WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION

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World Health Organization

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Preface

There are many ways to improve the lives of people with mental disorders. One important way is through policies, plans and programmes that lead to better services. To implement such policies and plans, one needs good legislation–that is, laws that place the policies and plans in the context of internationally accepted human rights standards and good practices. This Resource Book aims to assist countries in drafting, adopting and implementing such legislation. It does not prescribe a particular legislative model for countries, but rather highlights the key issues and principles to be incorporated into legislation.

As is true for all aspects of health, the marked differences in the financial and human resources available in countries affect how mental health issues are addressed. Indeed, the needs expressed by mental health service users, families and carers, and health workers are highly dependent on current and past service provision, and peoples' expectations vary significantly from country to country. As a result, certain services and rights that are taken for granted in some countries will be the objectives other countries strive for. However, efforts can be made in all countries to improve mental health services and promote and protect human rights in order to better meet the needs of people with mental disorders.

Most countries could improve mental health significantly if they had additional resources dedicated specifically to mental health. Yet, even when resources are constrained, means can be found – as this Resource Book makes clear – for international human rights standards to be respected, protected and fulfilled. In certain instances, reform can be undertaken with few or no additional resources, although a minimum level of resources is always necessary to attain even basic goals and, clearly, additional resources will need to be committed – especially in countries that now have only minimal or no mental health resources – if basic international human rights standards are to be met.

Legislation can itself be a means to secure more resources for mental health, improve rights and mental health standards and conditions in a country. However, in order for a law to make a positive difference to the lives of people with mental disorders, it must have realistic and attainable goals. An unrealistic law on which the country cannot deliver serves no purpose at all, and can result in unnecessary expenses related to litigation, thereby diverting resources from service development. Legislatures should therefore only pass a law after exploring the resource implications. The question of how the objectives set out in this Resource Book can realistically be achieved in each country should be a major consideration for all readers of this book.

What does this Resource Book provide?

The chapters and annexes of this book contain many examples of diverse experiences and practices, as well as extracts of laws and other law-related documents from different countries. These examples do not represent recommendations or "models" to be replicated; rather, they are designed to illustrate what different countries are doing in the area of mental health, human rights and legislation.

Three key elements of effective legislation are outlined: context, content and process – in other words, the "why", "what" and "how" of mental health legislation. In addition, Annex 1 contains a Checklist on Mental Health Legislation, which can be used in conjunction with the Resource Book. The checklist is designed to assist countries in assessing whether key components are included in their mental health law, and in ensuring that the broad recommendations contained in the Resource Book are carefully examined and considered.

Throughout the book, reference is also made to the WHO Mental Health Policy and Service Guidance Package. This Package consists of a series of interrelated modules on issues such as mental health policy development, advocacy, financing and service organization, among others, designed to assist countries in addressing key mental health reform issues.

For whom is this Resource Book intended?

A variety of individuals, organizations and government departments are likely to find this Resource Book useful. More specifically, it is aimed at those directly involved in drafting or amending mental-health-related legislation, as well as those responsible for guiding the law through the adoption and implementation process. Within most countries, this is likely to be several people rather than one individual. Working through the Resource Book as a team, and discussing and debating points raised and their specific cultural and country relevance, is likely to result in the most productive use of this resource.

Beyond this specific group of users, this volume identifies numerous stakeholders with varied aims and interests, all of whom may benefit from using it. These include: politicians and parliamentarians; policy-makers; staff in government ministries (health, social welfare, law, finance, education, labour, police and correctional services); health professionals (psychiatrists, psychologists, psychiatric nurses and social workers) and professional organizations; family members of those with mental disorders; users and user groups; advocacy organizations; academic institutions; service providers; nongovernmental organizations (NGOs); civil rights groups; religious organizations; associations such as employee unions, staff welfare associations, employer groups, resident welfare associations and congregations of particular communities; and organizations representing minorities and other vulnerable groups.

Some readers may turn to the Resource Book to understand the context of human rights-oriented mental health legislation, others to better understand their potential roles or to appreciate or argue what or why a particular item should be included. Yet others may wish to examine international trends or to assess how they may help with the adoption process or in implementing the legislation. It is our hope that all will find what they need and that, as a result, their shared goal of achieving better mental health support will be advanced through the adoption and implementation of legislation that meets human rights standards and good practices.

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1. Introduction

The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens. In the undeniable context that every society needs laws to achieve its objectives, mental health legislation is no different from any other legislation.

People with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights. Legislation that protects vulnerable citizens (including people with mental disorders) reflects a society that respects and cares for its people. Progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders.

The presence of mental health legislation, however, does not in itself guarantee respect and protection of human rights. Ironically, in some countries, particularly where legislation has not been updated for many years, mental health legislation has resulted in the violation, rather than the promotion, of human rights of persons with mental disorders. This is because much of the mental health legislation initially drafted was aimed at safeguarding members of the public from "dangerous" patients and isolating them from the public, rather than promoting the rights of persons with mental disorders as people and citizens. Other legislation permitted long-term custodial care of persons with mental disorders who posed no danger to society but were unable to care for themselves, and this too resulted in a violation of human rights. In this context, it is interesting to note that although 75% of countries around the world have mental health legislation, only half (51%) have laws passed after 1990, and nearly a sixth (15%) have legislation dating back to the pre-1960s (WHO, 2001a). Legislation in many countries is therefore outdated and, as mentioned above, in many instances takes away the rights of persons with mental disorders rather than protecting their rights.

The need for mental health legislation stems from an increasing understanding of the personal, social and economic burdens of mental disorders worldwide. It is estimated that nearly 340 million people worldwide are affected by depression, 45 million by schizophrenia and 29 million by dementia. Mental disorders account for a high proportion of all disability adjusted life years (DALYs) lost, and this burden is predicted to grow significantly (WHO, 2001b) in the future.

In addition to the obvious suffering due to mental disorders, there exists a hidden burden of stigma and discrimination faced by those with mental disorders. In both low- and high-income countries, stigmatization of people with mental disorders has persisted throughout history, manifested by stereotyping, fear, embarrassment, anger and rejection or avoidance. Violations of basic human rights and freedoms and denial of civil, political, economic, social and cultural rights to those suffering from mental disorders are a common occurrence around the world, both within institutions and in the community. Physical, sexual and psychological abuse is an everyday experience for many with mental disorders. In addition, they face unfair denial of employment opportunities and discrimination in access to services, health insurance and housing policies. Much of this goes unreported and therefore this burden remains unquantified (Arboleda-Flórez, 2001).

Legislation offers an important mechanism to ensure adequate and appropriate care and treatment, protection of human rights of people with mental disorders and promotion of the mental health of populations.

This chapter covers five main areas:

- The interface between mental health law and mental health policy;
- Protecting, promoting and improving lives through mental health legislation;
- Separate versus integrated legislation on mental health;
- Regulations, service orders and ministerial decrees;
- Key international human rights instruments related to the rights of people with mental disorders.

2. The interface between mental health law and mental health policy

Mental health law represents an important means of re-enforcing the goals and objectives of policy. When comprehensive and well conceived, a mental health policy will address critical issues such as:

- establishment of high quality mental health facilities and services;
- access to quality mental health care;
- protection of human rights;
- patients' right to treatment;
- development of robust procedural protections;
- integration of persons with mental disorders into the community; and
- promotion of mental health throughout society.

Mental health law or other legally prescribed mechanisms, such as regulations or declarations, can help to achieve these goals by providing a legal framework for implementation and enforcement.

