implementation; and the development of specific recommendations to enhance implementation both at local and national levels. Any NGO involved in the provision of such training should be given full access to psychiatric facilities and relevant documentation, and should be able to meet privately and confidentially with users of mental health services.

8.6. Funding to Implement Mental Health Law and 2001-2010 National Program

It is crucial that the government of the Kyrgyz Republic devote additional and sufficient funding for mental health care. Such funding should be made available not only to ensure adequate care and safety in the psychiatric institutions, but also to enhance local community-based care. Without additional funding, it will be virtually impossible to implement the 1999 Psychiatric Care Law. The withdrawal of bilateral donors from the National Program should be also actively addressed with both the World Bank and the British government in order to determine how and why the decision to withdraw funding from 2001-2010 Program was made.

At the same time, the program should be revised in order to better implement the recommendations made in the WHO World Health Report "2001: Mental Health: New Understanding, New Hope." This document articulates a number of basic principles for the provision of appropriate mental health care, including such absolute necessities as providing local, community-based, psychiatric treatment, a sufficient amount of medication, and the reduction in size of large psychiatric facilities as were observed at the RHMC in Bishkek and Chim-Korgon. Perhaps more significantly, the WHO report describes the means by which countries with very limited resources can nevertheless make certain immediate improvements to their mental health delivery system at no greater cost.

8.7. Funding to Implement Involuntary Commitment Legal Procedures of the 1999 Psychiatric Care Law

The Kyrgyz government should ensure that funding is available to pay for the costs of implementing the involuntary commitment court procedures. This should include court costs, and the costs of attorneys to represent individuals who have been detained under these involuntary treatment provisions.

8.8. Training for Patients and Family Members on Rights and Self Advocacy

It is important that training be provided to individuals with mental disabilities and their family members with regard to legal rights, how to obtain assistance with patients' rights violations, and self-advocacy skills. This training should be conducted on an ongoing basis by a qualified, independent entity knowledgeable in the area of mental health treatment, the 1999 Psychiatric Care Law, and other relevant law and standards. Ideally, this training would be conducted by the independent agency designated to protect human rights of psychiatric in-patients as recommended above in this Section. The training should be provided on an ongoing basis throughout the country as part of a regular outreach effort to patients with mental disabilities. Such training should be provided to patients who are residing in state-operated or locally-based psychiatric facilities, as well as to individuals who are residing in care homes or in other community placements, and to individuals who reside in their own homes with their families.

Additionally, the training must be made accessible at the broadest level possible to accommodate cultural and language differences among different populations residing in the Kyrgyz Republic. It should also be accessible to individuals with limited cognitive abilities, such as individuals who are diagnosed with borderline intellectual functioning and more severe intellectual disabilities.

APPENDIX A – Individuals interviewed, documented reviewed, psychiatric and social care institutions visited

Individuals Interviewed (in chronological order)

Burul Makenbaeva, M.D., Director of Mental Health and Society

Natalya Ablova, Director of the Kyrgyz American Bureau for Human Rights and Role of Law

Director and members of the User's Group in Bishkek

Valentin Bogatyrev, Director, Personal Assistant of the President, The International Institute of Strategic Research

Tashpolot Baltabaev, The Chairman of the Committee for Public Health, Parliament of the Kyrgyz Republic

Ishen Moldatashev, Member of the Committee for Public Health, Parliament of the Kyrgyz Republic

Suytbek Nazarculov, M.D., General Director of the RMHC

Valeri Solozjenkin, M.D., Chief Psychiatrist, Ministry of Health of the Kyrgyz Republic

Psychiatrists at the RMHC

Psychiatry students at the RMHC

Junior staff at the RMHC

Ulugbek Babakulov, Journalist for the Institute of War and Peace Reporting

Rosa Raimbekova, Former General Director of the RMHC

Professor Mamytov Mitalip, Minister of Health of the Ministry of Health of the Kyrgyz Republic

Januebek Agybekov, Chief Psychiatrist, Chim-Korgon Psychiatric Hospital

Nazgul Turdubekova, Coordinator for the Human Rights Monitoring of Psychiatric Care in the Kyrgyz Republic, Youth Human Rights Group

