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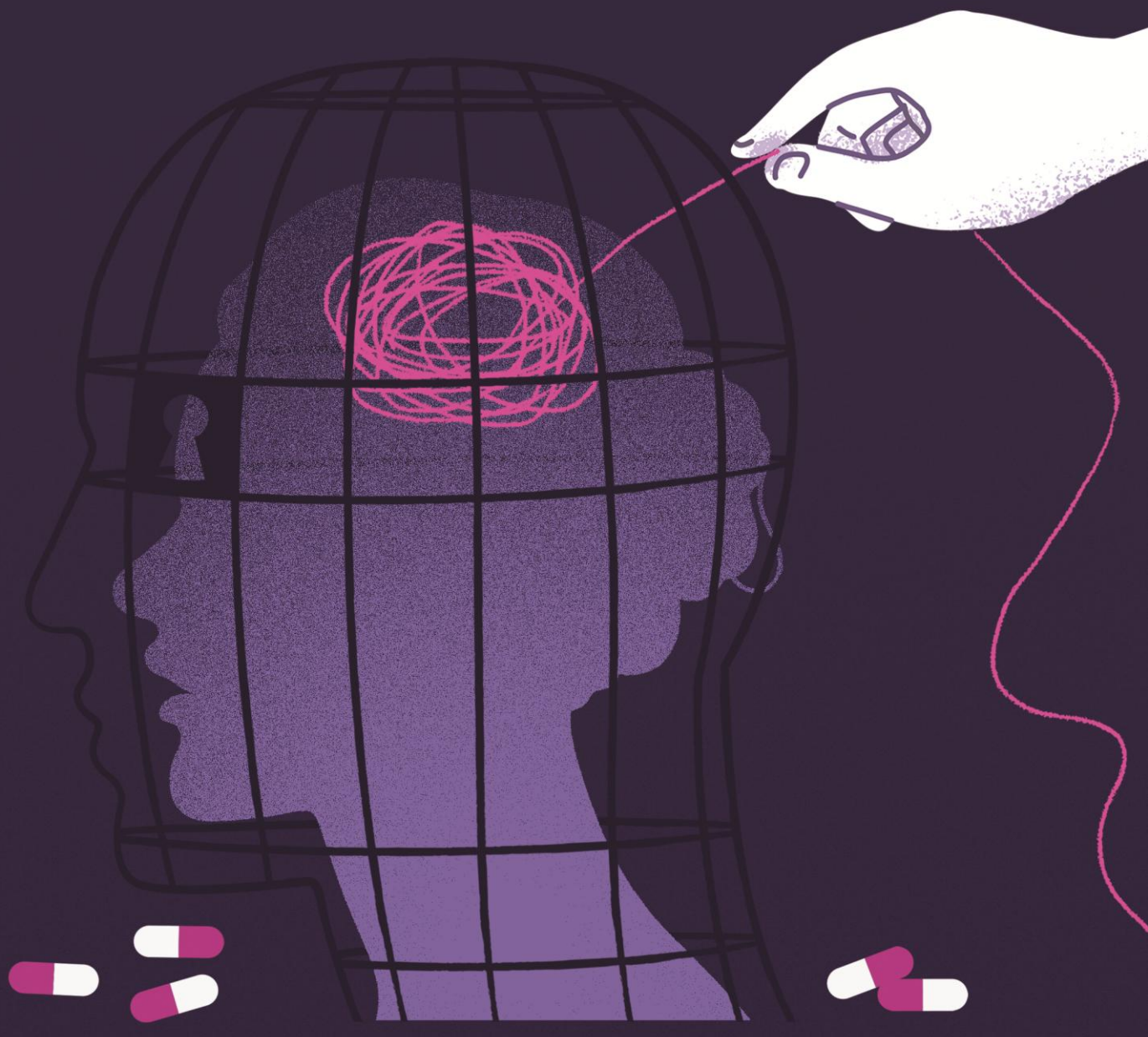
Caged in Care:

Investigating Human Rights Violations in Rehabilitation Centres

National Commission for Human Rights, Pakistan (NCHR)



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Caged in Care:

Investigating Human Rights Abuse in Rehabilitation Centres

National Commission for Human Rights, Pakistan (NCHR)

NATIONAL COMMISSION FOR HUMAN RIGHTS
Government Of Pakistan

National Commission for Human Rights (NCHR)

The National Commission for Human Rights (NCHR) is an independent statutory body established under the National Commission for Human Rights Act, 2012 (Act XVI of 2012). The Act empowers the Commission with a broad and comprehensive mandate to promote and protect human rights in accordance with the Constitution of Pakistan, relevant domestic legislation, and the country's ratified international human rights treaties.

NCHR holds A-status accreditation from the Global Alliance of National Human Rights Institutions (GANHRI), a United Nations–affiliated body, signifying its full compliance with the Paris Principles relating to the status and functioning of national human rights institutions. As Pakistan's principal national human rights body, the Commission is mandated to investigate human rights violations, facilitate redress for victims, review existing and proposed laws, policies, and administrative practices from a human rights perspective, and to make recommendations for their alignment with constitutional and international standards.

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Foreword

Rabiya Javeri Agha
Chairperson, NCHR

Across Pakistan, countless women disappear, not into myth or metaphor, but behind the locked doors of so-called rehabilitation and psychiatric facilities. They are teachers, lawyers, executives, mothers, and daughters. They are not confined because they are a danger to themselves or to others, but because they dared to say no: no to forced marriage, no to silence, and no to control.

The National Commission for Human Rights' investigation into rehabilitation centres in Islamabad exposes a system that enables such erasure to occur under the pretext of care. The findings reveal a deeply troubling pattern: facilities operating without psychiatric oversight, without due process, and without accountability. Many were licensed by the Islamabad Healthcare Regulatory Authority (IHRA), which failed to enforce even its own minimum standards. The Commission found women unlawfully detained, denied contact with families, sedated into submission, and branded with fabricated diagnoses. What was uncovered was not treatment, but punishment disguised as therapy.

These are not isolated incidents. They point to systemic regulatory failure, compounded by entrenched social biases and institutional neglect. Mental health services in Pakistan remain underfunded, underregulated, and undervalued. The absence of a national mental health policy and the inconsistent enforcement of provincial mental health laws have created an environment in which clinics profit from coercion and impunity. Oversight mechanisms exist only on paper. Accountability remains absent in practice.

At the heart of this crisis lies a deeper truth: this is not merely a failure of health governance but a manifestation of patriarchal control. The misuse of mental health institutions to silence and punish women reflects a cultural and structural intolerance toward autonomy. It converts defiance into diagnosis and transforms resistance into pathology. Adult women are infantilised, stripped of agency, and confined in the name of family honour and social order.

The Constitution of Pakistan guarantees the right to life, dignity, and equality before the law. The right to health, including mental health, flows directly from these guarantees. Yet for many women, these rights end at the threshold of a private rehabilitation centre. Their voices are dismissed, their consent disregarded, and their freedom taken under the false language of protection.

NCHR calls for immediate and comprehensive reform. Regulators must act with integrity. Lawmakers must amend and implement legislation that protects rather than imprisons. Practitioners must uphold ethical standards, and civil society must continue to demand transparency and accountability. The government must also recognise that the right to mental health cannot be separated from the right to dignity and choice.

The NCHR stands with every woman who was silenced, every survivor who spoke out, and every citizen who believes that dignity cannot be institutionalised away. This report is not only an investigation into malpractice but a call to conscience. The women we rescued were not sick; they were simply unwilling to live a lie. For their clarity, they were drugged. For their courage, they were silenced. For choosing themselves, they were erased.

Executive Summary

Across Pakistan, rehabilitation centres have morphed into spaces of confinement, where patients are stripped of dignity under the guise of care. Women have been taken from their homes and delivered into rehabilitation centres without consent, medical assessment, or legal authority. A high-court lawyer abducted as she worked in her home, a young professional pulled from her bed in the dead of night: these are just some of the stories of women who were forcibly admitted to rehabilitation centres in Islamabad.

This investigative report documents widespread deficiencies and human rights abuses in rehabilitation and drug therapy centres across the country, with a focus on facilities operating in Islamabad. Drawing on interviews with former patients, discussions with representatives of rehabilitation centres, and physical inspections of facilities, NCHR has uncovered evidence of systemic violations committed against those admitted for treatment. These include involuntary detention, coercive "pickups," physical and verbal abuse, medical malpractice, denial of privacy, and conditions that fall far below international standards of care.

Families routinely authorised involuntary pickups, whereby teams of men forcibly entered homes, subdued individuals through violence or sedation, and transported them to clinics. Once confined, patients were deprived of legal recourse or access to complaint mechanisms. Women, in particular, were found to be at heightened risk of exploitation and mistreatment. Several cases investigated by NCHR revealed that female patients were admitted under false pretences–often following domestic disputes or family property conflicts–and detained for months despite being medically fit for discharge.

Conditions inside these centres were degrading. Investigators observed unhygienic kitchens with spoiled food, filthy bathrooms, expired medicines, and sleeping spaces where dozens of people were crammed together without ventilation or privacy. Cameras installed in bedrooms stripped patients of privacy, while medical records showed widespread misuse of sedatives and non-prescribed drugs. The absence of qualified medical staff was routine, with attendants and untrained interns managing patient care. For breaking facility rules, such as attempting to escape or forming relationships, patients faced harsh reprimands and extended detention without medical justification.

The report also highlights the gendered nature of abuse. Pakistan remains one

of the lowest-ranking countries in the world for gender equality, and this disparity is acutely reflected within rehabilitation centres. Women and girls admitted to these institutions endure gender-specific forms of violence, including verbal harassment, sexualised comments, and invasive surveillance. The lack of access to complaint systems or judicial oversight means that such abuses persist with impunity.

Children and minors were not spared. NCHR documented cases in which adolescents as young as 15 were confined in adult wards to crush defiance, punish disobedience, or enforce so-called moral behaviour. These juveniles, stripped of dignity and childhood, were often forced to share rooms with adults, placing them in situations of vulnerability where safety was never assured and abuse could occur unchecked.

Rehabilitation centres currently operate with virtually no legal or regulatory control. Existing laws are outdated and fragmented, leaving those detained without meaningful protections or pathways to challenge illegal confinement. In the absence of proper oversight, these centres function primarily as profit-making enterprises rather than healthcare facilities, placing revenue above patient safety, dignity, and rights. NCHR documented one such case, acknowledged by the rehabilitation centre's owner, in which a woman, Sakeena (name changed), was kept confined for an additional two years despite being deemed no longer in need of treatment, solely because her family, residing abroad, had failed to pay the required lodging fees.

Treatment in these facilities rarely aligns with medical or therapeutic standards. Instead, it consists of sedation, isolation, and religious instruction. Patients described monotonous daily routines devoid of counselling, education, or rehabilitation activities. In one centre, so-called "detoxification" involved electroshock therapy without anaesthesia, leading to severe memory loss. In others, "therapy" was limited to group prayers or recitations of the Holy Qur'an. One resident told investigators, "We get up at 5 a.m. and spend the whole day praying. There was no treatment for my illness."

The investigation also revealed that private rehabilitation centres are operating under an alarmingly weak regulatory framework. Registering a clinic with the Islamabad Healthcare Regulatory Authority (IHRA) costs as little as PKR 5,000, and inspections are infrequent. Many of these facilities are run out of converted residential properties lacking proper medical infrastructure.

The abuses uncovered by this investigation contravene several core human rights instruments, including the Universal Declaration of Human Rights (Article 9), the International Covenant on Civil and Political Rights (Article 9), the Convention on the Rights of Persons with Disabilities (Article 14), and the Convention Against Torture (Articles 1 and 16). Pakistan's commitments under the Convention on the Elimination of All

Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (UNCRC) further obligate the state to protect women and children from arbitrary detention and abuse within institutional care settings.

The findings of this report underscore two deeply intertwined concerns. First, rehabilitation centres are being systematically misused as instruments of social control, particularly against women and girls, reflecting a deeply gendered approach to discipline in which perceived disobedience, moral nonconformity, or challenges to patriarchal authority are treated as pathologies requiring confinement.

Secondly, this misuse is enabled and sustained by a fundamentally broken regulatory framework. Rehabilitation centres operate in a legal vacuum that permits punitive, custodial practices to masquerade as treatment, prioritising profit and control over care and recovery. Addressing these failures requires urgent, comprehensive reform. Pakistan must move away from coercive and carceral models of mental health and addiction management and adopt evidence-based, rights-centred approaches to care. This includes robust regulation of all rehabilitation facilities, strict enforcement of licensing standards, the creation of independent oversight mechanisms, and guaranteed access for patients to complaint procedures, judicial review, and effective legal safeguards against involuntary and prolonged confinement.

NCHR calls upon the federal and provincial governments, the IHRA, and relevant ministries to ensure that rehabilitation centres operate in compliance with Pakistan's constitutional and international obligations. Every person, regardless of gender, class, or diagnosis, has the right to dignity, autonomy, and health. The state must take immediate steps to protect these rights and ensure that places meant for recovery do not become spaces of confinement, neglect, and abuse.

Introduction and Background

When masked men burst into 42-year old Saman's (name changed) home, she barely had time to react before she was incapacitated with chloroform. When she woke up, the safety of her home had been switched out for a clinical, tube-lit bedroom. She felt sluggish, and looked on helplessly as her blood samples were drawn. Eventually, she realized that her brothers had orchestrated her admission to a rehabilitation center. Months went by before the National Commission for Human Rights (NCHR) received a complaint from a work colleague regarding her captivity. The NCHR team intervened and rescued her.

Saman, a practicing lawyer, disclosed that she had no prior history of addiction or mental illness. Her confinement followed a legal dispute with her brothers over their late father's property. At the time of her admission, her brothers neither held a valid guardianship certificate nor had lawful possession of the family home. There was no medical basis for Saman's detention: her confinement was a deliberate effort to remove her from the premises and facilitate the unlawful seizure of the property.