Conversely, legislation can be used as a framework for policy development. It can establish a system of enforceable rights that protects persons with mental disorders from discrimination and other human rights violations by government and private entities, and guarantees fair and equal treatment in all areas of life. Legislation can set minimum qualifications and skills for accreditation of mental health professionals and minimum staffing standards for accreditation of mental health facilities. Additionally, it can create affirmative obligations to improve access to mental health care, treatment and support. Legal protections may be extended through laws of general applicability or through specialized legislation specifically targeted at persons with mental disorders.

Policy-makers within government (at national, regional and district levels), the private sector and civil society, who may have been reluctant to pursue changes to the status quo, may be obliged to do so based on a legislative mandate; others who may have been restricted from developing progressive policies may be enabled through legislative changes. For example, legal provisions that prohibit discrimination against persons with mental disorders may induce policy-makers to develop new policies for protection against discrimination, while a law promoting community treatment as an alternative to involuntary hospital admissions may provide policy-makers with much greater flexibility to create and implement new community-based programmes.

By contrast, mental health law can also have the opposite effect, preventing the implementation of new mental health policies by virtue of an existing legislative framework. Laws can inhibit policy objectives by imposing requirements that do not allow for the desired policy modifications or effectively prevent such modifications. For instance, in many countries, laws that do not include provisions related to community treatment have hindered the implementation of community treatment policies for persons with mental disorders. Additionally, policy may be hindered even under permissive legal structures due to a lack of enforcement powers.

Policy and legislation are two complementary approaches for improving mental health care and services; but unless there is also political will, adequate resources, appropriately functioning institutions, community support services and well trained personnel, the best policy and legislation will be of little significance. For instance, the community integration legislation mentioned above will not succeed if the resources provided are insufficient for developing community-based facilities, services and rehabilitation programmes. While legislation can provide an impetus for the creation of such facilities, services and programmes, legislators and policy-makers need to follow through in order to realize the full benefits of community integration efforts. All mental health policies require political support to ensure that legislation is implemented correctly. Political support is also needed to amend legislation after it has been passed to correct any unintended situations that may undermine policy objectives.

In summary, mental health law and mental health policy are closely related. Mental health law can influence the development and implementation of policy, while the reverse is similarly true. Mental health policy relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental disorders.

3. Protecting, promoting and improving rights through mental health legislation

In accordance with the objectives of the United Nations (UN) Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation. Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles. Equally, being unable to access care is an infringement of a person's right to health, and access can be included in legislation. This section presents a number of interrelated reasons why mental health legislation is necessary, with special attention to the themes of human rights and access to services.

3.1 Discrimination and mental health

Legislation is needed to prevent discrimination against persons with mental disorders. Commonly, discrimination takes many forms, affects several fundamental areas of life and (whether overt or inadvertent) is pervasive. Discrimination may impact on a person's access to adequate treatment and care as well as other areas of life, including employment, education and shelter. The inability to integrate properly into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate the mental disorder. Policies that increase or ignore the stigma associated with mental disorder may exacerbate this discrimination.

The government itself can discriminate by excluding persons with mental disorders from many aspects of citizenship such as voting, driving, owning and using property, having rights to sexual reproduction and marriage, and gaining access to the courts. In many cases, the laws do not actively discriminate against people with mental disorders, but place improper or unnecessary barriers or burdens on them. For example, while a country's labour laws may protect a person against indiscriminate dismissal, there is no compulsion to temporarily move a person to a less stressful position, should they require some respite to recover from a relapse of their mental condition. The result may be that the person makes mistakes or fails to complete the work, and is therefore dismissed on the basis of incompetence and inability to carry out allocated functions. Discrimination may also take place against people with no mental disorder at all if they are mistakenly viewed as having a mental disorder or if they once experienced a mental disorder earlier in life. Thus protections against discrimination under international law go much further than simply outlawing laws that explicitly or purposefully exclude or deny opportunities to people with disabilities; they also address legislation that has the *effect* of denying rights and freedoms (see, for example, Article 26 of the *International Covenant on Civil and Political Rights* of the United Nations).

3.2 Violations of human rights

One of the most important reasons why human-rights-oriented mental health legislation is vital is because of past and ongoing violations of these rights. Some members of the public, certain health authorities and even some health workers have, at different times and in different places, violated – and in some instances continue to violate – the rights of people with mental disorders in a blatant and extremely abusive manner. In many societies, the lives of people with mental disorders are extremely harsh. Economic marginalization is a partial explanation for this; however, discrimination and absence of legal protections against improper and abusive treatment are important contributors. People with mental disorders are often deprived of their liberty for prolonged periods of time without legal process (though sometimes also with unfair legal process, for example, where detention is allowed without strict time frames or periodic reports). They are often subjected to forced labour, neglected in harsh institutional environments and deprived of basic health care. They are also exposed to torture or other cruel, inhumane or degrading treatment, including sexual exploitation and physical abuse, often in psychiatric institutions.

Furthermore, some people are admitted to and treated in mental health facilities where they frequently remain for life against their will. Issues concerning consent for admission and treatment are ignored, and independent assessments of capacity are not always undertaken. This means that many people may be compulsorily kept in institutions, despite having the capacity to make decisions regarding their future. On the other hand, where there are shortages of hospital beds, the failure to admit people who need inpatient treatment, or their premature discharge (which can lead to high readmission rates and sometimes even death), also constitutes a violation of their right to receive treatment.

People with mental disorders are vulnerable to violations both inside and outside the institutional context. Even within their own communities and within their own families, for example, there are cases of people being locked up in confined spaces, chained to trees and sexually abused.

Examples of inhuman and degrading treatment of people with mental disorders

The BBC (1998) reported how in one country, people are locked away in traditional mental hospitals, where they are continuously shackled and routinely beaten. Why? Because it is believed that mental illness is evil and that the afflicted are possessed by bad spirits.

An NGO that campaigns for the rights of people with mental disorders, has documented neglect and ill-treatment of children and adults in institutions all over the world. Instances of children being tied to their beds, lying in soiled beds or clothing, and receiving no stimulation or rehabilitation for their condition are not uncommon.

Another NGO has reported that certain countries continue to lock up patients in "cage beds" for hours, days, weeks, or sometimes even months or years. One report indicated that a couple of patients have lived in these devices nearly 24 hours a day for at least the last 15 years. People in caged beds are also often deprived of any form of treatment including medicines and rehabilitation programmes.

It is also well documented that in many countries, people with mental disorders live with their families or on their own and receive no support from the government. The stigma and discrimination associated with mental disorders means that they remain closeted at home and cannot participate in public life. The lack of community-based services and support also leaves them abandoned and segregated from society.

3.3 Autonomy and liberty

An important reason for developing mental health legislation is to protect people's autonomy and liberty. Legislation can do this in a number of ways. For example, it can:

- Promote autonomy by ensuring mental health services are accessible for people who wish to use such services;
- Set clear, objective criteria for involuntary hospital admissions, and, as far as possible, promote voluntary admissions;
- Provide specific procedural protections for involuntarily committed persons, such as the right to review and appeal compulsory treatment or hospital admission decisions;
- Require that no person shall be subject to involuntary hospitalization when an alternative is feasible;
- Prevent inappropriate restrictions on autonomy and liberty within hospitals themselves (e.g. rights to freedom of association, confidentiality and having a say in treatment plans can be protected); and
- Protect liberty and autonomy in civil and political life through, for example, entrenching in law the right to vote and the right to various freedoms that other citizens enjoy.