Nurlan Sadykov, Lawyer, Association of Lawyers of the Kyrgyz Republic

Emil Jandive, Prosecutor

Court of Octyabskiy Raion of Bishkek City

Christian Knust, Human Dimension Officer, the OSCE Center in Bishkek

Ismailoc Bekmursa

Turnsunbay Bakir Uulu, the Ombudsman of the Kyrgyz Republic

Staff at "Ward 12" of the RMHC

Staff at the Issyk-Kul Oblast Hospital in Karakol

Legal Aid Foundation

Tilek S. Meimanaliev, First Deputy Minister, Ministry of Health of the Kyrgyz Republic

Documents Reviewed

"Law of Kyrgyz Republic On Psychiatric Care and Guaranteeing the Rights of Persons Receiving Such Care," enacted in 1999.

"Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" adopted by the General Assembly of the United Nations in General Assembly Resolution 46/119 of 17 December 1991 ("The MI Principles")

"Monitoring the Human Rights in Psychiatric Institutions," Office for Democratic Institutions and Human Rights OSCE Helsinki Foundation for Human Rights, Warsaw, Poland.

RMHC under the Ministry of Public Health Bylaws, Approved by the decree N 138 of the Ministry of Public Health of the Kyrgyz Republic of May 4, 2000.

Decree of the Ministry of Public Health of the Kyrgyz Republic On Establishment of the RMHC under the Ministry of Public Health of the Kyrgyz Republic, City of Bishkek, May 4, 2000, N 138.

"Mental Health System Users in Bishkek, Kyrgyzstan: Their Rights to Information," by Linda Light, Vancouver, British Columbia, Canada, April, 2003.

Biennial Collaborative Agreement between the Ministry of Health of Kyrgyzstan and the Regional Office for Europe of the World Health Organization 2002/2003.

World Psychiatric Association Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill, adopted by the World Psychiatric Association General Assembly in Athens, 17 October 1989.

World Psychiatric Association Declaration of Hawaii/II as Approved by the General Assembly of the World Psychiatric Association in Vienna, Austria, on 10 July 1983.

World Psychiatric Association Madrid Declaration on Ethical Standards for Psychiatric Practice (Approved by the General Assembly on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, August 2002.)

"Human Rights and Living Conditions in Psychiatric, Psycho-neurological and Psycho-Neurological Institutions of the Kyrgyz Republic," Youth Human Rights Group, Report on the 1st Stage of Monitoring, Bishkek-2002" Conducted by the Youth Human Rights Groups

"Mental Health in Kyrgyzstan Present Situation-Future Perspectives, Report of Assessment Mission 8-13 April 2000," by Wolfgang Rutz, M.D., Ph.D., Regional Advisor for Mental Health WHO Regional Office for Europe, Copenhagen

National Program "Mental Health of the Population of the Kyrgyz Republic in 2001-2010"

"Kyrgyz Republic County Reports on Human Rights Practices 1999", United States Department of State, February 2003.

Constitution of the Kyrgyz Republic (As Amended October 21, 1998 by the Law of the Kyrgyz Republic, N 134).

"World Health Report 2001, Mental Health: New Understanding, New Hope," World Health Organization, 2001.

"Round table: mental health. Report by the secretariat," World Health Organization, Fifty-fourth World Health Assembly, 19 May, 2001.

"Mental Health: Responding to the call for action. Report by the secretariat," World Health Organization, Fifty-fifth World Health Assembly, 11 April, 2002.

"International Covenant of Civil and Political Rights," adopted according to United Nations General Assembly resolution 2200A (XXI) of 16 December, 1966, entered into force 23 March, 1976.

"International Covenant of Economic, Social, and Cultural Rights," adopted according to United Nations General Assembly resolution 2200A (XXI) of 16 December, 1966, entered into force 3 January 1976.

"Convention on the Elimination of All Forms of Discrimination Against Women," adopted by the United Nations General Assembly and entered into force on 3 September 1981.

Institutions Visited

The RMHC in Bishkek

The Chim-Korgon Psychiatric Hospital in the Chim-Korgon Village

The "Labor Colony" at Chim-Korgon Psychiatric Hospital in the Chim-Korgon Village

"Ward 12" of the RMHC

The Issyk-Kul Oblast Hospital in Karakol

APPENDIX B – Excerpts from International and Kyrgyz Law and Standards

From the "International Covenant on Civil and Political Rights"

"Article 7: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

"Article 8(3)(a): No one shall be required to perform forced or compulsory labor."