During the period of Saman's confinement, her brothers took control of the house and dispossessed her. What initially appeared to be an isolated incident ultimately reflected a wider, pattern of gendered abuse, where women and girls in Pakistan are illegally confined in rehabilitation centres to silence them, strip them of autonomy, and deprive them of their lawful rights.

Islamabad is home to a fast-increasing number of rehabilitation clinics registered with the Islamabad Healthcare Regulatory Authority (IHRA). As of 2025, it costs only PKR 5,000 (USD 17.59) to register a rehabilitation clinic, and most of these establishments operate out of renovated residential properties. [1] Advertisements for these centres boast "high-tech" and "advanced" treatment options for loved ones suffering from conditions such as drug addiction, alcoholism, and even newly coined diagnoses like "phone addiction." The on-ground reality is far more troubling: poor healthcare practices intersect with a range of human rights violations, including forced admission, harassment, involuntary treatment, and denial of complaint mechanisms. Underqualified staff operate without oversight, and abusive practices persist with near-total impunity. Patients report inadequate food, unhygienic conditions, lack of access to medicines, and routine mistreatment by staff.

1 Islamabad Healthcare Regulatory Authority (IHRA), Minimum Service Delivery Standards for Rehabilitation Centers (Islamabad: IHRA, 2021), https://ihra.gov.pk/wp-content/uploads/2021/07/IHRA-Standards-for-Rehabilitation-Center.pdf

The situation in Islamabad's rehabilitation centres reflects the enduring influence of patriarchal norms that seek to discipline and control women under the guise of treatment. Every person has the right to the highest attainable standard of physical and mental health, as recognised under international law, and states are obligated to implement legislation and policies that ensure access to quality health services while addressing the root causes of inequality, including poverty, stigma, discrimination, and gender-based power imbalances. In Pakistan, however, these obligations remain unmet. For decades, public health expenditure has remained below 3 percent of Gross Domestic Product (GDP), far short of the World Health Organization (WHO) benchmark.[2] This chronic underinvestment in public mental health services has allowed private, largely unregulated rehabilitation facilities to flourish. Operating within a broader social context that tolerates the confinement of "disobedient" women and girls, these centres often function as tools of patriarchal control rather than institutions of care, placing profit, punishment, and social conformity above patient safety, dignity, and rights.

When NCHR began seeking reliable data on the regulation and functioning of these clinics, no official information existed. Neither government departments nor public databases contained records of how these centres were monitored or held accountable. This absence of data, combined with a rising number of complaints from citizens in Islamabad, Karachi, and Lahore, pointed to a systemic governance vacuum.

In response, NCHR launched a comprehensive investigation into rehabilitation centres in Islamabad, aimed at understanding the scale and nature of abuse, illegal confinement, and medical malpractice within these institutions, particularly as they affect vulnerable women and girls. The investigation sought to document patterns of involuntary detention and mistreatment, assess institutional compliance with IHRA regulations and international human rights obligations, identify gaps in oversight and accountability, and propose legal and policy reforms to prevent further abuse.

This report builds on months of fieldwork and testimony, exposing how the language of care and rehabilitation is frequently used to mask exploitation, violence, and control. It calls for an urgent policy response to ensure that rehabilitation in Pakistan restores dignity and health, rather than stripping individuals of their most fundamental rights

2 https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=PK

Methodology

This report is based on extensive field research and documentation carried out by NCHR between January 2024 and October 2025. The research was conducted primarily in Islamabad, with additional investigations in Karachi and Lahore, following reports and complaints of illegal confinement, involuntary detention, and abuse of women in private rehabilitation centres.

Methodological Limitations

In many cases, the families of the residents confined in rehabilitation centres were directly complicit in their detention and acted in coordination with facility management. This collusion severely limited both the scope of cooperation from family members and the options available for the safe relocation or protection of rescued individuals. Survivor testimonies were further constrained by fear of retaliation and the lack of secure alternative accommodation following rescue. Consequently, while the findings are grounded in verified evidence and triangulated sources, they reflect the challenges inherent in investigating abuses within institutional settings.

Legal Mandate and Scope of Inquiry

NCHR conducted this investigation by utilizing the powers granted by the National Commission for Human Rights Act, 2012,[3] and in accordance with the Paris Principles relating to the Status of National Human Rights Institutions (UNGA Resolution 48/134).[4]

Consistent with the Paris Principles' requirement that NHRIs possess a broad mandate, investigative authority, independence, and adequate powers to

- Receive complaints and initiate inquiries, including suo motu (Section 9(a)), reflecting the Paris Principles requirement for independent investigation powers.
- Visit places of detention and custodial settings (Section 9(c)), consistent with the Paris Principles standard that NHRIs must have unrestricted access to places of deprivation of liberty.
- Summon witnesses, require production of records, and call for official reports (Sections 12–13), mirroring Paris Principles standards on access to information and investigative competence.

3 Senate of Pakistan. National Commission for Human Rights Act, 2012. Islamabad: Senate of Pakistan, 2012. PDF. https://senate.gov.pk/uploads/documents/1358919417_548.pdf
4 https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-relating-status-national-institutions-paris

- Conduct or direct investigations and request state cooperation (Sections 9(i) and 17), aligning with the Principles' emphasis on functional independence and authority to compel cooperation.

- Review laws, policies, and safeguards and recommend reforms (Sections 9(d)–(f)), in line with the Paris Principles' advisory mandate to government on improving human rights protections.

For facilities not operating directly under state control, entry and documentation were secured through NCHR's inquiry powers under ss. 9(a), 9(i), 12 and 13, consistent with the Paris Principles' guarantee of access and authority to investigate all alleged violations, including by private actors.

Data Collection and Scope

The investigation draws on in-depth interviews, site inspections, and documentary review conducted by NCHR investigation teams. Researchers conducted 10 in-depth interviews with women and girls formerly confined in rehabilitation centres who described experiences of physical, emotional, and sexual abuse. Additionally, 10 male admittees facing unjust incarceration were also interviewed. Interviews were held with five mental-health specialists and representatives of mental-health rights organizations.

NCHR held three hearings with the IHRA to understand oversight mechanisms and complaint pathways.

Fieldwork included 10 on-site inspections of clinics in Islamabad, with follow-up visits in Karachi and Lahore. These inspections involved observation of living and medical areas and review of facility records. Telephonic interviews were conducted with 15 centres selected on the basis of concerns raised publicly and via complaints received. Anonymous questionnaires were administered to current and former patients to ensure pluralistic input.

Focus and Terminology

While men with psychosocial or intellectual disabilities also face discrimination in institutional settings and have been covered in parts of this report, the primary focus remains on women and girls. This reflects both the gendered nature of many of the violations documented and Pakistan's obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

In accordance with the Convention on the Rights of the Child, a child is defined as anyone under the age of 18.

Ethical Considerations

All participants were informed of the purpose of the interviews and their voluntary nature. No compensation was offered. Interviews were conducted in Urdu, English, or Punjabi. Identities are withheld to safeguard privacy and prevent retaliation.

Testimonies were corroborated through observation, medical documents, and cross-interviews. Allegations not independently verifiable were included only when

supported by consistent patterns across sources.

Objectives

- Investigate allegations of abuse, coerced confinement, and medical malpractice against women and girls
- Document lived experiences and patterns of sexual and physical abuse, privacy violations, and restricted complaint pathways
- Assess compliance with IHRA standards, constitutional protections, and international obligations
- Identify systemic gaps enabling rights violations in rehabilitation settings
- Recommend reforms to strengthen oversight, accountability, and protection mechanisms

NCHR Investigation of Rehabilitation Clinics

NCHR received a complaint regarding Ms. Farzana (name changed), a senior executive at a tech company who had been abducted and forcibly confined for approximately six months in a private rehabilitation centre. In accordance with its established complaints procedure, the Commission conducted an initial visit to the facility, during which serious human rights concerns were identified.

During its visit to the facility, the Commission found Ms. Farzana confined in a small 9-by-9-foot room, subjected to constant surveillance through multiple CCTV cameras, with male attendants positioned in and around the area. These conditions constituted a serious violation of her right to privacy, dignity, and bodily autonomy, as protected under international human rights standards governing healthcare and detention settings. The Commission facilitated Ms. Farzana's release and took steps to ensure her safe return, while securing safeguards to protect her from future coercion or abuse by her family.

In the months that followed, the NCHR received five additional complaints describing similar experiences of unlawful confinement and abuse in private rehabilitation centres, suggesting that Farzana's experience was part of a broader and deeply troubling pattern of gendered abuse, arbitrary detention, and the misuse of rehabilitation centres as tools of control rather than care.

In response, NCHR constituted a dedicated investigative team to conduct a comprehensive inquiry into the broader systemic issues underlying these reports. Demonstrating the Commission's commitment to direct oversight, the Chairperson of NCHR personally joined the investigative team during the rescue operations. As a result of these coordinated efforts, NCHR successfully secured the release of four women from rehabilitation

centres in Islamabad, one woman from Karachi, and one man from Lahore. The Commission continues to follow up on several additional cases; however, in one instance, the concerned individual could not be traced and is currently reported missing.

Research

After identifying recurring patterns of abuse during initial rescue operations, NCHR decided to initiate a broader research inquiry.

To understand the scale of the issue, the NCHR:

- Designed and disseminated a survey;
- Issued a public call inviting citizens to share their experiences with rehabilitation centres in Islamabad and other cities;
- Conducted an initial mapping and identified 15 rehabilitation centres with concerning reputations through publicly available reviews and online diagnostics.

NCHR researchers then contacted these centres, held telephonic interviews, and completed standardized information forms. The responses revealed alarming patterns:

Key Indicators	Result	Implication
Centres willing to admit a person against their will	100%	Confirms systemic lack of due process
Centres not requiring any medical certificate or diagnosis for admission	100%	Indicates arbitrary detention practices and lack of medical oversight
Centres housing minors and adults together without safeguards	100%	Suggests serious child protection violations and heightened risk of abuse

Table1.

In addition to these, the NCHR assessment examined a range of critical safeguards that speak directly to the legality and therapeutic integrity of rehabilitation facilities. Particular attention was paid to the presence of qualified psychiatrists and multidisciplinary staff, the use of informed consent procedures, and the existence of individualised treatment plans. The Commission also reviewed the use of physical restraint and chemical sedation, especially where no clinical justification was documented; the continued detention of residents after completion of treatment due to non-payment of fees; and the adequacy of living conditions, including hygiene, overcrowding, and freedom of movement. Equally significant were gaps in internal complaint mechanisms and the absence of regular external inspections or licensing oversight. Taken together, these indicators provide a clearer picture of whether centres function as legitimate treatment environments or operate in a largely custodial and unregulated manner, with serious implications for residents' liberty, dignity, and right to health.These findings demonstrated a systemic absence of due

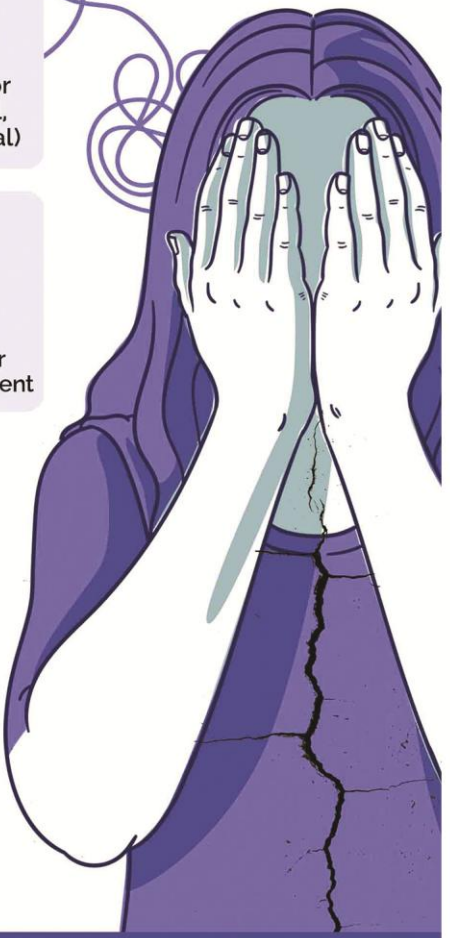
HELP US HOLD REHAB CENTERS ACCOUNTABLE.

Share Your Story!

Have you or someone you know ever been admitted to a ***Rehabilitation Center*** in Islamabad (ICT) or anywhere in Pakistan?

We're collecting ***Real Stories*** from people, especially women, who have experienced:

- Forced Admissions
- Being drugged or sedated against your will
- Harassment or abuse (verbal, physical, sexual)
- Poor living conditions or unsanitary facilities
- Denial of your right to complain
- Medical malpractice or unethical treatment



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process, consent, or medical oversight.

In parallel, the NCHR:

- Held detailed consultations and in-depth interviews with 20 former residents who described consistent patterns of human rights abuse;

- Conducted a desk review of relevant laws, regulations, and international human rights standards related to mental health, deprivation of liberty, and informed consent.

NCHR also issued a formal notice and summoned the Islamabad Healthcare Regulatory Authority (IHRA) for a public hearing. When no response was received, the Commission sent three reminders requesting information and a meeting.

The Commission's engagement with the regulatory authority exposed a troubling degree of indifference. Despite issuing a formal notice and three successive reminders seeking information and requesting a meeting with IHRA, they remained non responsive. This disregard persisted notwithstanding NCHR's clear statutory authority under Section 13 of the NCHR Act, 2012, to summon public officials. IHRA's failure to engage reflected a cursory and alarmingly detached approach to serious allegations involving the unlawful detention and abuse of women in this country.