In addition, legislation can allow people with mental disorders, their relatives or other designated representatives to participate in treatment planning and other decisions as a protector and advocate. While most relatives will act in the best interests of a member of their family with a mental disorder, in those situations where relatives are not closely involved with patients, or have poor judgement or a conflict of interest, it may not be appropriate to allow the family member to participate in key decisions, or even to have access to confidential information about the person. The law, therefore, should balance empowering family members to safeguard the person's rights with checks on relatives who may have ulterior motives or poor judgement.

Persons with mental disorders are also at times subject to violence. Although public perceptions of such people are often of violent individuals who are a danger to others, the reality is that they are more often the victims than the perpetrators. Sometimes, however, there may be an apparent conflict between the individual's right to autonomy and society's obligation to prevent harm to all persons. This situation could arise when persons with a mental disorder pose a risk to themselves and to others due to an impairment of their decision-making capacity and to behavioural disturbances associated with the mental disorders. In these circumstances, legislation should take into account the individuals' right to liberty and their right to make decisions regarding their own health, as well as society's obligations to protect persons unable to care for themselves, to protect all persons from harm, and to preserve the health of the entire population. This complex set of variables demands close consideration when developing legislation, and wisdom in its implementation.

3.4 Rights for mentally ill offenders

The need to be legally fair to people who have committed an apparent crime because of a mental disorder, and to prevent the abuse of people with mental disorders who become involved in the criminal justice system, are further reasons why mental health legislation is essential. Most statutes acknowledge that people who did not have control of their actions due to a mental disorder at the time of the offence, or who are unable to understand and participate in court proceedings due to mental illness, require procedural safeguards at the time of trial and sentencing. But how these individuals are handled and treated is often not addressed in the legislation or, if it is, it is done poorly, leading to abuse of human rights.

Mental health legislation can lay down procedures for dealing with people with mental disorders at various stages of the legal process (see section 15 below).

3.5 Promoting access to mental health care and community integration

The fundamental right to health care, including mental health care, is highlighted in a number of international covenants and standards. However, mental health services in many parts of the world are poorly funded, inadequate and not easily accessible to persons in need. Some countries have hardly any services, while in others services are available to only certain segments of the population. Mental disorders sometimes affect people's ability to make decisions regarding their health and behaviour, resulting in further difficulties in seeking and accepting needed treatment.

Legislation can ensure that appropriate care and treatment are provided by health services and other social welfare services, when and where necessary. It can help make mental health services more accessible, acceptable and of adequate quality, thus giving persons with mental disorders better opportunities to exercise their right to receive appropriate treatment. For example, legislation and/or accompanying regulations can include a statement of responsibility for:

- Developing and maintaining community-based services;
- Integrating mental health services into primary health care;
- Integrating mental health services with other social services;
- Providing care to people who are unable to make health decisions due to their mental disorder;
- Establishing minimum requirements for the content, scope and nature of services;
- Assuring the coordination of various kinds of services;
- Developing staffing and human resource standards;
- Establishing quality of care standards and quality control mechanisms; and
- Assuring the protection of individual rights and promoting advocacy activities among mental health users.

Many progressive mental health policies have sought to increase opportunities for persons with mental disorders to live fulfilling lives in the community. Legislation can foster this if it: i) prevents inappropriate institutionalization; and ii) provides for appropriate facilities, services, programmes, personnel, protections and opportunities to allow persons with mental disorders to thrive in the community.

Legislation can also play an important role in ensuring that a person suffering from a mental disorder can participate in the community. Prerequisites for such participation include access to treatment and care, a supportive environment, housing, rehabilitative services (e.g. occupational and life skills training), employment, non-discrimination and equality, and civil and political rights (e.g. right to vote, drive and access courts). All of these community services and protections can be implemented through legislation.

Of course, the level of services that can be made available will depend on a country's resources. Legislation that contains unenforceable and unrealistic provisions will remain ineffective and impossible to implement. Moreover, mental health services often lag behind other health care services, or are not provided in an appropriate or cost-effective manner. Legislation can make a big difference in securing their parity with other health care services, and in ensuring that what is provided is appropriate to people's needs.

Provision of medical insurance is another area where legislation can play a facilitating role. In many countries, medical insurance schemes exclude payment for mental health care or offer lower levels of coverage for shorter periods of time. This violates the principle of accessibility by being discriminatory and creating economic barriers to accessing mental health services. By including provisions concerning medical insurance, legislation can ensure that people with mental disorders are able to afford the treatment they require.

4. Separate versus integrated legislation on mental health

There are different ways of approaching mental health legislation. In some countries there is no separate mental health legislation, and provisions related to mental health are inserted into other relevant legislation. For example, issues concerning mental health may be incorporated into general health, employment, housing or criminal justice legislation. At the other end of the spectrum, some countries have consolidated mental health legislation, whereby all issues of relevance to mental health are incorporated into a single law. Many countries have combined these approaches, and thus have integrated components as well as a specific mental health law.

There are advantages and disadvantages to each of these approaches. Consolidated legislation has the ease of enactment and adoption, without the need for multiple amendments to existing laws. The process of drafting, adopting and implementing consolidated legislation also provides a good opportunity to raise public awareness about mental disorders and educate policy-makers and the public about human rights issues, stigma and discrimination. However, consolidated legislation emphasizes segregation of mental health and persons with mental disorders; hence, it can potentially reinforce stigma and prejudice against persons with mental disorders.

The advantages of inserting provisions relating to mental disorders into non-specific relevant legislation are that it reduces stigma and emphasizes community integration of those with mental disorders. Also, by virtue of being part of legislation that benefits a much wider constituency, it increases the chances that laws enacted for the benefit of those with mental disorders are actually put into practice. Among the main disadvantages associated with “dispersed” legislation is the difficulty in ensuring coverage of all legislative aspects relevant to persons with mental disorders; procedural processes aimed at protecting the human rights of people with mental disorders can be quite detailed and complex and may be inappropriate in legislation other than a specific mental health law. Furthermore, it requires more legislative time because of the need for multiple amendments to existing legislation.

There is little evidence to show that one approach is better than the other. A combined approach, involving the incorporation of mental health issues into other legislation as well as having a specific mental health law, is most likely to address the complexity of needs of persons with mental disorders. However, this decision will depend on countries’ circumstances.

When drafting a consolidated mental health legislation, other laws (e.g. criminal justice, welfare, education) will also need to be amended in order to ensure that provisions of all relevant laws are in line with one another and do not contradict each other.

Example: Amending all laws related to mental health in Fiji

During the process of mental health law reform in Fiji, 44 different Acts were identified for review to ensure that there were no disparities between the new mental health law and existing legislation. In addition, the Penal Code and Magistrates Court rules were reviewed and a number of sections identified as needing change in order to maintain legal consistency.

WHO Mission Report, 2003

5. Regulations, service orders, ministerial decrees

Mental health legislation should not be viewed as an event, but as an ongoing process that evolves with time. This necessarily means that legislation is reviewed, revised and amended in the light of advances in care, treatment and rehabilitation of mental disorders, and improvements in service development and delivery. It is difficult to specify the frequency with which mental

health legislation should be amended; however, where resources allow, a 5- to 10-year period for considering amendments would appear appropriate.