"Article 10(1): All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

From the "International Covenant on Economic, Social and Cultural Rights"

"Article 11(2). The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international cooperation, the measures, including specific programs, which are needed: (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources; (b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of would food supplies in relation to need."

"Article 12(1): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

"Article 15(1): The States Parties to the present Covenant recognize the right of everyone: (a) to take part in cultural life."

From the "Convention on the Elimination of All Forms of Discrimination against Women"

"Article 1. For the purposes of the present Convention, the term 'discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women irrespective of their marital status, on a basis of equality of men and women of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

From "UN Principles for the protection of persons with mental illness and the improvement of mental health care":

"Principle 1. Fundamental freedoms and basic rights.

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

"Principle 1(3)
All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment."

"Principle 7. Role of community and culture.
1. Every person shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background."

"Principle 8. Standards of care.
1. Every person shall have the right to receive such health and social care as if appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every person shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort."

"Principle 13. Rights and conditions in mental health facilities.
1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
   (a) Recognition everywhere as a person before the law;
   (b) Privacy;
   (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio, and television;
   (d) Freedom of religion or belief.

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

3. In no circumstances shall a patient be subject to forced labor. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform. 4. The labor of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work, which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work."

"Principle 14. Resources for mental health facilities.

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
   (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a program of appropriate and active therapy;
   (b) Diagnostic and therapeutic equipment for the patient;
   (c) Appropriate professional care; and
   (d) Adequate, regular and comprehensive treatment, including supplies of medication. 2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these principles."

From the World Psychiatric Association "Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill":

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

"Mentally ill persons have the right to professional, human and dignified treatment. They shall be protected from exploitation, abuse and degradation…."

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

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

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

From the World Psychiatric Association's "Declaration of Hawaii":

"The psychiatrist should inform the patients of the nature of their condition, therapeutic procedures, including possible alternatives, and of the possible outcome."

"As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent."

From the World Health Organization's Fifty-fourth World Health Assembly, Agenda Item 10, 19 May, 2001, "Mental health round table: report by the Secretariat":

"Ministers unanimously agreed that mental health problems are significant contributors to the global disease burden, have huge economic and social costs, and cause human suffering. The fact that countries have to face other health problems and that their health budgets are limited can no longer be deterrents to actions. New developments persuasively indicate that cost-effective solutions are possible in all contexts. Many strategies, approaches, and interventions have been identified and are being used in numerous small projects around the world. These need to be evaluated and the results disseminated widely so that they may be included in national mental health programs.

Ministers repeatedly made urgent calls for action to reduce further stigmatization, discrimination and the violations of rights of persons with mental illness, since these affect the whole continuum of care. For instance, the stigma of mental disorders feeds the discrimination practiced by health insurance schemes in the coverage of mental illness compared with that of physical illness. There is a need to address the institutionalized stigmatization of persons with mental illness, a process exacerbated by the placement of psychiatric hospitals far away from public regard. Shifting mental health services to general hospitals and community services had helped to bring mental health into the mainstream of health. Efficiency can be gained by making use of former mental hospitals for general health care purposes. Enforcing minimum standards in infrastructure and in the provision of high quality care, with the backing of updated legislation, is a critical step in protecting the rights of people with mental illness. Most importantly, stigmatization, by all health professionals including mental health workers needs to be overcome.

Ministers discussed strategies to advance mental health care beyond the level of acceptance of parity between care for physical and mental disorders. They agreed that mental health care should be integrated into the general health care system. They repeatedly noted the significant role of primary health care in the delivery of mental health services, even in countries with highly specialized care. Integration into primary health care is in line with the global movement, in which many nations are engaged, to transfer the provision of mental health care from psychiatric hospitals to the community. For this shift to occur budgets must be maintained or even increased; mental health teams, with multidisciplinary representation, must be developed; the needs of especially vulnerable groups must be met through supervised care; communities must have access to crisis centers for the management of acute conditions; and broad public support for community care must be secured. Shifting the location of care also facilitates collaboration with nongovernmental organizations, social services and community agents, many of which are motivated to fill some of the service gaps.

Mental health treatments should be affordable to all those in need. Given that poverty is a risk factor for mental disorders, the principle of equitable treatment for the poor must be preserved.