In light of this continued disregard, the Chairperson of the National Commission for Human Rights (NCHR) raised the matter with the Secretary, Ministry of Health, formally invoking the Commission's statutory mandate and enforcement powers. Only after this intervention did the Secretary direct the Islamabad Healthcare Regulatory Authority to comply with NCHR's proceedings. This sequence of events underscored the regulatory authority's failure to act with urgency or basic regard for human dignity, while simultaneously reaffirming, both in practice and precedent, NCHR's institutional independence and its authority to hold state bodies accountable, consistent with the Paris Principles and its mandate as Pakistan's premier National Human Rights Institution.

Public Hearing

NCHR exercised its statutory powers to summon relevant government bodies such as IHRA, Ministry of Health and Ministry of Human Rights for a public hearing on the unlawful confinement of individuals in unregulated rehabilitation centres. Despite multiple notices and reminders, responses were delayed from the government's side

Finally, NCHR called stakeholders to a public hearing and;

- Summoned regulatory and government representatives from IHRA (Islamabad Health Regulatory Authority) and Government to explain their oversight failures.

- Presented evidence from survivors and shared findings from NCHR's investigation and research.

- Directed authorities from IHRA to

conduct inspections of identified rehabilitation centres and submit detailed reports within specified timelines.

- Directed compliance with its orders and reinforced the Commission's mandate and authority.

When reports remained inadequate, NCHR escalated the matter and initiated joint visits with regulatory authorities to verify conditions on-ground.

Public Outreach and Engagement

As part of its broader outreach methodology, Ms. Rabiya Javeri Agha, Chairperson NCHR, authored an op-ed titled *"Silencing Women,"* published in one of Pakistan's leading newspapers, *Dawn,* on 19 September 2025.[5]

The article sought to raise public awareness and encourage victims, witnesses, and professionals to come forward with testimonies and insights. This strategic public engagement helped the Commission expand its evidence base, capture diverse perspectives, and ensure that lived experiences informed its findings and recommendations.

Through these steps, NCHR established, both practically and procedurally, its independence, oversight powers, and enforcement authority under the NCHR Act and the Paris Principles.

2 https://www.dawn.com/news/1943065

Findings of the Investigation

Deprivation of Liberty and Denial of Due Process

Involuntary Admission and Illegal Confinement

NCHR's investigation revealed deeply disturbing practices surrounding involuntary admissions to rehabilitation centres. One of the most common methods of confinement is the forcible "pickup" of individuals from their own homes, almost always initiated by family members acting as so-called guardians. On their instructions, teams from private rehabilitation centres enter private residences, physically restrain individuals, most often women who are perceived as disobedient, non-conforming, or inconvenient, and administer sedatives to render them unconscious. Once incapacitated, they are removed from their homes and transported to rehabilitation facilities, where they may be held for weeks, months, or even years. These detentions frequently occur without any prior medical evaluation, judicial authorization, or meaningful opportunity to challenge the confinement, reducing rehabilitation centres to instruments for silencing and controlling family members rather than providing care.

One woman informed the Commission that she was taken from her home late at night, while preparing a presentation for her employer at a multinational company. According to her account, three men and one woman forcibly entered her residence, repeatedly shouting that she was "mad" and needed to be taken away. When she resisted, she was chemically sedated and transported against her will to a rehabilitation centre on the outskirts of Islamabad. NCHR recovered her nine days later.

This incident reflects a broader pattern of abuse rooted in entrenched patriarchal attitudes that normalize coercion and unlawful confinement. Families frequently initiate confinement in rehab centres in response to perceived disobedience, mere suspicion of substance use, or even a single unverified urine test. In some cases, individuals who initially consent to treatment are later unlawfully detained and denied release. This was a case of a young female journalist first incarcerated for alcohol usage and then left abandoned for close to one year.

Unmarried women, despite being adults, are especially vulnerable, as they are often treated as the property of self-appointed male relatives who assume the authority to control their lives. In one instance, the owner of one such centre emphatically stated to the NCHR that a woman's brothers were

entitled to decide her fate "because she was unmarried," claiming that such control was sanctioned by religion. The invocation of culture and religion to justify coercion and confinement exposes a deeply disturbing power dynamic in which patriarchy is exercised through institutionalised control, stripping women of their autonomy and dignity.

NCHR found that 100 percent of the rehabilitation centres interviewed offer involuntary pickup services. Every single centre stated that they do not require any documentation to carry out an admission, and that a family member's verbal request alone is sufficient. None of the facilities visited by NCHR required or verified a guardianship certificate, even in cases involving adult women or children. When asked about this, one facility director said simply:

> *"We don't need any tests or anything, just let us know the address where we should pick the patient up."*

Another staff member added:

> *"Our male staff grabs the women when they are aggressive, but there is no skin-to-skin contact because the staff is wearing gloves."*

In most cases, women and elderly persons are institutionalized solely because they are deemed to fall under the "guardianship" of male relatives and are therefore denied the right to give or refuse consent. Their admission takes place without proper medical assessment, without due legal process, and without their involvement, amounting to arbitrary deprivation of liberty. National research on older persons in Pakistan shows that approximately 15 percent of elderly individuals report experiencing emotional or psychological abuse, with higher vulnerability among those living in urban settings.[6] In one instance documented by the NCHR in Islamabad, a 90-year-old man had been confined by his son for over twenty years on the allegation that he had once smoked marijuana. Now frail and dependent, he had nowhere else to go and had resigned himself to spending the remaining years of his life in the rehabilitation centre. Such abuse reflects the ease with which age, dependency, and familial power can be

6 British Council and HelpAge International, Moving from the Margins: Promoting and Protecting the Rights of Older Persons in Pakistan (Islamabad: British Council, 2019)https://www.google.com/url?q=https://www.britishcouncil.pk/sites/default/files/promoting_and_protecting_the_rights_of_older_persons_in_pakistan-_british_council_2019.pdf&sa=D&source=docs&ust=1771313258563865&usg=AOvVaw0yOypKOJW0lUZYWcnh7Ebo

exploited to justify prolonged and unlawful confinement.

According to international medical standards, admission to a rehabilitation hospital or unit is a complex process that requires careful evaluation by multiple parties including the patient, admitting and discharging physicians, and relevant therapists, and must be based on clinical necessity.[7] In June 2020, thirteen United Nations agencies, including the Office of the High Commissioner for Human Rights, the World Health Organization, the UN Office on Drugs and Crime, and UNICEF, issued a joint statement calling for the closure of all compulsory drug detention and rehabilitation centres in the Asia-Pacific region.[8]

In Pakistan, however, the absence of clear legal safeguards and the persistence of colonial-era laws continue to enable such abuses.[9] Multiple pieces of legislation dating back to the British period still restrict the rights of people with psychosocial or intellectual disabilities on the basis of disability alone.[10] These outdated frameworks reinforce a system where medical paternalism and family control override individual autonomy.

Testimonies of Forced Abduction

Sarah (name changed), a woman living in Karachi, had been residing with her brother when a domestic disagreement occurred with her sister in law. Within a few hours of the argument, a group of men arrived unannounced, forced her to the ground, injected her against her will, and removed her from her home. She was taken to Rehabilitation Centre C (name changed), and locked in. She was only released when her employee noted her absence and complained to NCHR.

Shazia (name changed) recounted a similarly harrowing experience. She described being taken from her own bedroom, in her nightclothes.

"A man climbed on top of me," she said. *"He grabbed me and injected me."*

Only hours earlier, Shazia had also argued with her father who had threatened to have her locked away. The threat was carried out. These acts go far beyond unlawful confinement; they represent grave violations of bodily integrity, carried out with terrifying ease under the guise of family authority and treatment.

Detention for Non-Medical Reasons

In some cases, admissions have no relation to health or addiction whatsoever. Hira (name changed) was admitted to a rehabilitation centre after being allegedly raped by her brother, which resulted in a pregnancy. During her confinement, she suffered a miscarriage and was briefly taken to a hospital before being returned to the facility. Her medical file showed that

7 World Health Organization (WHO). Rehabilitation in Health Systems (Geneva: WHO, 2017), 34–36.
8 United Nations Office of the High Commissioner for Human Rights (OHCHR) et al., "Joint Statement on Compulsory Drug Detention and Rehabilitation Centres," March 2012, https://www.ohchr.org/en/statements-and-speeches/2012/03/joint-statement-compulsory-drug-detention-and-rehabilitation
9 World Health Organization (WHO). WHO-AIMS Report on Mental Health System in Pakistan. Islamabad: Ministry of Health & WHO, 2009.
10 https://docs.un.org/en/A/HRC/40/54

facility. Her medical file showed that her treatment had concluded, yet she remained detained for two years. Her family continued to pay fees, and the centre administered muscle relaxants to keep her sedated. Letters recovered by NCHR reveal her desperate pleas to be released: she apologizes for "not behaving" and begs her father to take her home.

In another case, NCHR intervened to rescue a woman whose mother had admitted her to Rehabilitation Centre D (title changed) because she refused to marry. Staff at the centre kept her sedated and occasionally dressed her in sportswear to stage photographs of her *"recovery"* and *"good health"*. The images sent to her family showed her playing badminton in the sunshine, masking the reality that she was being forcibly confined and drugged.

At Rehabilitation Clinic A (title changed), the NCHR team reviewed a case where a patient had been admitted for drug addiction solely on the basis of a parent's word. No toxicology test had been conducted, and when questioned about the criteria for admission, the clinic manager said:

> *"The mother told us that he smokes marijuana."*

Violations of Consent, Privacy, and Dignity

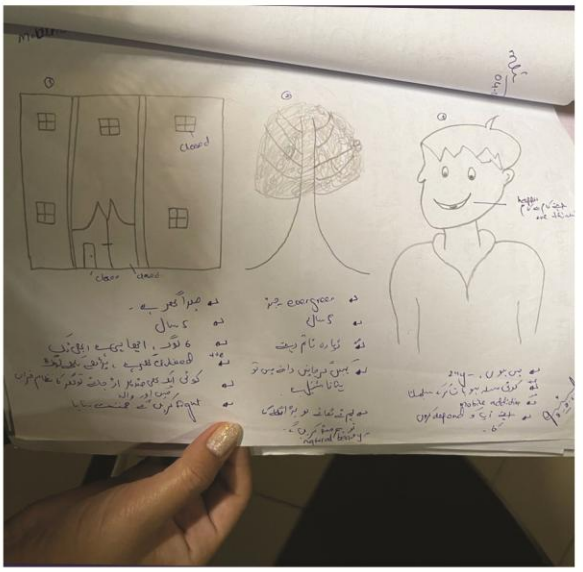
Even patients who enter treatment voluntarily often find themselves detained indefinitely, denied contact with the outside world, and subjected to forced medication or sedation. Staff frequently search patients' phones and monitor personal communications. One head of a rehabilitation centre admitted that he had gone through a patient's text messages with her partner. He also told the NCHR team that he had admitted a young woman for engaging in premarital sex, claiming he had seen the act on CCTV footage provided by her family.

It is illegal to post identifiable images of patients, yet many rehabilitation centres maintain highly monetized social media presences, including podcasts and promotional videos that display patients' faces or blurred profiles. These marketing campaigns exploit patient vulnerability for profit, further eroding dignity and privacy.

Faiza (name changed), who entered a centre voluntarily, recalled:

> *"I was forcibly tranquilized even though I went there of my own free will. Four men pushed me down and injected me. I was knocked out for three days. There was no proper check-up done by any doctors whatsoever."*

Diagnosis and testing procedures are often unscientific and arbitrary. In one case reviewed by NCHR, a young man was admitted for being *"rude to his parents."* His file contained results from a Baum test, a psychological drawing exercise in which a person draws a tree and the evaluator interprets its features, branches, roots, and leaves, for emotional meaning. While the evaluator has scribbled *"Attention to hair means homosexual",* there is no other official diagnosis. Despite this, the patient has been admitted to the rehabilitation centre for four months. Furthermore, patient blood tests were often conducted in small, unreputable laboratories located in Banigala and Barakahu area.



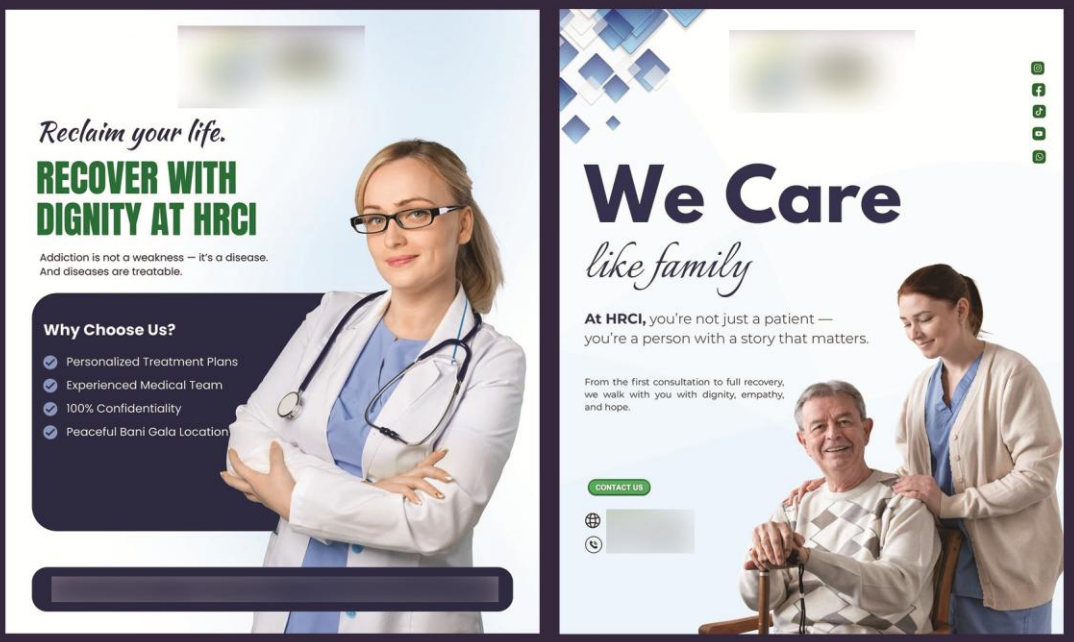
Across all interviews conducted by NCHR, 100 percent of victims said they were not informed about the treatment they were receiving, and none knew the names of the medicines administered to them. Concerningly, many residents alleged that non-licensed clinic staff such as psychologists and assistants often administered medicine and injections.