In reality, frequent amendments to legislation are difficult due to the length of time and the financial costs of an amendment process and the need to consult all stakeholders before changing the law. One solution is to make provisions in the legislation for the establishment of regulations for particular actions that are likely to need constant modifications. Specifics are not written into the legislation but, instead, provision is made in the statute for what can be regulated, and the process for establishing and reviewing regulations. For example, in South African law, rules for accreditation of mental health professionals are not specified in the legislation, but are part of the regulations. Legislation specifies who is responsible for framing the regulations and the broad principles upon which these regulations are based. The advantage of using regulations this way is that it allows for frequent modifications to the accreditation rules without requiring a lengthy process of amending primary legislation. Regulations can thus provide flexibility to mental health legislation.

Other alternatives to regulations in some countries are the use of executive decrees and service orders. These are often short- to medium-term solutions where, for various reasons, interim interventions are necessary. For example, in Pakistan, an ordinance was issued in 2001 amending the mental health law, even though the National Assembly and the Senate had been suspended under a Proclamation of Emergency. The preamble to the ordinance stated that circumstances existed which made it necessary to "take immediate action" (Pakistan Ordinance No. VIII of 2001). This was required and deemed desirable by most people concerned with mental health, given the country's existing outdated law. Nonetheless, the issuance of such an ordinance needs to be ratified by the elected body within a specified time frame, as is the case in Pakistan, to ensure that potentially retrogressive and/or undemocratic legislation does not persist.

6. Key international and regional human rights instruments related to the rights of people with mental disorders

The requirements of international human rights law, including both UN and regional human rights instruments, should form the framework for drafting national legislation that concerns people with mental disorders or regulates mental health and social service systems. International human rights documents broadly fall into two categories: those which legally bind States that have ratified such conventions, and those referred to as international human rights "standards", which are considered guidelines enshrined in international declarations, resolutions or recommendations, issued mainly by international bodies. Examples of the first are international human rights conventions such as the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966). The second category, which includes UN General Assembly Resolutions such as Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991), while not legally binding, can and should influence legislation in countries, since they represent a consensus of international opinion.

6.1 International and regional human rights instruments

There is a widespread misconception that because the human rights instruments relating specifically to mental health and disability are non-binding resolutions, rather than obligatory conventions, mental health legislation is therefore subject only to the domestic discretion of governments. This is not true, as governments are under obligation, under international human rights law, to ensure that their policies and practices conform to binding international human rights law – and this includes the protection of persons with mental disorders.

Treaty monitoring bodies at the international and regional levels have the role of overseeing and monitoring compliance by States that have ratified international human rights treaties. Governments that ratify a treaty agree to report regularly on the steps they have taken to implement that treaty at the domestic level through changes in legislation, policy and practice. Nongovernmental organizations (NGOs) can also submit information to support the work of monitoring bodies. Treaty monitoring bodies consider the reports, taking into account any information submitted by NGOs and other competent bodies, and publish their recommendations and suggestions in "concluding observations", which may include a determination that a government has not met its obligations under the treaty. The international and regional supervisory and reporting process thus provides an opportunity to educate the public about a specialized area of rights. This process can be a powerful way to pressure governments to uphold convention-based rights.

The treaty bodies of the European and Inter-American human rights system have also established individual complaints mechanisms, which provide the opportunity for individual victims of human rights violations to have their cases heard and to seek reparations from their governments.

This section provides an overview of some of the key provisions of international and regional human rights instruments that relate to the rights of persons with mental disorders.

6.1.1 International Bill of Rights

The Universal Declaration of Human Rights (1948), along with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), together make up what is known as the "International Bill of Rights". Article 1 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, provides that all people are free and equal in rights and dignity. Thus people with mental disorders are also entitled to the enjoyment and protection of their fundamental human rights.

In 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment 5, detailing the application of the International Covenant on Economic, Social and Cultural Rights (ICESCR) with regard to people with mental and physical disabilities. General Comments, which are produced by human rights oversight bodies, are an important source of interpretation of the articles of human rights conventions. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body.

The UN Human Rights Committee, established to monitor the ICCPR, has yet to issue a general comment specifically on the rights of persons with mental disorders. It has issued General Comment 18, which defines protection against discrimination against people with disabilities under Article 26.

A fundamental human rights obligation in all three instruments is the protection against discrimination. Furthermore, General Comment 5 specifies that the right to health includes the right to access rehabilitation services. This also implies a right to access and benefit from services that enhance autonomy. The right to dignity is also protected under General Comment 5 of the ICESCR as well as the ICCPR. Other important rights specifically protected in the International Bill of Rights include the right to community integration, the right to reasonable accommodation (General Comment 5 ICESCR), the right to liberty and security of person (Article 9 ICCPR) and the need for affirmative action to protect the rights of persons with disabilities, which includes persons with mental disorders.

The right to health, as embodied in various international instruments

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The right to health is also recognized in other international conventions, such as Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and Article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1996, as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10).

General Comment 14 of the Committee on Economic, Social and Cultural Rights aims to assist countries in implementation of Article 12 of ICESCR. General Comment 14 specifies that the right to health contains both freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements also include the right to a system of health protection that provides people with equality of opportunity to enjoy the highest attainable level of health. According to the Committee, the right to health includes the following interrelated elements:

(i) *Availability*, i.e. health care facilities and services have to be available in sufficient quantity.

(ii) *Accessibility*, which includes:

- **non-discrimination, i.e. health care and services should be available to all without any discrimination;**
- **physical accessibility, i.e. health facilities and services should be within safe physical reach, particularly for disadvantaged and vulnerable populations;**
- **economic accessibility, i.e. payments must be based on the principle of equity and affordable to all; and**
- **information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues.**

(iii) *Acceptability*, i.e. health facilities and services must respect medical ethics and be culturally appropriate.

(iv) *Quality*, i.e. health facilities and services must be scientifically appropriate and of good quality.

General Comment 14 further states that the right to health imposes three types or levels of obligations on countries: the obligations to *respect*, *protect* and *fulfil*. The obligation to *respect* requires countries to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. The obligation to *protect* requires countries to take measures to prevent third parties from interfering with the guarantees provided under Article 12. Finally, the obligation to *fulfil* contains obligations to facilitate, provide and promote. It requires countries to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Article 7 of the ICCPR provides protection against torture, cruel, inhuman or degrading treatment, and it applies to medical institutions, especially institutions providing psychiatric care. The General Comment on Article 7 requires governments to "provide information on detentions in psychiatric hospitals, measures taken to prevent abuses, appeals process available to persons admitted to psychiatric institutions and complaints registered during the reporting period".

A list of countries that have ratified both the ICESCR and the ICCPR can be accessed at http://www.unhchr.ch/pdf/report.pdf

6.1.2 Other international conventions related to mental health

The legally binding UN Convention on the Rights of the Child contains human rights provisions specifically relevant to children and adolescents. These include protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child. A number of its articles are specifically relevant to mental health:

- Article 23 recognizes that children with mental or physical disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
- Article 25 recognizes the right to periodic review of treatment provided to children who are placed in institutions for the care, protection or treatment of physical or mental health.
- Article 27 recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
- Article 32 recognizes the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical, mental spiritual, moral or social development.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) is also relevant to those with mental disorders. Article 16, for example, makes States that are party to the Convention responsible for preventing acts of cruel, inhuman or degrading treatment or punishment.