Ministers expressed concern that access to basic psychotropic drugs, especially in rural areas, was an issue that cuts across disciplines and that strategies to reduce costs, including the bulk purchase of essential psychotropic drugs, should be considered by groups of countries and regionally."

From the World Health Organization's Fifty-Fifth World Health Assembly, Provisional agenda item 13.13, 11 April 2002, "Mental health: responding to the call for action: report by the Secretariat":

"In January of 2002 at its 109th session the Executive Board approved resolution EB 109.RB on strengthening mental health. This resolution calls on Member States to adopt the recommendations of "The World Health Report 2001" and to invest more, both nationally and in cooperation, in mental health and urges the Director General and regional committees to implement those recommendations."

From The World Health Organization's "The World Health Report 2001, Mental Health: New Understanding, New Hope":

"1. Provide treatment in primary care. The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services. It needs to be recognized that many are already seeking help at this level. This not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services."

"2. Make psychotropic drugs available. Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country's essential drug list, and the best drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable."

"3. Give care in the community. Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, back by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift toward community care requires health workers and rehabilitative services to be available at the community level, along with the provision of crisis support, protected housing, and sheltered employment."

From "Law of Kyrgyz Republic: On psychiatric care and guaranteeing the rights of persons receiving such care":

"Article 5. Rights of persons having mental disorders.
1. Persons having mental disorders have all the rights and freedom provided by the Constitution of the Kyrgyz Republic. Limitations of rights and freedom related to psychiatric care are permitted only in cases provided by the legislation of the Kyrgyz Republic.
2. All persons having mental disorders and receiving psychiatric care have rights for:
- respectful and humane treatment excluding humiliation of human dignity;
- receiving information about their rights, the nature of mental disorders and treatment methods applied in a comprehensible manner and taking into account their medical condition;
- psychiatric care in conditions limiting their freedom to the least possible extent and if possible at home;
- to be kept in in-patient psychiatric institutions only for a period necessary for examination and treatment;
- all kinds of care (including resorts) based on medical indications in the absence of contraindications;
- psychiatric care in conditions satisfying basic sanitary-hygiene requirements;
- prior permission or rejection at any stage regarding usage as objects of experiments of medical means and methods, scientific research of training process, photo/video/film recording;
- invitation of any specialist participating in the provision of psychiatric care to engage in activities of medical committee regarding matters specified in the present Law;
- assistance of a lawyer, legal representative or other persons in accordance with procedures set by the legislation of the Kyrgyz Republic."

"Article 16. Types of psychiatric care and social protection guaranteed by the state.

1. The State guarantees:
- emergency psychiatric care;
- consultative-diagnostic, treatment, preventive and rehabilitation care in out-patient and in-patient institutions;
- all types of psychiatric assessment, identification of temporary inability to work;
- social and legal assistance and support in finding employment for person having mental disorders;
- guardianship issues;
- consultations on legal matters and other kinds of legal assistance in psychiatric and psycho-neurological institutions;
- provision of social assistance for the disabled and elderly having mental disorders as well as provision of care;
- training of disabled and minors having mental disorders;
- psychiatric care during disasters and emergencies.

2. For the provision of psychiatric care and social protection for persons having mental disorders, the State:
- establishes all kinds of institutions providing out-patient and in-patient care, if possible near the residence of the patients;
- organizes mainstream and vocational education for minors having mental disorders;

- creates special production enterprises for work therapy, vocational training and employment for persons having mental disorders, including the disabled as well as special production shops or sections with simple working conditions for such persons;
- receives complete and efficient information regarding the availability of vacancies from employment agencies;
- establishes obligatory quotas for various enterprises, institutions and organizations to employ persons having mental disorders;
- applies methods of economic stimulation for enterprises, institutions and organizations accepting persons having mental disorders;
- creates dormitories for persons having mental disorders who have lost their social connections;
- takes other measures necessary for the social support of persons having mental disorders.

3. Provisions of all types of psychiatric care and social protection for persons having mental disorders, is implemented by central and local government agencies in accordance with their competencies determined by the legislation of the Kyrgyz Republic."

"Article 17. Funding of psychiatric care.
Funding of institutions and persons providing psychiatric care is implemented from the state budget, the fund of compulsory medical insurance and other sources not forbidden by the legislation of the Kyrgyz Republic in amounts necessary for the guaranteed level and high quality of psychiatric care."