Case Study 1: A Lawyer in Captivity

"Reclaim your life. Recover with Diginity" reads a colorful instagram post by the Rehabilitation Centre B (name changed for anonymity). These words of hope are misleading, and cheerful graphics conceal the startling truth: interviews with ex-patients of this centre reveal concerning stories of forced admission, physical harassment, emotional harassment, medical malpractice, verbal abuse and more.

In February 2024, Ms. Saman, a practicing high court lawyer and long-time resident of Islamabad, was forcibly removed from her home and admitted against her will to Rehabilitation Centre B in Banigala. According to her testimony, a team of five individuals, four men and one woman, entered the upper floor of her home, restrained her, and administered sedatives through injections in both arms. She lost consciousness soon after and woke up two to three days later in a locked rehabilitation facility.

When she regained awareness, Saman was told she had been admitted for treatment as either an addict or a mentally ill patient. She denied both assertions and asked why she was there. Clinic staff informed her that she had anger issues and that her brothers, both residents of the United States, had arranged for her confinement. She was told she could not leave until they authorized her release. Saman remained in the facility for eight months.



Social media posts from Rehab Centre B convey misleading messages of hope.


REHAB

When NCHR received a complaint regarding her forced admission, a team visited Rehab Centre B to investigate. By then, Saman had been in custody for several months and was visibly sedated. “She was slurring her words and appeared heavily drugged,” a member of the team reported. The clinic’s owner admitted that no guardianship certificate had been produced for her admission, effectively confirming that the process violated legal requirements.

Conditions at the clinic raised further concerns. The NCHR team observed surveillance cameras installed in bedrooms, lack of complaint mechanisms, and an unhygienic environment. Patients were denied access to phones or outside communication. Saman stated that she was given unidentified medication daily and, on occasions when she resisted, staff forcibly opened her mouth to make her swallow the pills. She described the food as inadequate, the sanitation as worse than public bathrooms, and recounted instances of male staff entering female quarters without restriction.

Allegations of mistreatment went beyond her own experience. According to Saman, women in the facility reported being admitted not for clinical reasons but because of family disputes, often related to property or marriage choices. She recounted an incident in which a female patient was slapped by a male staff member in front of others.

The NCHR intervention led to Saman’s release and safe return home, only to find that her brothers had boarded up the home and seized all her valuables. Her case underscores systemic gaps in oversight of private mental health and rehabilitation centers. It highlights the absence of clear legal safeguards to prevent misuse of medical facilities for coercion and control. For a lawyer of the High Court to be deprived of liberty without due process is a serious breach that raises urgent questions about consent, accountability, and the protection of fundamental rights in Pakistan.

Lack of Complaint Mechanisms and Rights Awareness

The IHRA standards for rehabilitation centres explicitly require that patients have access to an independent complaint mechanism and be informed of their rights upon admission.[11] Yet, NCHR found that most facilities investigated did not meet these basic obligations.

Absence of Complaint Mechanisms

Section 5.1 of the IHRA regulations stipulates that patients must be informed about their care management and the options available to make an informed decision about treatment. In addition, Standard 33 guarantees patients the right to appeal and mandates access to a formal grievance system. Despite these clear protections, none of the rehabilitation centres visited by the NCHR had a helpline, email address, or external reporting channel to reach IHRA, NCHR, FOSPAH, or any other oversight body.

In some centres, the only mechanism available was to report abuse to the institution's own staff, a measure that cannot be considered independent, given that staff members themselves are often implicated in acts of coercion and mistreatment. This structural flaw leaves patients with no safe avenue to report abuse, enabling a culture of silence and fear.

One woman told the NCHR team:

> ***"My husband and father once came, and I hugged my husband and whispered in his ear, 'Get me out of here. This is hell.' Sadaf, a staff member, interrupted and said, ' Stay away from him! You can't do this. I'm going to cancel the meeting.' No meeting was allowed unsupervised."***

Lack of Awareness of Rights

Interviews revealed that patients were unaware of even the most basic rights afforded to them under the law. None of the women interviewed knew that after three months of treatment, they have a legal right to request a review of their admission and to seek discharge if no major diagnosis is established.

This lack of legal literacy leaves patients entirely dependent on the same institutions that confine them. In some cases, patients who attempted to assert their rights were met with intimidation and violence. One of the women interviewed described how a resident tried to sneak a letter to her sister inside a handbag:

> ***"We were not even allowed paper, bags, pencils, or things like that inside. Everything was confiscated."***

When the letter was discovered, staff called the resident into a private room where the owner, a licensed doctor, verbally assaulted and humiliated her, screaming slurs such as *"jhooti, behnchod, kanjari."*

11 Islamabad Healthcare Regulatory Authority (IHRA), Minimum Service Delivery Standards for Rehabilitation Centers (Islamabad: IHRA, 2021), https://ihra.gov.pk/wp-content/uploads/2021/07/IHRA-Standards-for-Rehabilitation-Center.pdf

Several patients told the NCHR team they rarely report abuse by caretakers or fellow residents, fearing retaliation, prolonged confinement, or physical punishment. As one woman explained, " If you complain, they double your medicines or lock you in isolation."

The Right to Information and Independent Redress

Without awareness of their legal entitlements, patients, particularly women, remain vulnerable to arbitrary detention, abuse, and coercion under the guise of medical care.

The NCHR findings underscore the urgent need for the IHRA to enforce compliance with its own standards, establish independent hotlines and external monitoring channels, and ensure that every patient admitted to a rehabilitation centre receives written and verbal information about their rights, including how to appeal their admission or report mistreatment without fear of reprisal.

Case Study 2: Shazia's Story

When 27-year-old working professional Shazia jumped over the wall of a rehabilitation centre in Islamabad, she thought she had finally escaped her ordeal.

Earlier, after a heated argument with her younger brother, a team of men had arrived at her home, forcibly restrained her, and injected her with a sedative. A few days later, Shazia woke up alone in a rehabilitation clinic.. Disoriented and frightened, Shazia managed to climb over the centre's boundary wall and flee to a local police station to ask for help. Instead of protecting her, the police returned her to her family, who assured her that the matter was over.

The next morning, however, another team, this time from Rehabilitation Centre B in Banigala, arrived at her home. Thinking she was safe, Shazia was resting in her bedroom when they entered. She described the moment of her re-capture to NCHR:

"I was resting in my nightclothes when men burst into my room. One climbed on top of me, pressed his knee on my chest, and injected me."

On 22 October 2024, NCHR received an email complaint alleging that Shazia was being illegally confined at Rehabilitation Centre B. She had been admitted by her younger brother following their domestic dispute. When the NCHR investigation team visited the premises, they met the owners of the facility, a husband-and-wife duo, whose conduct during the visit was notably defensive and hostile, reflecting the resistance often encountered by oversight bodies in such cases.

The owners confirmed that Shazia had been admitted for "adulteration" and "use of ICE." The clinic's owner further admitted that no psychiatrist was present on site, claiming that "a psychiatrist was not relevant" to her case. When questioned about the basis for her continued confinement, he stated that her treatment had concluded but she remained detained because her family had not yet paid the outstanding dues.

A review of her medical and therapy records (Annexure 1) revealed that Shazia had not been treated for any substance use. Instead, she had been questioned about her personal and romantic relationships and told to " apologize for her sins." Furthermore, Shazia shared the stories of her fellow residents with NCHR, mentioning that one girl has been admitted for close to four years because her dues were not paid by her family who lived abroad.

Following these findings, the NCHR team intervened and secured Shazia's release from Rehabilitation Centre B. Pursuant to court orders, in proceedings where the family had challenged the matter and NCHR appeared as a party to support her protection, Shazia was placed in a women's shelter. She spent two weeks there in restorative recovery before resuming an independent life.

Shazia's case illustrates how women in Pakistan can be institutionalized repeatedly and without due process, often through collusion between family members, unregulated clinics, and indifferent state actors.

Inadequate Treatment Practises

Across Pakistan, mental health care remains poorly understood and inconsistently practiced, even among medical professionals. A 2015 cross-sectional study in Lahore assessing the attitudes of doctors toward depression found that 37 percent of respondents believed supernatural forces were responsible for mental illness, while 21 percent attributed depression to "a lack of stamina or will-power" and considered it a "natural part of aging."[12] Such misconceptions are particularly prevalent among practitioners in rural areas and contribute to a climate where mental health is treated through stigma rather than science.

The consequences of these attitudes are visible across private rehabilitation centres, where non-evidence-based, experimental, and punitive methods dominate daily operations. Many facilities are staffed by individuals with undergraduate degrees in psychology or untrained caregivers, and not by licensed psychiatrists or medical officers, as required under IHRA regulations. During inspections, the NCHR found that in 10 out of 10 private institutions visited, attendants or support staff responsible for the everyday care of patients were insufficiently trained to address psychosocial or intellectual disabilities, substance use, or comorbid conditions.

Site inspections revealed widespread medical neglect and pseudoscientific treatment practices. In several centres, the attending doctor was absent for days at a time, leaving untrained staff to administer medications. One woman at Rehabilitation Centre B told investigators that she developed a high fever and severe body pain but was locked in her room without medical care. "I hung out of the window and begged people on the street for a paracetamol," she said.

At two facilities, NCHR inspectors discovered expired medicines stored and used in treatment rooms. In another case, a woman reported that she developed a burning rash extending from her chin to her shoulders after being repeatedly given a drug to which she was allergic. Despite her complaints, the staff continued to administer the same medication. She still bears the scars of the rash that she developed from the drug.

Another woman described:

> *"I had head lice a lot. The conditions there were so bad. There were lice, and I was shaking my leg uncontrollably. I was crying a lot. I became very reserved and locked up and angry."*

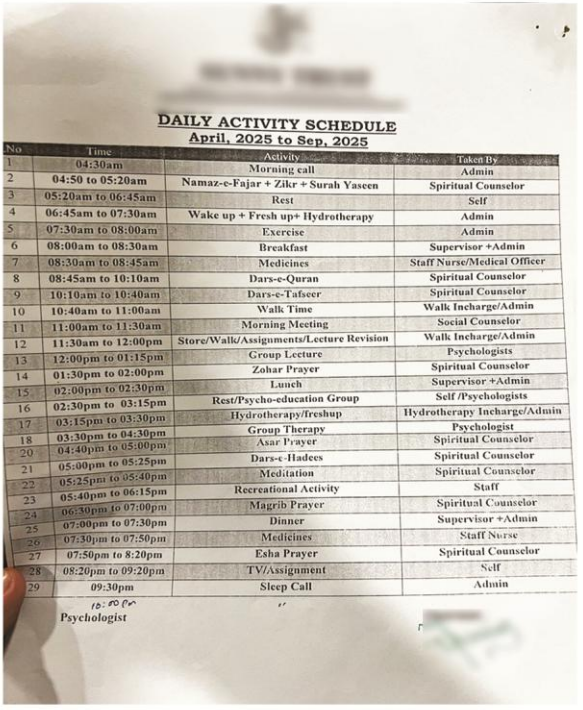
Basic clinical needs were often unmet. One patient told the NCHR team,

> *"When I was admitted there, I was wearing lenses. My roommate helped me get a small container with rose water so I could take them off after*

8 Haddad M, Waqas A, Qayyum W, Shams M, Malik S. The attitudes and beliefs of Pakistani medical practitioners about depression: a cross-sectional study in Lahore using the Revised Depression Attitude Questionnaire (R-DAQ). BMC Psychiatry. 2016;16(1):349. Available at: https://doi.org/10.1186/s12888-016-1069-1

three days of wearing them. Imagine the condition my eyes were in."

In many centres, "treatment" consisted primarily of religious instruction, humiliating treatment and shaming rather than medical or therapeutic intervention. Some facilities required patients to spend most of the day in prayer. At one such centre, Rehabilitation Centre A, the daily schedule included five mandatory prayer sessions, extended recitations of the Quran, and hours of religious lectures without break.