In certain mental health institutions there are a vast number of examples that could constitute inhuman and degrading treatment. These include: lack of a safe and hygienic environment; lack of adequate food and clothing; lack of adequate heat or warm clothing; lack of adequate health-care facilities to prevent the spread of contagious diseases; shortage of staff leading to practices whereby patients are required to perform maintenance labour without pay or in exchange for minor privileges; and systems of restraint that leave a person covered in his or her own urine or faeces or unable to stand up or move around freely for long periods of time.

The lack of financial or professional resources is not an excuse for inhuman and degrading treatment. Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment that is respectful of individual dignity.

There is no specific UN convention that addresses the special concerns of individuals with disabilities. However, on 28 November 2001, the United Nations General Assembly adopted a resolution calling for the creation of an ad hoc committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities". Work is currently under way to draft this convention. Persons with mental disorders would be among beneficiaries.

Apart from the various international systems for monitoring human rights, there are also a number of regional conventions for the protection of human rights. These are discussed briefly below.

African Region

African (Banjul) Charter on Human and Peoples' Rights (1981) – This is a legally binding document supervised by the African Commission on Human and People's Rights. The instrument contains a range of important articles on civil, political, economic, social and cultural rights. Clauses pertinent to people with mental disorders include Articles 4, 5 and 16, which cover the right to life and the integrity of the person, the right to respect of dignity inherent in a human being, prohibition of all forms of exploitation and degradation (particularly slavery, slave

trade, torture and cruel, inhuman or degrading punishment), and the treatment and the right of the aged and disabled to special measures of protection. It states that the "aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs". The document guarantees the right for all to enjoy the best attainable state of physical and mental health.

African Court on Human and People's Rights – The Assembly of Heads of State and Government of the Organization of African Unity (OAU) – now the African Union – established an African Court on Human and People's Rights to consider allegations of violations of human rights, including civil and political rights and economic, social and cultural rights guaranteed under the African Charter and other relevant human rights instruments. In accordance with Article 34(3), the Court came into effect on 25 January 2004 after ratification by a fifteenth State. The African Court has the authority to issue binding and enforceable decisions in cases brought before it.

European Region

European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) – The European Convention for the Protection of Human Rights and Fundamental Freedoms, backed by the European Court of Human Rights, provides binding protection for the human rights of people with mental disorders residing in the States that have ratified the Convention.

Mental health legislation in European States is required to provide for safeguards against involuntary hospitalization, based on three principles laid down by the European Court of Human Rights:

- Mental disorder is established by objective medical expertise;
- Mental disorder is of a nature and degree warranting compulsory confinement; and
- For continued confinement, it is necessary to prove persistence of the mental disorder (Wachenfeld, 1992).

The European Court of Human Rights provides interpretation of the provisions of the European Convention and also creates European human rights law. The evolving case law of the Court has led to fairly detailed interpretations of the Convention concerning issues related to mental health.

European Convention for the Protection of Human Rights and Dignity of the Human Being, with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1996) – This Convention, adopted by Member States of the Council of Europe and other States of the European Community, was the first internationally legally binding instrument to embody the principle of informed consent, provide for equal access to medical care and for the right to be informed, as well as establishing high standards of protection with regard to medical care and research.

Recommendation 1235 on Psychiatry and Human Rights (1994) – Mental health legislation in European States is also influenced by Recommendation 1235 (1994) on Psychiatry and Human Rights, which was adopted by the Parliamentary Assembly of the Council of Europe. This lays down criteria for involuntary admission, the procedure for involuntary admission, standards for care and treatment of persons with mental disorders, and prohibitions to prevent abuses in psychiatric care and practice.

Recommendation Rec (2004)10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (2004) – In September 2004, the Committee of Ministers of the Council of Europe approved a recommendation which calls upon member states to enhance the protection of the dignity, human rights and fundamental freedoms of people with mental disorders, in particular, those subject to involuntary placement or involuntary treatment.

Other European Conventions – *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987)* provides another layer of human rights protection. The 8th Annual Report of the Committee on Torture, Council of Europe, stipulated standards to prevent mistreatment of persons with mental disorders.

The revised European Social Charter (1996) provides binding protection for the fundamental rights of people with mental disabilities who are nationals of the States that are parties to the Convention. In particular, Article 15 of the Charter provides for the rights of these persons to independence, social integration and participation in the life of the community. Recommendation No R (83) 2, adopted by the Council of Ministers in 1983, is another important legal protection of persons with mental disorder who are placed in institutions as involuntary patients.

Region of the Americas

American Declaration of the Rights and Duties of Man (1948) – This provides for the protection of civil, political, economic, social and cultural rights.

American Convention on Human Rights (1978) – This Convention also encompasses a range of civil, political, economic social and cultural rights, and establishes a binding means of protection and monitoring by the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. The Commission's recent examination of a case entitled *Congo v Ecuador* has provided an opportunity for further interpretation of the Convention in relation to mental health issues.

Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (1988) – This Convention refers specifically to the rights of persons with disabilities. Signatories agree to undertake programmes aimed at providing people with disabilities with the necessary resources and environment for attaining the greatest possible development of their personalities, as well as special training to families (including specific requirements arising from the special needs of this group). Signatories also agree to these measures being made a priority component of their urban development plans and to encouraging the establishment of social groups to help persons with disabilities enjoy a fuller life.

Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999) – The objectives of this Convention are to prevent and eliminate all forms of discrimination against persons with mental or physical disabilities, and to promote their full integration into society. It is the first international convention that specifically addresses the rights of persons with mental disorders. In 2001, the Inter-American Human Rights Commission issued a Recommendation on the Promotion and Protection of Human Rights of Persons with Mental Disabilities (2001), recommending that countries ratify this Convention. The Recommendation also urges States to promote and implement, through legislation and national mental health plans, the organization of community mental health services, in order to achieve the full integration of people with mental disorders into society.

7. Major human rights standards applicable to mental health

7.1 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991)

In 1991, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, see Annex 3) established minimum human rights standards of practice in the mental health field. International oversight and enforcement bodies have used the MI Principles as an authoritative interpretation of the requirements of international conventions such as the ICESCR.

The MI Principles have also served as a framework for the development of mental health legislation in many countries. Australia, Hungary, Mexico and Portugal, among others, have incorporated the MI Principles in whole or in part into their own domestic laws. The MI Principles establish standards for treatment and living conditions within mental health facilities, and they create protections against arbitrary detention in such facilities. These principles apply broadly to persons with mental disorders, whether or not they are in psychiatric facilities, and they apply to all persons admitted to a mental health facility – whether or not they are diagnosed as having a mental disorder. The last-mentioned provision is important because in many countries long-term mental health facilities serve as repositories for people who have no history of mental disorder or no current mental disorder, but who remain in the institution due to the lack of other community facilities or services to meet their needs. The MI Principles recognize that every person with a mental disorder shall have the right to live and work, as far as possible, in the community.

The MI Principles have, however, been subject to some criticism. In 2003 the UN Secretary-General in a report to the General Assembly noted that the MI Principles *"offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment. In this regard, some organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles (and in particular, principles 11 and 16) and their consistency with existing human rights standards in the context of involuntary treatment and detention."* (United Nations, 2003)

7.2 Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Standard Rules, 1993)

The World Conference on Human Rights, which took place in Vienna in 1993, reiterated the fact that international human rights law protects people with mental and physical disabilities, and that governments should establish domestic legislation to realize those rights. In what has come to be known as the Vienna Declaration, the World Conference declared that all human rights and fundamental freedoms are universal, and thus unreservedly include persons with disabilities.