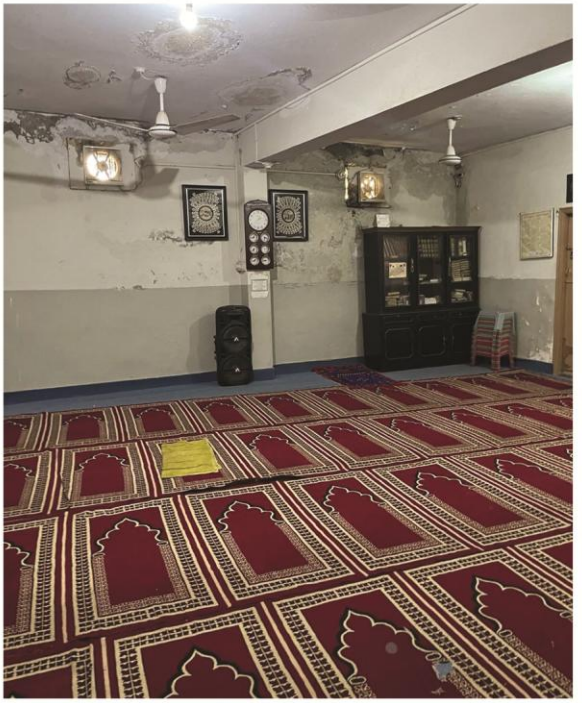
DAILY ACTIVITY SCHEDULE
April, 2025 to Sep, 2025

No	Time	Activity	Taken By
1	04:30am	Morning call	Admin
2	04:50 to 05:20am	Namaz-e-Fajar + Zikr + Surah Yaseen	Spiritual Counselor
3	05:20am to 06:45am	Rest	Self
4	06:45am to 07:30am	Wake up + Fresh up+ Hydrotherapy	Admin
5	07:30am to 08:00am	Exercise	Admin
6	08:00am to 08:30am	Breakfast	Supervisor +Admin
7	08:30am to 08:45am	Medicines	Staff Nurse/Medical Officer
8	08:45am to 10:10am	Dars-e-Quran	Spiritual Counselor
9	10:10am to 10:40am	Dars-e-Tafseer	Spiritual Counselor
10	10:40am to 11:00am	Walk Time	Walk Incharge/Admin
11	11:00am to 11:30am	Morning Meeting	Social Counselor
12	11:30am to 12:00pm	Store/Walk/Assignments/Lecture Revision	Walk Incharge/Admin
13	12:00pm to 01:15pm	Group Lecture	Psychologists
14	01:30pm to 02:00pm	Zohar Prayer	Spiritual Counselor
15	02:00pm to 02:30pm	Lunch	Supervisor +Admin
16	02:30pm to 03:15pm	Rest/Psycho-education Group	Self /Psychologists
17	03:15pm to 03:30pm	Hydrotherapy/freshup	Hydrotherapy Incharge/Admin
18	03:30pm to 04:30pm	Group Therapy	Psychologist
20	04:40pm to 05:00pm	Asar Prayer	Spiritual Counselor
21	05:00pm to 05:25pm	Dars-e-Hadees	Spiritual Counselor
22	05:25pm to 05:40pm	Meditation	Spiritual Counselor
23	05:40pm to 06:15pm	Recreational Activity	Staff
24	06:30pm to 07:00pm	Magrib Prayer	Spiritual Counselor
25	07:00pm to 07:30pm	Dinner	Supervisor +Admin
26	07:30pm to 07:50pm	Medicines	Staff Nurse
27	07:50pm to 8:20pm	Esha Prayer	Spiritual Counselor
28	08:20pm to 09:20pm	TV/Assignment	Self
29	09:30pm	Sleep Call	Admin

10:00 pm
Psychologist

One resident of Rehabilitation Centre B described a routine focused entirely on religious practice:

"We get up at 5 a.m. for prayer, and then we mostly pray all day or read the Quran."



The same resident was housed with patients suffering from severe drug addiction and aggressive behavioural disorders, including one man who had previously committed a homicide. The practice of mixing patients with drastically different diagnoses and needs under a single regimen violates basic medical ethics and international standards, which require individualised, diagnosis-specific care plans. As defined by the World Health Organization (WHO), rehabilitation is a highly person-centered process, with interventions tailored to each individual's goals, diagnosis, and preferences. It can take place in diverse settings: hospitals, outpatient facilities, schools, workplaces, or community programmes. The concept assumes choice, consent, and collaboration.[13] Yet in Pakistan's rehabilitation centres, these principles are routinely ignored.

13 World Health Organization (WHO), "Compulsory Drug Detention and Rehabilitation Centres," June 1, 2020, https://www.who.int/news/item/01-06-2020-compulsory-drug-detention-and-rehabilitation-centres vccxd

There is no rationale for why a person with "phone addiction" should receive the same treatment regimen as someone addicted to methamphetamine, or why individuals with learning disabilities are subjected to the same punitive schedule as those diagnosed with psychosis. Such uniformity reflects a failure to distinguish medical care from social discipline, revealing a system rooted more in control than in healing.

At another facility, a woman belonging to a religious minority community reported that an Islamic cleric questioned her faith and told her:

> ***"Your nikah is not valid in Islam."***
>
> ***When she insisted that she was legally married and had a child, he repeated, "No, it's not valid."***

Engaging in moral or religious interrogation of a patient crosses the professional boundary between clinician and patient, replacing therapeutic care with personal or ideological authority. Such acts of discrimination and religious coercion fall far outside any legitimate treatment framework and represent an abuse of power cloaked in moral judgement. Treating a patient differently on the basis of religion contravenes the principle of non-discrimination (e.g., Article 12 of the ICESCR and Article 5 of the CRPD) and undermines the therapeutic alliance necessary for recovery.

Prolonged Detention After Treatment

Even after treatment was reportedly complete, families were often persuaded by staff to extend the patient's stay, ostensibly for "further care," while continuing to pay monthly fees. In one particularly severe case, an elderly man had been confined at Rehabilitation Centre B since 2022. His diagnosis stated that he had experienced "psychosis after smoking marijuana once." When NCHR investigators asked whether he was ever allowed outside in his 23 years of rehabilitation, staff replied:

> *"He walks in the hallways sometimes."*

Such indefinite confinement, particularly in the absence of clinical justification, informed consent, or independent legal review, is deeply concerning. In the case of older patients, prolonged institutionalisation can further intensify existing vulnerabilities, placing them at heightened risk of neglect, coercion, and abuse within custodial settings. This is reflected in broader patterns of age-based discrimination documented in Pakistan. According to the British Council's report *Moving from the Margins* [14] 15 percent of older people reported experiencing emotional or psychological distress caused by others, while one in ten stated that they had been looked down upon or treated in a humiliating, shameful, or degrading manner because of their age.

14 British Council. Moving from the Margins: Promoting and Protecting the Rights of Older Persons in Pakistan. Islamabad: British Council, 2019. https://www.britishcouncil.pk/sites/default/files/promoting_and_protecting_the_rights_of_older_persons_in_pakistan-_british_council_2019.pdf.

Case Study 3: Fatima's Story

Fatima, a 28-year-old woman, was admitted against her will to Rehabilitation Centre C in Islamabad. Her family arranged the admission after she filed a khula (divorce) case against her husband. Instead of support, she was forcibly confined in a facility meant for addiction treatment, even though there was no medical basis for her admission. Fatima told the NCHR team that she was injected with a sedative without her consent, lost consciousness, and woke up inside the centre with no understanding of how she had been brought there.

She remained confined for three and a half months, isolated from the outside world. Her family had no legal guardianship or court authorization to detain her. When she asked the staff if she could leave, they told her, "When you're better, we'll inform your family," effectively denying her the right to leave or to contact legal counsel. She was never informed of her legal rights, nor of any complaint or grievance mechanism.

The staff claimed she was being treated because "her friends and drugs had taken control of her mind," a statement unsupported by any medical examination. Fatima said she was never seen by a licensed psychiatrist or psychologist, nor told what medications she was being given. The facility, she recalled, had cameras installed even in bedrooms and bathrooms, violating her privacy and dignity.

Conditions at the centre were poor and degrading. She described the food as unhygienic and said she was kept locked in a room for most of her stay, with minimal sunlight or human contact. "It was mental torture," she told NCHR. "It felt like a jail with staff only there to watch over us. There was no light, no proper food, no privacy, everything was against my will."

Fatima reported that the clinic's staff routinely extended patients' stays to extract additional payments from their families. Her family was told she was "not stable" and required more treatment, leading them to pay three to four lakh rupees per month. "All they needed was money," she said. "They kept lying to my family so they could keep me longer."

By the end of her confinement, Fatima had suffered severe psychological distress and described her experience as one of complete disempowerment, a situation where her autonomy, rights, and personhood were systematically denied under the guise of treatment.

Admission & Treatment of Minors

Children admitted to rehabilitation centres represent one of the most vulnerable groups affected by institutional abuse and neglect. Their age, dependency, and limited ability to understand or challenge confinement increases the risk of coercion, prolonged detention, and harm disguised as " treatment." Over the course of its investigation, NCHR interacted with multiple minors who had been forcibly admitted to rehabilitation centres by their parents or guardians, often for reasons unrelated to health. In most cases, these facilities had no pediatric or child psychology units, and minors were housed alongside adult patients, exposing them to significant risk of physical and sexual exploitation.

In one case, a 17-year-old boy was admitted to a rehab centre after attempting suicide at boarding school. The boy explained that he had been struggling with a learning disability and felt isolated from his peers. Now 19 years old, he remains institutionalized and expressed to NCHR his desire to study culinary arts once released. The NCHR team observed that his clothing was unwashed and that his treatment regimen consisted largely of religious instruction rather than therapeutic intervention. When the team raised these concerns with his father, he responded that he was "satisfied" with the facility and his son's progress, reflecting the deep societal misunderstanding of mental health care and the normalization of confinement as a form of discipline.

In another case, a 15-year-old girl was admitted to Rehabilitation Centre B by her family because they believed she was queer. She was forced to live in a room with an adult woman, under constant surveillance by a security camera installed in the bedroom, recording all her private moments. This invasive monitoring represents a gross violation of privacy and bodily autonomy, and places children at heightened risk of trauma and exploitation.

Children as young as 15 years old were found in rehabilitation centres during NCHR inspections. Many were confined with adults suffering from severe addiction or mental illness, and in some cases, had been subjected to physical abuse, forced medication, or arbitrary drug treatment. The centres' environments, marked by neglect, coercion, and religious moralization, are profoundly unsuitable for minors, and risk causing long-term psychological harm.

NCHR's findings reveal that minors are routinely admitted, confined, and medicated without consent or medical evaluation, reflecting a systemic failure of state oversight. These children are not patients, they are victims of a system that confuses control with care.

Case Study 4:
Two Brothers, Punished for Neglect

During its inspection of a private rehabilitation facility, the NCHR encountered two brothers who had been confined alongside adult patients, despite their young age and the absence of any medical or legal justification for their detention

At the time of the visit, one boy was 16 years old, while the other had just turned 18. Their histories revealed a pattern not of addiction or diagnosed mental illness, but of prolonged neglect following the breakdown of their family structure. Their parents had divorced and subsequently remarried, and neither household assumed consistent responsibility for their care. As a result, the boys had been largely left unsupervised and unsupported.

According to the boys, their behavioural issues consisted primarily of smoking cigarettes, getting into fights, and struggling with basic hygiene, including repeated infestations of head lice. These behaviors, while indicative of neglect and lack of adult supervision, were treated not as child protection concerns but as grounds for institutionalization.

Their father ultimately decided to place both boys in a rehabilitation centre. There was no evidence of substance dependence, psychiatric diagnosis, or court authorization supporting this decision. Once admitted, the boys reported being heavily medicated, leaving them disoriented and emotionally distressed. Both boys were visibly upset during the NCHR interaction and repeatedly stated that they wanted to go home. One of them broke down crying while speaking to investigators.

In addition to medication, the boys alleged that they were physically beaten and restrained by staff members. They stated that they were tied up on multiple occasions. When questioned about these practices, rehabilitation centre staff confirmed that restraints had been used, stating that the boys were “aggressive” and frequently fought with one another. Staff justified the use of tying and physical control measures as necessary to manage their behaviour.

The use of physical restraint and violence against minors, particularly in the absence of medical oversight, individualised assessment, or documented protocols, raises serious concerns. Even if behavioural challenges were present, the response adopted by the facility was

punitive rather than therapeutic, and entirely inappropriate for children and adolescents.

The confinement of these brothers amounts to a clear deprivation of liberty, particularly in the case of the younger boy, who was legally a child at the time of admission. Even the elder brother, having only just turned 18, had spent his formative years under conditions of neglect and was abruptly transitioned from abandonment to incarceration-like confinement, without any rehabilitative or protective framework.

Rather than receiving care, protection, or family-based intervention, the boys were placed in an adult rehabilitation environment ill-suited for their age, needs, and vulnerabilities. Such facilities are not designed to address childhood neglect, behavioral challenges arising from family breakdown, or adolescent development. Instead, the use of medication, restraint, and violence functioned as tools of control, suppressing distress rather than responding to it.

This case illustrates how rehabilitation centres are increasingly misused as substitutes for parenting, social welfare systems, and child protection mechanisms. When families fail, or are allowed to fail children, the response cannot be incarceration under the guise of treatment. These boys were not patients in need of rehabilitation; they were children in need of care.

Harassment & Torture

In rehabilitation centres across Pakistan, NCHR documented recurring patterns of physical, verbal, and sexual abuse by staff members. Patients described being slapped, shoved, and insulted by attendants, often as punishment for perceived disobedience or as part of so-called "therapy." One woman recalled, "A girl once insulted a staff member, and when she used two curse words at him, he backhanded her twice across the face. There were many patients who saw it. That's not how you treat someone who's mentally unwell. They can't help it."

Others spoke of being forced to take medication against their will. "If we said no to taking a big pile of tablets," said one former patient, "they forced their fingers down our throats and put the pills in. We felt like animals." Many of the people working in these facilities have no formal medical or psychological training. Due to the largely disconnected structure of professional regulation, many practitioners at present are able to practice without any checks and balances. The lack of licensure allows both professionals with valid mental health backgrounds and quacks practice within the field alike. Without a significant legal basis or existing regulatory bodies enforcing their mandate, many of the "quacks" in the field are able to label themselves as mental health practitioners. Mental health practitioners with valid degrees and experience have no licensure requirements and no requirements to keep themselves up to date to changes in diagnosis and management. Only informal professional bodies, such as the Pakistan Psychiatric Society and Pakistan Psychological Association fulfill this gap. However, as private bodies with no regulatory, licensure or government mandated authority, they cannot enforce these requirements. There is also limited professional oversight of these without individual governing bodies. Meanwhile, non-professionals or "quacks" are freely able to label themselves as mental health practitioners and enter the field with little or no oversight. They are able to play the role of caregiver and exploit already vulnerable clients. The lack of supervision or accountability allows for the routine use of violence, intimidation, and humiliation to control patients.

Neglect and cruelty often intersect. In one case documented by NCHR, a young woman had been sedated for several days. When her menstrual period began, she remained unconscious. Her roommates, also patients, had to carry her to the bathroom, clean her, and apply sanitary napkins while staff ignored them. Such treatment violates fundamental standards of medical ethics and dignity.

Women and girls confined in rehabilitation centres face particular vulnerability to harassment. Gendered insults such as "gashti" and "kanjari" are common, as are inappropriate comments and sexualized attention from male staff. "I remember once I wore a red shalwar kameez to lunch," one woman said. "A staff member looked me up and down and said, ' Mashallah, Mashallah, Mashallah.'" In

many centres, women have no way to report such misconduct, no contact with lawyers, and no opportunity to speak to family members without supervision.

Some facilities also engage in coercive or experimental "treatments." A survivor of one such centre described being subjected to electroshock therapy during "detoxification," which left her with memory lapses lasting days. Another said she was heavily medicated after refusing to participate in religious activities. WHO research indicates that up to one in four patients in long-term psychiatric or rehabilitation institutions worldwide experience physical or sexual abuse by staff, particularly in places without independent monitoring or complaint mechanisms. Pakistan's rehabilitation centres match this description closely.[15]

Several patients reported that staff members manipulated families into believing their relatives were improving. Residents were ordered to smile, play games, or pose for photos and videos that were later sent to families. "They made us laugh and wave for pictures," one woman said. "They told our families we were doing better. But inside, we were prisoners."

Patients also described being confined indoors for extended periods without sunlight or outdoor access. At Rehabilitation Centre B, whose advertisements show open gardens and mountain views, residents reported being locked inside for months or years. One elderly man, admitted in 2002, had been allowed outside only a handful of times in twenty-three years. Now in his nineties, the resident was admitted by his father after suffering psychosis as a result of smoking marijuana.

NCHR's findings show that most facilities operate without oversight, employ unqualified staff, and face no consequences for violations. The absence of monitoring, combined with profit-driven motives, has created environments where cruelty is normalized and patients are denied even the most basic rights.

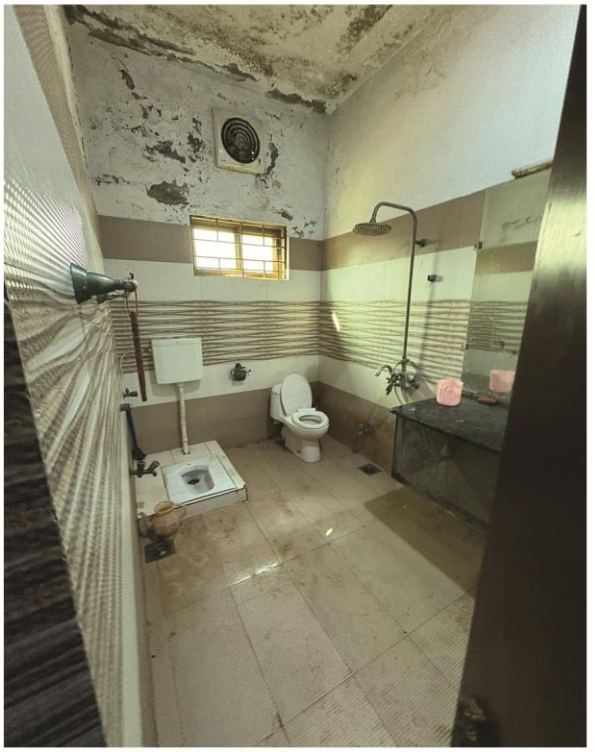
Physical Conditions at the Centres

When families bring their loved ones to rehabilitation centres, they are often persuaded by glossy brochures and assurances of comfort, care, and professional oversight. One woman told NCHR that her family had been promised a clean, well-equipped facility. "They told them, 'We have a gym here, we have a swimming pool here,'" she recalled. "I remember my brother asking me, 'Are you working out in the gym?' I said, 'What gym? There's no gym here.'"

However, inspections conducted by NCHR across multiple private rehabilitation centres revealed living conditions fundamentally incompatible with dignity, health, or recovery. Many of these institutions operate out of converted residential properties; houses repurposed into clinics without structural modification or appropriate medical infrastructure. Bedrooms were

11 [1] World Health Organization, World Report on Violence and Health, Chapter 7: "Violence against people with disabilities and institutional abuse" (Geneva: WHO, 2019).

routinely cramped and poorly ventilated, with windows sealed shut and limited access to natural light. In several facilities, six to ten residents shared a single room furnished with rusted metal beds and thin, stained mattresses. Bedding was visibly unclean, and residents reported that bed sheets were not changed regularly.



Sanitation conditions were equally concerning. Bathrooms were unhygienic, water supply was inconsistent, and personal hygiene items were restricted or unavailable. Some facilities lacked access to clean water and functional toilets, requiring patients to fetch water from outdoor taps. NCHR teams documented open and dirty cooking areas, kitchens infested with flies and insects, and food stored without refrigeration. Meals were widely described by patients as insufficient, unhygienic, and nutritionally inadequate. Many residents reported resulting physical weakness, illness, and emotional distress.

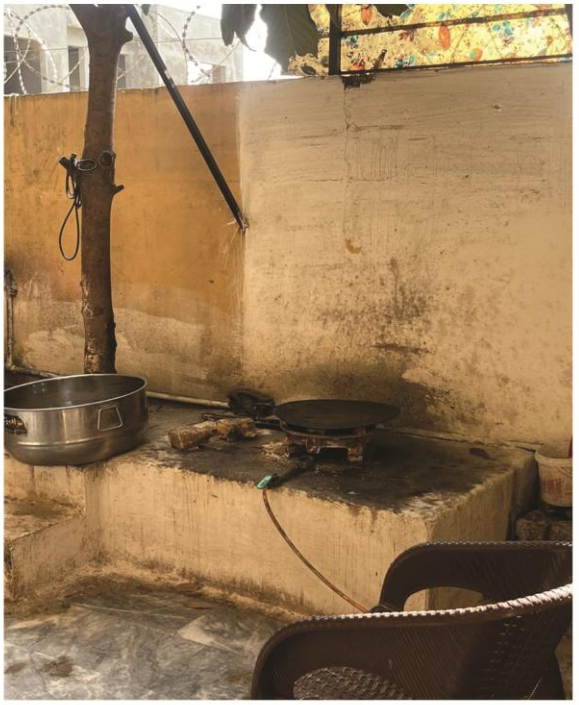
Beyond physical deprivation, patients were subjected to extreme confinement. Many were not permitted outdoor access for extended periods, and communication with family members was tightly restricted. Women and girls in particular spent their days in enforced idleness, as most centres provided no educational, recreational, or therapeutic programming. One resident reported, " They took away YouTube because someone tried to log in and send a message to their family. Now there's nothing to do but sleep and walk around." The absence of meaningful engagement further deteriorated residents' mental well-being, reinforcing isolation, depression, and worthlessness.

Surveillance practices compounded these harms. In multiple facilities, cameras were installed in bedrooms and living spaces, creating a constant sense of monitoring and control. Female residents described the experience as deeply humiliating. "You couldn't change your clothes in peace," one former patient said. "They said it was for our safety, but it felt like they were always watching." In several centres, male staff freely entered female wards without notice, raising additional concerns regarding privacy and safety.

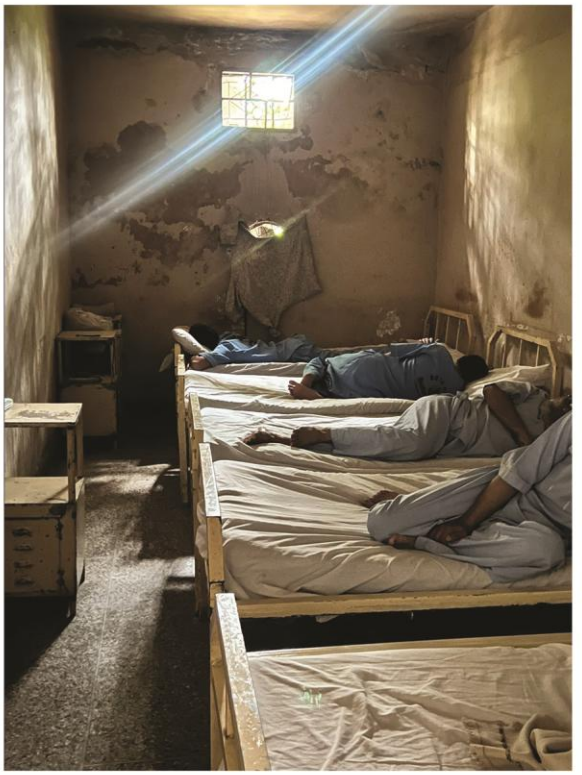
The IHRA standards for rehabilitation centres require facilities to maintain adequate living arrangements, hygiene, and privacy for all patients. Yet NCHR found widespread non-compliance. Many centres lacked functioning medical rooms, isolation wards, and gender-segregated spaces.

These conditions fundamentally undermine the stated purpose of rehabilitation. Recovery from mental health challenges or substance use requires safety, stability, dignity, and trust. Clean living environments, adequate nutrition, privacy, access to

light and space, and humane treatment are not optional comforts, they are preconditions for healing. International medical and human rights standards recognise that poor institutional living conditions may amount to inhuman and degrading treatment and directly impede recovery. When individuals are confined in overcrowded, unhygienic, and punitive environments, treatment becomes ineffective and, in many cases, actively harmful.



It is important to note that the rehabilitation centres examined in this investigation were registered with the IHRA and therefore subject to mandatory periodic inspections under its regulatory framework. The conditions documented by NCHR persisted despite this licensing and inspection regime. This points to a serious failure of regulatory enforcement and oversight, raising concerns that inspections are either ineffective or treated as a procedural formality rather than a meaningful safeguard for patients' rights and safety. In such environments, rehabilitation is not merely unlikely, it is structurally impossible.



Case Study 5: Ayesha's Story (Name Changed)

Ayesha, a 50-year-old woman working in the media industry in Karachi, had long struggled to rebuild her life after the death of her mother three years earlier. With a bachelor's degree in psychology, she believed she was fully capable of making her own decisions regarding her mental health. Her therapist had diagnosed her with mild depression related to grief but declared her mentally fit and independent. When she began living with her younger brother and his wife, domestic disputes over property grew increasingly tense. Each time an argument escalated, her brother had her forcibly admitted to a rehabilitation centre, claiming she was "unstable." On both occasions, she was released without any diagnosis beyond depression, findings the NCHR team later corroborated through her medical records.

In early 2025, Ayesha was at her brother's home when a team from a rehabilitation centre arrived unannounced. They injected her forcibly, and she regained consciousness hours later in a clinic, with a drip attached to her arm. She remained there for one and a half months, confused and sedated, unaware of the medications administered to her. She described feeling "groggy and slow," sharing a room with another patient who frequently screamed and acted violently, leaving her unable to sleep. Her elder brother eventually intervened and secured her release.

After filing a complaint with the National Commission for Human Rights, Ayesha abruptly ceased contact. Soon after, NCHR investigators began receiving emails from her family demanding that her complaint be withdrawn and deleted and that NCHR back off from its investigation. When the team visited the rehabilitation centre where she had been detained, they found her confined again and secured her release for the second time. NCHR officials formally warned her family that their actions were illegal under national and international law. Since then, Ayesha has reported living with autonomy and comfort, but she continues to struggle with the trauma of repeated captivity at the hands of those closest to her. Although she was a financially independent professional working in a reputed advertising firm, she fell prey to the patriarchal society and unregulated rehabilitation centres.

Impact on Women & Girls

Women and girls in Pakistan already face profound disadvantage in nearly every sphere of life, from economic opportunity to health and personal security. When they enter the unregulated world of rehabilitation centres, their vulnerability is further magnified. Pakistan was ranked 148th out of 148 countries in the World Economic Forum's *Global Gender Gap Report 2025*, with a gender parity score of only 56.7 percent.[16] Women make up just 22.8 percent of the labour force, according to the World Bank, reflecting stark underrepresentation both economically and socially.[17]

Many women are admitted to rehabilitation centres under false pretenses, labeled as "addicts," "mentally unwell," or "morally unstable." In several cases documented by NCHR, women were institutionalised by relatives after domestic or property disputes, or for failing to conform to family expectations. Consent is rarely sought, and when it is, it is seldom informed. Additionally, women and girls with psychosocial or intellectual disabilities, already marginalised and stigmatised, are placed in environments where diagnoses are weakly supported, documentation is inadequate, and inadequate, and practitioners frequently dismiss their concerns.

Victims interviewed by NCHR described how staff ignored their trauma or history of gender-based violence, neglected their medical needs, and confined them without explanation. Many of the issues identified in this report affect women disproportionately. These include the absence of independent complaint mechanisms, violations of confidentiality and privacy such as surveillance cameras in female wards, misrepresentation of staff qualifications, and inappropriate or unethical provider behaviour. Women also reported being subjected to verbal abuse and harassment by male staff.

Globally, women face higher risks than men in institutional or custodial healthcare settings. Studies show that women in long-term institutions are more likely to experience sexual violence, invasive treatment, and limited access to reproductive and mental health care. Women lost approximately 1.2 million disability-adjusted life years (DALYs) to depression in 2013, compared to 495,000 among men.[18]

16 Profit by Pakistan Today, "Featured," accessed April 23, 2026, https://profit.pakistantoday.com.pk/category/featured/
17 Saima Shabbir, "Pakistan Ranks Last Among 148 Nations in WEF Global Gender Gap Index," Arab News, June 12, 2025, https://www.arabnews.com/node/2604282/pakistan
18 Asma Ghani, "The Express Tribute: Mental Health Disorders: Pakistani Women Suffer More Than Men," University of Washington Department of Global Health, February 8, 2017, https://globalhealth.washington.edu/news/2017/02/08/express-tribute-mental-health-disorders-pakistani-women-suffer-more-men

This gendered disparity in mental health outcomes is compounded by systemic discrimination and the lack of regulation in Pakistan's rehabilitation sector. The absence of documentation, evidence-based practice, and clear diagnostic protocols results in harm that falls disproportionately on women and girls. One former patient told NCHR, "They said I had anger issues, but no one ever asked why I was angry." Another recalled, "When I tried to tell them about my anxiety, they told me to pray more." These experiences reflect a broader culture in which women's emotional and psychological needs are invalidated rather than understood.