The *Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)* were adopted at the end of the Decade of Disabled Persons (1982-1993) by General Assembly Resolution 48/96. As a policy guidance instrument, the Standard Rules reiterate the goals of prevention, rehabilitation and equalization of opportunities established by the World Programme of Action. These 22 rules provide for national action in three main areas: preconditions for equal participation, targets for equal participation, and implementation measures. The Standard Rules are a revolutionary new international instrument because they establish citizen participation by people with disabilities as an internationally recognized human right. To realize this right, governments are expected to provide opportunities for people with disabilities and organizations made up of people with disabilities to be involved in drafting new legislation on matters that affect them. The Standard Rules call on every country to engage in a national planning process to bring legislation, policies and programmes into conformity with international human rights standards.

8. Technical standards

In addition to UN General Assembly resolutions, UN agencies, world conferences, and professional groups meeting under UN auspices have adopted a broad array of technical guidelines and policy statements. These can be a valuable source of interpretation of international human rights conventions.

8.1 Declaration of Caracas (1990)

The *Declaration of Caracas* (1990), adopted as a resolution by legislators, mental health professionals, human rights leaders and disability activists convened by the Pan American Health Organization (PAHO/WHO), has major implications for the structure of mental health services (see Annex 4). It states that exclusive reliance on inpatient treatment in a psychiatric hospital isolates patients from their natural environment, thereby generating greater disability. The Declaration establishes a critical link between mental health services and human rights by concluding that outmoded mental health services put patients' human rights at risk.

The Declaration aims to promote community-based and integrated mental health services by suggesting a restructuring of existing psychiatric care. It states that resources, care and treatment for persons with mental disorders must safeguard their dignity and human rights, provide rational and appropriate treatment, and strive to maintain persons with mental disorders in their communities. It further states that mental health legislation must safeguard the human rights of persons with mental disorders, and services should be organized so as to provide for enforcement of those rights.

8.2 Declaration of Madrid (1996)

International associations of mental health professionals have also attempted to protect the human rights of persons with mental disorders by issuing their own sets of guidelines for standards of professional behaviour and practice. An example of such guidelines is the Declaration of Madrid adopted by the General Assembly of the World Psychiatric Association (WPA) in 1996 (see Annex 5). Among other standards, the Declaration insists on treatment based on partnership with persons with mental disorders, and on enforcing involuntary treatment only under exceptional circumstances.

8.3 WHO technical standards

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* (see box below) as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. In 1996, WHO also developed *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the MI Principles and evaluate human rights conditions in institutions.

Mental Health Care Law: Ten Basic Principles

1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments in accordance with internationally accepted principles
4. Provision of least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodic review mechanism
9. Qualified decision-maker
10. Respect of the rule of law

WHO, 1996

8.4 The Salamanca Statement and Framework for Action on Special Needs Education (1994)

In 1994, the World Conference on Special Needs Education adopted *The Salamanca Statement and Framework for Action on Special Needs Education*, which affirmed the right to integrated education for children with mental disabilities. The *Salamanca Declaration* is of particular importance in implementing the *World Declaration on Education for All* (WDEA) and enforcing the right to education established under the ICESCR.

9. Limitation of rights

There are a number of human rights where no restrictions are permissible under any circumstances, such as freedom from torture and slavery, and freedom of thought, conscience and religion. However, limitation and derogation clauses in most human rights instruments recognize the need to limit human rights in certain instances, and within mental health there are conditions when limitations need to be applied (see Chapter 2 for examples).

The *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights (Siracusa Principles)* set criteria that should be met when rights are restricted. Each one of the five criteria must be met, and the restrictions should be of limited duration and subject to review.

The Siracusa Principles in summary

- **The restriction is provided for and carried out in accordance with the law.**
- **The restriction is in the interest of the legitimate objective of general interest.**
- **The restriction is strictly necessary in a democratic society to achieve the objective.**
- **The restriction is necessary to respond to a public health need.**
- **The restriction is proportional to the social aim, and there are no less intrusive and restrictive means available to reach this social aim.**
- **The restriction is not drafted or imposed arbitrarily (i.e. in an unreasonable or otherwise discriminatory manner).**

For a more detailed discussion on the role of international human rights documents in protecting the rights of persons with mental disorders, see *The Role of International Human Rights in National Mental Health Legislation* (WHO, 2001c), also available at: http://www.who.int/mental_health/resources/policy_services/en/. Also, for a summary of major provisions and international instruments related to the rights of people with mental disorders, see Annex 2.

In summary, legislation should enable the achievement of public health and health policy objectives. Governments are under an obligation to respect, promote and fulfil the fundamental rights of people with mental disorders as outlined in binding international human rights documents. In addition, other standards such as the MI Principles, which represent an international consensus, can be used as guidelines for enacting legislation and implementing policies that promote and protect the rights of people with mental disorders. Legislation can assist persons with mental disorders to receive appropriate care and treatment. It can protect and promote rights and prevent discrimination. It can also uphold specific rights, such as the right to vote, to property, to freedom of association, to a fair trial, to judicial guarantees and review of detentions, and to protection in such areas as housing and employment. Criminal justice legislation can ensure appropriate treatment and protection of the rights of mentally ill offenders. These are just a few examples that clearly illustrate that mental health law is more than just "care and treatment" legislation limited to involuntary admission processes and care within institutions.

Yet, despite the critical role of legislation, it is not the sole or a simple solution to the myriad of problems faced in mental health, but only an enabling tool to achieve these objectives. Even in countries with good legislation, informal systems may subvert legislative intent. For example, mental health professionals who are not familiar with the provisions of a new law may continue with "customary" practices in treatment provision, thus defeating the purpose of new, progressive mental health legislation. Without adequate training and education – and the full involvement of a number of role players – legislation may have little impact.

A strong commitment to ethical self-regulation by mental health professionals is another important component in any system. Furthermore, over-restrictive legislation, even if it is well intentioned, can impede rather than promote access to mental health care. For example, legislative provisions related to admission or involuntary treatment might be so restrictive that they cannot be fulfilled in a given resource scenario, resulting in a lack of necessary care. The provision of adequate and appropriate care and treatment, and the promotion and protection of human rights for persons with mental disorders are of primary importance. Legislation can play an important role.

Context of Mental Health Legislation: Key issues

- **Legislation is complementary to mental health policies, plans and programmes, and can serve to reinforce policy goals and objectives.**
- **Persons with mental disorders are a vulnerable segment of society and they need special protections.**
- **Mental health legislation is necessary for protecting the rights of persons with mental disorders in institutional settings and in the community.**
- **Mental health legislation is more than just "care and treatment" legislation. It provides a legal framework for addressing critical mental health issues such as access to care, rehabilitation and aftercare, the full integration of people with mental disorders into the community, and the promotion of mental health in different sectors of society.**
- **Governments are under an obligation to respect, promote and fulfil the fundamental rights of people with mental disorders, as outlined in binding international and regional human rights documents.**
- **Legislative issues pertaining to mental health can be consolidated into one single statute or they may be dispersed in different legislative documents.**
- **Progressive mental health legislation should incorporate human rights protections, as included in international and regional human rights documents and technical standards. Legislation should also enable the achievement of public health and health policy objectives.**

Chapter 2 Content of mental health legislation

1. Introduction

This chapter covers important areas that need to be incorporated into mental health legislation. Frequently, such legislation focuses only on involuntary admission and treatment, and neglects or omits equally important concerns related to persons with mental disorders. While it is not possible in this chapter to cover every area that affects mental health, a wide range of important legislative matters are considered. The issues discussed may be included in general health laws, or those related to such areas as social welfare and benefits, disability, guardianship, employment equity and housing, or they may be included in specific mental health law. As discussed in Chapter 1, laws related to mental health can satisfactorily be dispersed in a number of different legislative measures or contained in a single statute. The type or form of the legislative text will vary from country to country. For example, some countries may choose to spell out only the key principles in a mental health act, and use regulations to specify the procedural details for translating legislative intent into action; others may include the procedural aspects within the main body of the mental health law.

In this chapter, a practical format is provided for the content of mental health legislation. It is recognized that this format is likely to conform better with certain legislative frameworks than with others, and it is emphasized that this is not the "suggested" format, since, in drafting laws, countries will follow their own legislative patterns.

The extracts of national laws in this chapter are for illustrative purposes only; they serve as examples of different texts and terminologies that have been adopted by different countries in relation to their particular country situation and context. They do not represent "suggested" text or terminology to be used.

2. Preamble and objectives

Mental health legislation is commonly divided into sections, often starting with a preamble (or introduction) that outlines reasons why legislation is necessary.

Example of a preamble

Preamble of Polish Mental Health Protection Act

Acknowledging that mental health is a fundamental human value and acknowledging that the protection of the rights of people with mental disorders is an obligation of the State, this Act proclaims the following:

(Mental Health Protection Act, M284 1994, Poland)

The next section (or chapter) of a law often outlines the purpose and objectives the statute aims to achieve. A statement of objectives is important, as it provides a guide for interpreting legislative provisions. The preamble, together with the purpose and objectives, helps courts and others to interpret legislative provisions whenever there is any ambiguity in the substantive provisions of the statute.

Example of objectives

Objectives of the South African law

Objectives of this Act are to –

- a) **Regulate the mental health care environment in a manner which –**
  - (i) **enables the provision of the best possible mental health care, treatment and rehabilitation that available resources can afford;**
  - (ii) **makes effective mental health care, treatment and rehabilitation services available to the population equitably, effectively and in the best interests of the mental health care user;**
  - (iii) **co-ordinates access to and the provision of mental health care, treatment, and rehabilitation services; and**
  - (iv) **integrates access to and the provision of mental health care services within the general health services environment.**
- b) **Set out the rights and obligations of mental health care users and the obligations of mental health care providers;**
- c) **Regulate access to and the provision of mental health care and treatment to –**
  - (i) **voluntary, assisted and involuntary mental health care users;**
  - (ii) **[S]tate patients (unfit to stand trial or of comprehending their criminal actions); and**
  - (iii) **mentally ill prisoners.**
- d) **Regulate the manner in which the property of those with a mental illness may be dealt with by courts of law; and**
- e) **Provide for related matters.**

(Extract from Mental Health Care Act, Act 17 of 2002, Republic of South Africa)

The subsequent section (or chapter) of a mental health law often contains definitions of terms used in the legislation, (i.e. the substantive provisions and procedural aspects of the legislation). These are discussed in detail below.

3. Definitions

The definition section in legislation provides interpretation and the meaning of the terms used. Clear and unambiguous definitions are extremely important for those who need to understand and implement the legislation, and for members of the public who may be affected by the legislation, such as patients and their families. Courts also find this useful, as they have to make rulings based on the stated definitions.

Defining the target group, or beneficiaries, of the legislation is usually an important role of the definitions section.

3.1 Mental illness and mental disorder

Defining mental disorder is difficult because it is not a unitary condition but a group of disorders with some commonalties. There is intense debate about which conditions are or should be included in the definition of mental disorders. This can have significant implications when, for example, a society is deciding on the types and severity of mental disorders that are potentially eligible for involuntary treatment and services.

The definition of mental disorder adopted by any national legislation depends on many factors. Foremost, the purpose of legislation will determine the exact boundaries of the category. Thus, legislation that is primarily concerned with involuntary admission and treatment may restrict the category to only severe mental disorders. On the other hand, legislation concerned with positive rights may define mental disorder as broadly as possible to extend the benefits of legislation to all

persons with mental disorders. The definition of mental disorder also depends on the social, cultural, economic and legal context in different societies. This Resource Book does not advocate a particular definition; it only aims to make lawmakers and others involved in the process of drafting legislation aware of the various choices and advantages and disadvantages of different approaches to definitions (see Table 1 below).

A number of consumer organizations oppose use of the terms "mental illness" and "mental patient" on the grounds that these support the dominance of the medical model. Most international clinical documents avoid use of the term "mental illness", preferring to use the term "mental disorder" instead (see, for example, *Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (ICD–10)* (WHO, 1992) and *Diagnostic and Statistical Resource Book on Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994)). The ICD-10 states that 'the term "disorder" is used so as to avoid the even greater problems inherent in the use of terms such as "disease" and "illness". "Disorder" is not an exact term, but it is used here *"to imply the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here"* (WHO, 1992).

The term "mental disorder" can cover mental illness, mental retardation (also known as mental handicap and intellectual disability), personality disorders and substance dependence. Not everyone considers all of these to be mental disorders; yet many legislative issues that pertain to conditions such as schizophrenia and bipolar depression apply equally to other conditions such as mental retardation, and therefore a broad definition is preferred.

People with mental retardation are often exposed to the same discrimination and abuse as people with severe mental illness, and the legal protections needed are often the same for both groups. However, there are major differences between the two groups; for example, with regard to short- and longer-term ability to consent. Countries must therefore decide whether a single law or separate laws are required. If mental retardation is included in mental health legislation, it is important that sufficient safeguards be built in to ensure that mental retardation is not considered synonymous with "other" mental disorders. A single law may be particularly relevant to those countries that are unlikely to be able to draft and enact two separate laws due, for example, to resource constraints. This option was utilized in South Africa. However, while both mental illness and mental retardation were covered in the same mental health legislation, relevant sections specified where only one or the other was implied. Many jurisdictions (e.g. India) specifically exclude mental retardation from the purview of mental health legislation, but cover it under separate legislation.

Inclusion of personality disorder in the definition of mental disorder is an equally complex issue. Personality disorders are considered part of the mental disorders spectrum at a clinical level, as reflected by their inclusion in classificatory systems such as ICD-10 and DSM-IV. However, there are doubts about the validity and reliability of diagnosis of many subtypes of personality disorders. Moreover, questions arise regarding the amenability of personality disorders to treatment. While there are still few well validated and broadly accepted treatment modalities for most types of such disorders, there is growing evidence that many personality disorders are in fact amenable to treatment (Livesley, 2001; Sperry, 2003). If a particular condition is not responsive to treatment, or if no treatments are available, it is difficult to justify involuntary admission of persons with this condition to a mental health facility. However, it is noted that legislation in many countries allows for protective custody of severely disturbed people who are unresponsive to available treatments, although many would argue that this should not be the purpose of mental health legislation.

Another risk of including personality disorders in mental health legislation is that in many countries a diagnosis of personality disorder has been used against vulnerable groups, especially young women, whenever they do not conform with the dominant social, cultural, moral and religious standards. Political dissidents and minorities are also vulnerable to being diagnosed as having a personality disorder when they take positions in opposition to the local norms.

If personality disorders are included in legislation, countries need to incorporate substantial legal provisions to prevent misuse. This Resource Book does not advocate a particular approach of either including or excluding personality disorders. Countries need to address this taking into account the unique structure and traditions of their health care and legal systems.