To fulfill these commitments, Pakistan must strengthen oversight and regulation of mental health and rehabilitation facilities, enforce licensing requirements, and develop gender-sensitive protocols for treatment. Awareness campaigns are also essential to challenge stigma and improve understanding of women's mental health. Without accountability, ethical practice, and public awareness, rehabilitation centres will continue to serve as spaces of control rather than recovery, deepening the systemic harm faced by women and girls.

Gaps in Policy and Legislation

Legal Overview

Although the Constitution of Pakistan does not explicitly guarantee the right to health, Article 9 affirms the right to life, Article 14 protects human dignity, and Article 25 ensures equality before the law. Interpreted collectively, these provisions encompass the right to physical and mental health as an essential component of life and dignity.

Pakistan lacks a comprehensive national mental health plan or policy framework. The outdated Lunacy Act of 1912 was replaced by the *Mental Health Ordinance 2001,* intended to establish safeguards for mental health care. However, following the 18th Amendment, health became a provincial subject, resulting in fragmented governance and weak implementation. Although Sindh (2013), Punjab (2014), Khyber Pakhtunkhwa (2017), and Balochistan (2019) have enacted provincial mental health acts, enforcement remains negligible. In Islamabad, the *Mental Health Ordinance 2001* continues to apply but is effectively dormant.

Across jurisdictions, mental health facilities, including psychiatric clinics and rehabilitation centres, operate without adequate oversight. Service providers frequently lack certification, and there are no regulatory mechanisms to verify qualifications, enforce ethical standards, or prevent malpractice. This regulatory vacuum perpetuates systemic neglect and undermines the protection of persons with psychosocial disabilities.

Islamabad Health Regulatory Authority (IHRA)

The comprehensive NCHR investigation into rehabilitation centres in Islamabad revealed that the IHRA had granted licenses to facilities operating in violation of its own minimum standards for rehabilitation centres.[19] The matrix below places IHRA's stated standards against actual conditions observed during NCHR investigations, thereby illustrating consistent non-compliance across all facilities.

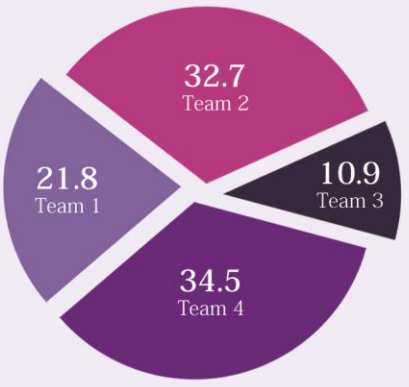
19 Islamabad Healthcare Regulatory Authority (IHRA), Minimum Service Delivery Standards for Rehabilitation Centers (Islamabad: IHRA, 2021), https://ihra.gov.pk/wp-content/uploads/2021/07/IHRA-Standards-for-Rehabilitation-Center.pdf

Standard No. & Title	Key Indicators (from IHRA)	Breaches in Individual Patient Cases Investigated by NCHR
Standard-24: Admission/Detention & Discharge	Indicator-91: Reasons for admission documented. Indicator-92: Admission/discharge documented.	Admitted without guardianship certificate or legal authorization; resident held against will.
Standard-25: Patient Management Based on Diagnosis	Indicator-93: Substantiated diagnosis documented. Indicator-95: Comprehensive treatment plan prepared.	No substantial diagnosis or psychological assessment; no individualized care plan.
Standard-31: Informed Consent Process	Indicator-118: Policy on who can give consent. Indicator-119: Informed consent obtained before treatment.	No informed consent obtained; patient sedated and confined without approval.
Standard-28: Prescription of Medications	Indicator-109: SOPs for prescription writing. Indicator-111: Standardized drug treatment protocols followed.	Unidentified medications given for months; patient unaware of purpose or type of drugs.
Standard-29: Safe Medication Administration	Indicator-112: Medicines stored per guidelines. Indicator-115: Dispensing by authorised person.	Expired medication found. Medicines administered forcibly; staff pried open patient's mouth to ensure ingestion.
Standard-30: Right to Comprehensive Mental Health Care	Indicator-116: Charter of rights displayed and explained to patients.	No psychiatric therapy or structured treatment; detention was punitive, not therapeutic.

Standard-33: Appeals and Complaints	Indicator-123: Patient informed of complaint rights. Indicator-124: Documented complaint process exists.	No complaint mechanism; patient smuggled message to legal assistant for help.
Standard-34: Confidentiality of Ailment	Indicator-126: SOPs for confidentiality exist. Indicator-127: Patient identity protected.	Cameras in bedrooms; male staff reviewing footage of female patients. Footage of patients pasted on social media.
Standard-26: Prevention of Maltreatment	Indicator-105: SOPs to prevent maltreatment practiced.	Reports of harassment, physical coercion, and a patient being slapped; male staff in female wards.
Standard-7: Safe and Secure Environment	Indicator-28: Physical safety ensured. Indicator-29: Safe food arrangements. Indicator-31: Clean linen and hygiene maintained.	Unhygienic conditions, lack of privacy, male staff in female areas.
Standard-21: Patient Management System	Indicator-80: Initial assessment for treatment planning. Indicator-81: Use of standard diagnostic tools.	No structured assessment or management plan; ad hoc treatment based on family instructions.

Collectively, these breaches reveal that licensing functions as a formality rather than a safeguard, and that enforcement mechanisms remain virtually absent.

Figure 1:
Point Scored



Contravention of International Human Rights Conventions and Standards

Pakistan has ratified several core international human rights instruments that obligate the State to protect individuals especially women, children, and persons with psychosocial disabilities from arbitrary detention, coercion, violence, and degrading treatment. The findings of this investigation demonstrate repeated breaches of these commitments.

The report documents forced "pickups," illegal confinement for months or years, detention beyond the completion of treatment, and confinement for reasons unrelated to health, such as property disputes, family honour, allegations of relationships, or refusal to marry.

Such practices constitute arbitrary deprivation of liberty and violate international guarantees of freedom and security, including protections reflected within:

- The Universal Declaration of Human Rights (UDHR)
- The International Covenant on Civil and Political Rights (ICCPR)
- The Convention on the Rights of Persons with Disabilities (CRPD)

These standards collectively require that detention must be lawful, proportionate, medically justified, and subject to review.

A consistent pattern across testimonies and inspections was the administration of sedatives, tranquilizers, and injections without patient consent and without transparent medical records. Many individuals reported being held unconscious for days, denied access to information about their treatment, and physically forced to ingest pills.

International standards prohibit forced medical interventions without informed consent and emphasise bodily autonomy as a core dimension of the right to health. These violations are particularly severe where treatment was not therapeutic but punitive in nature, including the reported use of electroshock therapy without anaesthesia and prolonged sedation to enforce compliance.

The report documents violence, humiliation, verbal abuse, threats, intimidation, and punishment practices within rehabilitation centres, including slapping, backhanding, derogatory slurs, isolation, and coercive discipline framed as "therapy."

Such acts meet the threshold of cruel, inhuman, or degrading treatment under international human rights law and contravene protections established by Convention Against Torture (CAT).

Women's experiences documented throughout the investigation demonstrate a pattern of gendered institutional abuse, where women are frequently confined not because they are ill or dangerous, but because they refused compliance within family structures.

This includes admission for:

- Refusing marriage
- Filing divorce or khula
- Property disputes

- Allegations of relationships
- Perceived "defiance" or "anger issues"

Such practices contravene Pakistan's international obligations to eliminate gender-based discrimination and violence, particularly under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

Under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Pakistan is obligated to ensure that women enjoy the right to the highest attainable standard of physical and mental health without discrimination. This includes protection from gender-based violence and coercion in both public and private healthcare settings. The Convention on the Rights of Persons with Disabilities (CRPD) further guarantees women with disabilities the right to be free from exploitation, violence, and abuse, and to receive healthcare on an equal basis with others.

The investigation also confirms that minors were admitted to rehabilitation facilities without child protection safeguards, frequently housed alongside adults, and confined for extended periods for reasons including behavioural control, perceived sexuality, or emotional distress. This violates protections under the ***United Nations Convention on the Rights of the Child (UNCRC).*** The report further establishes that the detention and treatment of minors in adult rehabilitation centres also violates Pakistan's own legal frameworks, including the ***Juvenile Justice System Act (JJSA) 2018,*** which affirms a child's right to protection from torture and degrading treatment and requires safeguards for detention conditions.

The findings demonstrate a serious departure from accepted medical and ethical practice. Many centres were found to be staffed by underqualified personnel, lacked psychiatric oversight, and delivered treatment regimes rooted in moral discipline rather than evidence-based care.

International approaches to rehabilitation emphasize individual-centered care, diagnosis-specific planning, and informed consent. Yet, the investigation reveals that patients with drastically different needs, substance use disorders, psychosocial disabilities, grief-related depression, trauma, or so-called "phone addiction", were often subjected to identical routines of confinement, sedation, prayer schedules, and isolation.

The absence of qualified staff, the presence of expired medication, and the normalization of coercive practices reflect an institutional culture that prioritizes control over care. Beyond direct abuse, several facilities also failed to provide environments consistent with international health benchmarks for humane care. According to WHO's QualityRights Toolkit, which provides key standards for evaluating mental health and social care facilities, residents are entitled to live in "safe, sanitary, and dignified conditions," with access to adequate space, light, privacy, and opportunities for social and recreational activity.

Unlike countries that have developed structured community mental health programmes, Pakistan lacks a cohesive, community-based mental health care framework. The National Mental Health Policy, revised intermittently since 2001, has never been effectively implemented. Integration between mental health and general health services remains minimal, leaving most care to unregulated private providers. The absence of national licensing standards, oversight systems, and continuing education for practitioners has resulted in a sector that operates largely outside professional accountability. This vacuum fuels both neglect and abuse.

Recommendations

1. Policy Recommendations

1.1 Establish National and Provincial Oversight Mechanisms

- Strengthen the Islamabad Healthcare Regulatory Authority (IHRA) to function as an effective oversight body with adequate staff, inspection capacity, and enforcement mechanisms.
- Mandate quarterly inspection and public disclosure of compliance reports for all rehabilitation and mental health facilities.

1.2 Institutionalize Human Rights-Based Care Standards

- Develop gender-sensitive and child protection guidelines for all facilities, prohibiting the admission of minors to adult wards and ensuring separate, safeguarded spaces for women.
- Ensure IHRA and provincial authorities follow their own best practices for rehabilitation centre standards, including sanitation, privacy, and access to complaint mechanisms.

1.3 Reform of the Islamabad Healthcare Regulatory Authority (IHRA)

- Conduct an independent review of IHRA's licensing and monitoring systems to prevent abuse and regulatory capture.
- Introduce mandatory SOPs for investigations and checklists for registration, re-registration, and compliance audits.
- Establish clear procedures for suspension or closure of non-compliant centres and prohibit unlicensed operations.
- Require IHRA to appoint qualified psychiatrists to inspection teams and ensure regular review of staff credentials and clinical protocols.

1.4 Financial and Resource Allocation

- Increase national spending on mental health.
- Allocate dedicated funds for public mental health facilities and community-based care programs to reduce reliance on private, unregulated centres.

1.5 Rehabilitation and Redress Mechanisms for Survivors

- Develop and fund state-supported rehabilitation and reintegration mechanisms for individuals unlawfully detained in private rehabilitation centres.
- Create psychosocial support programmes and compensation

mechanisms for victims of abuse, particularly women and minors.

2. Legislative Recommendations

2.1 Enact a Federal Mental Health Act

- Replace the outdated *Mental Health Ordinance 2001* with a comprehensive *Federal Mental Health Act* that harmonises minimum standards across provinces.
- Include explicit safeguards for involuntary admission, requiring judicial authorization, medical justification, and periodic review.
- Ensure that any confinement for mental health treatment follows due process, with oversight by independent medical and legal professionals.

2.2 Amend and Enforce Provincial Mental Health Acts

- Mandate provincial governments to revise their existing Mental Health Acts (Sindh 2013, Punjab 2014, KP 2017, Balochistan 2019) to incorporate stakeholder input, gender sensitivity, and compliance with international human rights treaties.

2.3 Regulate Education and Licensing

- Mandate the Higher Education Commission (HEC) to certify only those psychology and counselling programmes that meet international standards and practical training requirements.
- Establish licensing bodies for mental health practitioners with power to review curricula, monitor continuing education, and revoke licenses for malpractice.
- Make periodic re-certification and adherence to ethical codes mandatory.

2.4 Legal Safeguards for Patients' Rights

- Codify patients' rights to informed consent, privacy, and communication with legal representatives or family.
- Legally regulate the use of sedatives, restraints, and isolation, ensuring transparency and documentation for all such interventions.
- Require every rehabilitation facility to display and communicate a Charter of Patient Rights in Urdu and English upon admission.

3. Advocacy and Awareness Recommendations

3.1 National Mental Health Awareness Campaigns

- Launch public education campaigns to destigmatise mental health and promote help-seeking from legitimate, licensed practitioners.
- Collaborate with media, schools, universities, and workplaces to disseminate accurate information about mental health and available support services.

3.2 Community Engagement and Rights Literacy

- Partner with civil society organizations to provide community-based legal and psychological aid for victims and families.
- Conduct rights-awareness sessions for patients and families at the time of admission, ensuring they understand complaint mechanisms and discharge rights.
- Promote survivor-led advocacy networks to influence future mental health policy and legislation.

3.3 Multi-Stakeholder Collaboration

- Ensure coordination between the judiciary, police, and health authorities for enforcement of patient protection laws.

Annexure

ISLAMABAD HEALTHCARE REGULATORY AUTHORITY

Minimum Service Delivery Standards For Psychiatric & Addiction Treatment / Rehabilitation Facilities

Table of Contents

Standards & Indicators

1.1 Responsibilities of Management (ROM)

Standard-1: The HCE is identifiable as a legal entity and easily accessible to the patients and the surveyors

Indicator-01: The HCE is identifiable with a signboard conforming to the legal requirements and depicting Name and IHRA Registration / License Number on the Sign Board/s.

Indicator-02: The HCE is registered/licensed with IHRA.

Indicator-03: The HCE is easily reachable.

Standard-2: The Staff on duty is identifiable

Indicator-04: The Staff on duty uses the authorized Identity Badge.

Indicator-05: Door plate/s at clinics/offices clearly displays name, qualification/s, and designation/s of the staff on duty.

Standard-3: The HCE premises support the scope of work / services

Indicator-06: The HCE premises have demarcated areas according to the scope of work/services.

Indicator-07: HCE has adequate facilities/civic amenities for the comfort of the patients and attendants and these are adequately maintained.

Indicator-08: The HCE has adequate arrangements for the privacy of patients during consultation, examination, procedures etc.

Indicator-09: The HCE has arrangements to provide safe recreational activities.

Indicator-10: The HCE provides psychosocial rehabilitation services.

Standard-4: Responsibilities of management are defined.

Indicator-11: The management of the facility has laid down mission statement of the HCE.

Indicator-12: Those responsible for management establish the HCE organogram.

Indicator-13: The management ensures appointment of competent professionals according to organogram.

Indicator-14: Those responsible for management appoint a technically qualified and experienced professional to head the HCE.

Indicator-15: Those responsible for management lay down the overall Policy, Standing Orders and SOPs.

Indicator-16: The management is responsible for arranging/designating a substitute when particularly the head or any section in charge is absent due to any reason.

Indicator-17: Those responsible for management lay down standing orders and SOPs for emergency situations.

Indicator-18: Those responsible for management lay down security standing orders and SOPs.

Indicator-19: Those responsible for management monitor and measure the performance of the HCE against the assigned roles.

Indicator-20: The HCE management addresses the HCE's social and community responsibilities.

Indicator-21: Those responsible for management support research activities.

Standard-5: The management ensures functioning of the HCE according to relevant statutes.

Indicator-22: The management ensures availability of the applicable laws/by-laws/codes/rules/ regulations.

Indicator-23: The management is conversant with the relevant laws/bylaws/codes/rules/regulations and knows their applicability to the HCE.

Indicator-24: The management regularly updates any amendments in the prevailing relevant laws/Rules/ regulations/SOPs and SMPs.

Indicator-25: The management ensures implementation of the applicable laws/rules/regulations/SOPs and SMPs.

1.2. Facility Management and Safety (FMS)

Standard-6: Facility design supports the scope of work.

Indicator-26: There is effective separation between different areas including administrative, clinical consultation, Indoor and counseling etc.

Indicator-27: HCE design supports the arrangements for the security of premises against unauthorized entry/exit.

Standard-7: The HCE maintains a safe and secure environment for patients/attendants and the staff.

Indicator-28: The HCE has arrangements to ensure physical safety of patients/attendants in the HCE.

Indicator-29: There are arrangements to ensure safety / security of food / eatables for resident patients/attendants/staff in the HCE.

Indicator-30: There are arrangements to ensure safety of medicines/drugs for resident patients in the HCE.

Indicator-31: There are arrangements for provision of clean clothing/linen to the resident patients.

Standard-8: The HCE has plans for fire and non-fire emergencies.

Indicator-32: There is plan and provisions for early detection of fire and non-fire emergencies.

Indicator-33: There are provisions for abatement of fire and non-fire emergencies.

Indicator-34: Provisions are made for containment of fire and non-fire emergencies.

Indicator-35: Safe exit points in case of fire and non-fire emergencies are displayed.

Indicator-36: Mock drills are conducted at least once in a year.

Indicator-37: Staff members are trained for their role in case of such emergencies.

Standard-9: The HCE has a system for management of equipment for clinical and support services.

Indicator-38: The HCE has equipment in accordance with the scope of its services.

Indicator-39: Equipment is operated and maintained by qualified/trained personnel.

1.3. Human Resource Management (HRM).

Standard-10: Staff deployment is in accordance with scope of services.

Indicator-40: Eligibility criteria regarding qualification and experience for each job are available.

Indicator-41: Recruitment is made according to the laid down criteria.

Indicator-42: Job description for every post is defined and documented.

Indicator-43: Requisite staff is available at HCE for provision/supervision of prescribed psychiatric and/or addiction treatment services.

Standard-11: Staff members joining the HCE are oriented to HCE environment, different sections and their Individual jobs.

Indicator-44: There is an appropriate orientation plan for newly Inducted staff.

Indicator-45: Each staff member is aware of his/her rights and responsibilities.

Indicator-46: All employees are educated with regard to patient's rights and responsibilities.

Indicator-47: Staff receives refresher training/certification to continue to perform the jobs effectively.

Standard-12: An appraisal system for evaluating the performance of employees exists as an integral part of the Human Resource Management.

Indicator-48: There is a well-documented performance appraisal system and tools in the HCE.

Indicator-49: All of the employees / Consultants / Students / voluntary workers are made aware of the performance appraisal tools at the time of Induction.

Indicator-50: The appraisal is used as a tool for further development.

Indicator-51: Performance appraisal is carried out at pre-defined intervals and is documented.

Standard-13: Documented personal record for each staff member exists.

Indicator-52: Personal files are maintained in respect of all full time/part time employees.

Standard-14: There is a system for collecting, verifying and evaluating the credentials.
Education, registration, training & experience of professionals including doctors, and others

Indicator-53: System for verification of documents and certificates of employees exists in the HCE.

Indicator-54: Only medical professionals permitted by law/regulation provide patient care without supervision.

1.4. Information Management System (IMS).

Standard-15: The HCE has a complete and accurate medical record for every patient.

Indicator-55: Every medical record has a unique identifier.

Indicator-56: The staff authorized to make entries in the medical record is reflected in the HCE's policy/SOPs and is identifiable.

Indicator-57: Every medical record entry is dated, timed and signed.

Indicator-58: Complete medical record of the patients is maintained at HCE.

Indicator-59: The progress notes are recorded by the professionals responsible for the care of the patient.

Indicator-60: Every dormant record has a discharge summary.

Indicator-61: The SOPs for safety and security of patient record exist and are practiced.

Indicator-62: Authorized care providers have access to current and past medical records.

Standard-16: The HCE regularly carries out review of medical records.

Indicator-63: The medical records are reviewed regularly / periodically.

Indicator-64: The review focuses the timeliness, legibility and completeness of both active/current and discharged patient (closed/dormant) records.

Indicator-65: Any deficiency, found in the review and corrective measure taken, is documented.

1.5. Continuous Quality Improvement (CQI).

Standard-17: The HCE has a structured Quality Improvement system in place.

Indicator-66: A comprehensive plan covering ALL the major elements related to quality improvement is developed, implemented and maintained by a notified CQI Committee.

Indicator-67: There is a designated Individual for coordinating and implementing the quality improvement program.

Indicator-68: The CQI program is communicated and coordinated amongst all the employees of the HCE, through proper training mechanism.

Indicator-69: The quality improvement program is a continuous process and updated at least once in a year.

Standard-18: The monitoring system for CQI exists at the HCE.

Indicator-70: Monitoring includes appropriate patient assessment.

Indicator-71: Monitoring includes adverse drug events.

Indicator-72: Monitoring includes availability and content of medical records.

Indicator-73: Monitoring includes recommendations from appropriate services concerning follow-up or aftercare.

Standard-19: Sentinel events are assessed and managed.

Indicator-74: The HCE has defined sentinel events.

Indicator-75: Sentinel events are intensively analyzed when they occur.

1.6. Access, Assessment and Continuity of Care (AAC)

Standard-20: Services are provided as portrayed / claimed.

Indicator-76: Only the services registered with IHRA are provided and the same are displayed at the HCE.

Indicator-77: Health education is provided as per guidelines.

Indicator-78: The preventive services are provided as per guidelines.

Standard-21: HCE has a well-established patient management system.

Indicator-79: The HCE employs a comprehensive patient management process.

Indicator-80: An initial assessment is made in order to diagnose and prioritize interventions in a coordinated treatment plan.

Indicator-81: The assessment of patients employs standard tools for classification of mental disorder.

Indicator-82: Patients being evaluated for addiction also undergo an assessment of mental health status and possible psychiatric disorders.

Indicator-83: Assessment of female patients includes their gynecological status.

Standard-22: Adequate diagnostic facilities are in place/accessible.

Indicator-84: Laboratory/testing arrangements to facilitate the assessment of patients are available.

Indicator-85: Imaging services are available / accessible as per the clinical requirements of the patients.

Indicator-86: Only those diagnostic services are provided / accessed which comply the prescribed minimum standards.

1.7. Care of Patients (COP).

Standard-23: Emergency services are guided by policies, procedures and applicable laws and regulations.

Indicator-87: Documented SOPs for emergency care exist.

Indicator-88: Policies address handling of medico-legal cases.

Indicator-89: SOPs guide the prioritization of patients for initiation of appropriate care.

Indicator-90: Staff members are familiar with the SOPs for care of emergency patients and trained on the same and the patients receive care in consonance with the SOPs.

Standard-24: Policies and procedures guide the admission/detention and discharge of the patients.

Indicator-91: The reasons for admission/detention must be clearly documented as stated by the patient and/or others significantly involved.

Indicator-92: Admission/detention, discharge or referral to another HCE is documented.

Standard-25: Patient management is planned on the basis of assessment & diagnosis.

Indicator-93: A substantiated diagnosis is established and documented.

Indicator-94: A complete neurological assessment is also undertaken when indicated.

Indicator-95: A comprehensive treatment is planned for each female patient on the basis of her assessment including gynecological status.

Indicator-96: The treatment plan is reviewed, on the basis of patient's strengths and disabilities.

Indicator-97: The treatment provided is comprehensibly entered in the medical records.

Indicator-98: Contact with visitors is monitored/supervised and possibly restricted, particularly in the early stages of treatment.

Indicator-99: Psychotherapy services are provided as prescribed.

Indicator-100: SOPs for care of patients requiring any non-psychiatric intervention/s exist.

Indicator-101: Drug dependents are isolated in a nearby separate section of HCE as legally required.

Indicator-102: The treatment plans are periodically revised on the basis of regular patient monitoring/evaluation and the data on drug use trends in populations.

Indicator-103: Addiction treatment services are networked with other medical and social services for providing comprehensive care to the patients.

Indicator-104: Psycho-social interventions for rehabilitation of drug addicts and prevention of health and social consequences of addiction are operational.

Standard-26: Policies and procedures guide prevention of maltreatment of patient by the healthcare provider.

Indicator-105: SOPs to prevent maltreatment of patients by the care providers are practiced.

Standard-27: Policies and procedures guide the administration of anesthesia when required

Indicator-106: Documented SOPs for the administration of anesthesia exist.

Indicator-107: Informed consent for administration of anesthesia is obtained by the anesthetist.

Indicator-108: Periodic monitoring during anesthesia is regularly conducted.

1.8. Management of Medications (MOM).

Standard-28: Policies and procedures exist for the prescription of medications.

Indicator-109: Documented SOPs for prescription writing are available.

Indicator-110: SOPs are followed for prescription writing.

Indicator-111: Standardized drug treatment protocol is observed.

Standard-29: Policies and procedures guide the safe storage, dispensing and administration of medications.

Indicator-112: Medicines / disposables are stored as per guidelines.

Indicator-113: Expiry dates / shelf life are checked prior to administering, as applicable.

Indicator-114: Labeling requirements are implemented.

Indicator-115: Dispensing/utilization are by an authorized person.

1.9. Patient Rights and Education (PRE).

Standard-30: Patients have the right to comprehensive and integrated mental health care that meets their Individual needs and achieves the best possible outcome in terms of their recovery/rehabilitation.

Indicator-116: Charter of rights and responsibilities is displayed and patients / families are guided.

Indicator-117: Patients/families are guided and facilitated in protecting patient's assets.

Standard-31: A documented process for obtaining patient and/or family consent exists for informed decision making about their care.

Indicator-118: The policy describes who can give consent when patient is incapable of Independent decision-making.

Indicator-119: Informed consent must be obtained from the patient / legal representative before the initiation of the examination / treatment/ management.

Standard-32: Patient and families have a right to information on expected costs.

Indicator-120: The patient/family is informed about the cost of treatment.

Indicator-121: There is uniform category specific pricing policy in a given setting.

Indicator-122: Patients and family are informed about the financial implications when a change in the treatment plan is necessitated due to patient's condition.

Standard-33: Patient Rights for Appeals and Complaints are respected.

Indicator-123: The HCE informs the patient of his/her right to express relevant concern or complain either verbally or in writing.

Indicator-124: There exists a documented complaint management process which is fair and timely.

Indicator-125: The HCE uses the results of complaints investigations as part of the quality improvement process.

Standard-34: Patient Rights regarding confidentiality of their ailment are respected.

Indicator-126: The HCE has documented SOPs to ensure confidentiality of patient identity and ailment

Indicator-127: The HCE ensures that patient identity is not disclosed to public through press or electronic media

1.10. Infection Control (IC)

Standard-35: The HCE has a comprehensive and coordinated infection control program aimed at reducing/eliminating risks to patients, visitors and care providers

Indicator-128: The HCE infection control plan is documented which aims at preventing and reducing risk of nosocomial infections

Indicator-129: The HCE has an Infection Control Committee

Indicator-130: The HCE has designated a qualified infection control nurse(s)/officer for this activity.

Indicator-131: The HCE has appropriate consumables, collection and handling systems, equipment and facilities for control of infection.

Indicator-132: All staff involved in the patient care, creation, handling and disposal of medical waste shall receive regular training and ongoing education in infection control and safe handling of medical waste.

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