Another debatable issue is whether or not substance addiction should be included as a mental disorder. While substance dependence is also included in most international mental health classificatory systems such as ICD–10, many countries specifically exclude this disorder from mental health legislation. The England and Wales Mental Health Act of 1983, for example, allows a person to be excluded from its scope "for reasons only of promiscuity or other immoral conduct, sexual deviancy or *dependence on alcohol or drugs*" (emphasis added). Clinical experience indicates that people who abuse alcohol and drugs are generally not good candidates for involuntary admission and treatment, and that other laws may be required to deal effectively with this group of people.

Example of definitions

Below are examples of definitions of mental disorder used in legislation in two different countries, which reflect some of the complexities in defining the term.

Mauritius: "Mental disorder" means a significant occurrence of a mental or behavioural disorder exhibited by symptoms indicating a disturbance of mental functioning, including symptoms of a disturbance of thought, mood, volition, perception, orientation or memory which are present to such a degree as to be considered pathological.

(Mental Health Care Act, Act 24 of 1998, Mauritius)

Jamaica: "Mental disorder" means (a) a substantial disorder of thought, perception, orientation or memory which grossly impairs a person's behaviour, judgement, capacity to recognise reality or ability to meet the demands of life which renders a person to be of unsound mind, or (b) mental retardation, where such a condition is associated with abnormally aggressive or seriously irresponsible behaviour.

(The Mental Health Act of 1997, Jamaica)

The MI Principles use the term "mental illness" but do not define it. Instead, they provide guidelines for how a mental illness can and cannot be determined. These include:

- A determination of mental illness shall never be made on the basis of political, economic or social status or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.
- Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in the diagnosis of mental illness.
- A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
- No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness, except for purposes directly relating to mental illness or the consequence of mental illness.
- A determination that a person has mental illness shall be made in accordance with internationally accepted medical standards.

3.2 Mental disability

An alternative to "mental disorder" is the concept of "mental disability". The *International Classification of Functioning, Disability and Health* (ICIDH-2) (WHO, 2001d) defines disability as "an umbrella term for impairments, activity limitations, and participation restrictions". It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Mental disability is not synonymous with mental disorder, but includes persons with mental disorder. Persons who have recovered from a mental disorder may continue to have disabilities and many persons with ongoing mental disorder will also have disability due to the disorder. "Disability" is, in some instances, an intrinsic sign of a specific disease or syndrome (e.g. some mental disorders require the presence of functional impairment for the diagnosis to be made), and in others it is a consequence of that disease or syndrome (Bertolote & Sartorius, 1996).

Advantages of using the term "mental disability" are that the concept of "disability" refers directly to people's immediate perceptions of their lives, their environment and their needs and limitations (Bertolote & Sartorius, 1996), and that professionals from outside the health sector more easily understand this concept. One obvious disadvantage of the term is its broad nature, which brings many more people under the purview of mental health legislation than would be the case with more restrictive terms such as "mental disorder" or "mental illness". Moreover, the term "mental disability" is unpopular among some mental health service users who prefer the use of the term "psychosocial disability". They believe that psychiatric or mental disability belongs to the "medical" sphere, and they therefore tend to prefer a distinct separation between illness and disability.

3.3 Mental incapacity

Another alternative in defining a target group is the concept of "mental incapacity". Decisions are then based on the ability of the individual, as determined by medical and other professional staff, to understand the nature of the issue at hand (e.g. concerning treatment or admission), evaluate the benefits of this issue, make a choice and communicate that choice. "Mental incapacity" is a narrower concept than "mental disorder". The use of this term may be advantageous in laws that focus essentially on admission and treatment aspects of mental health. However, the narrow scope of this term may not be appropriate in laws which cover a broad range of mental health issues, as this would exclude the majority of mental health service users from the purview of important rights such as access to care, rights and conditions in mental health care facilities, confidentiality and access to information.

One merit of this option is that it does not make mental disorder and incapacity interchangeable. The range and severity of mental disorders are accepted, but lack of capacity has to be expressly established before the law is allowed to intervene in a person's life. There is a danger, however, that if the judicial interpretation of this formulation is not sufficiently rigorous, incapacity may be presumed when mental disorder alone has been established. To offset such a consequence, it can be expressly stated in the statute that incapacity shall not be presumed upon proof of mental disorder, and that incapacity should be separately established.

Example of definitions

The *Ontario (Canada) Health Care Consent Act* states: "…a person is capable with respect to treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

(Health Care Consent Act of 1996 Ontario, Canada)

3.4 Unsoundness of mind

Some jurisdictions use the legal term "unsoundness of mind" as an alternative to "mental disorder", e.g. the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (1950). It is assumed that all persons are of "sound mind unless proved otherwise". "Unsoundness of mind" is defined as not of sound mind, which, of course, risks circularity. The concept of "unsound mind" is close to, but not the same as, the concept of "mental incapacity". There is no clinical equivalent of "unsound mind", and in many instances "unsound mind" will include conditions not necessarily attributable to mental disorders. According to the European Court, because of the fluidity of the term's usage, it should not be given a definitive interpretation (Gostin, 2000).

Table 1. Comparison of definitions of mental ill health

Term	Mental Illness	Mental Disorder
1. Scope	Very narrow	Narrow
2. Advantages	• Well defined • In common usage and hence understood by all stakeholders (albeit occasionally with different meanings)	• Compatible with medical classificatory systems • Easy to operationalize
3. Disadvantages	• Reinforces the "medical model"	• Includes a range of conditions, from the most benign to extremely serious; this may be a limitation in situations when the aim is to restrict applicability to only the most serious mental health conditions • Includes a range of conditions, some of which may not be the focus of mental health legislation e.g. mental retardation

	Mental Disability	Mental Incapacity	Unsoundness of Mind
	Broad	Extremely narrow	Variable, but tending to be broad
	• Broad scope of the term, useful for positive protection of rights by ensuring that all persons with the disability, irrespective of severity, are included • Closer to consumers' and lay persons' perception of the effects of mental health problems on their lives	• Similarly defined and understood by medical and legal disciplines • Does not equate mental disorder/illness with incompetence • Narrow focus provides greater protection to patients when rights are being taken away by excluding all but those with the most serious mental illness/disorder	• Fluidity of definition may be of some advantage when interpreted in person's best interests
	• Not well defined • Broad scope of the term means that many people may be included within the scope of involuntary admission and treatment	• Narrow scope of the term limits its usefulness for positive promotion of rights of persons with mental disorders	• A legal concept, not equivalent to specific medical categories • Risk of abuse • Likely to impair dialogue between medical and legal disciplines

In summary, countries need to decide how broadly or narrowly to define the beneficiaries or target group of the legislation. Choosing between a broader definition and a narrow one is complex. If mental health legislation covers purely "care and treatment", most mental health users, advocates and human rights activists prefer a narrower definition. On the other hand, if such legislation is aimed at protecting a broad range of rights of persons with mental health problems and includes, for example, anti-discrimination clauses and protection from abuse, a more inclusive definition of mental health problems appears preferable.

Another approach may be to use a broader definition in provisions of the law that create entitlement to services and rights. A narrower definition could then be used in sections that govern the involuntary admission and involuntary treatment process. However, this may be too complicated for many countries where "straight and simple" legislation is more likely to gain favour with the legislature and the courts. In such instances, choices will have to be made one way or the other, taking the above considerations into account.

Once a particular term has been chosen and defined, it is important that it be used consistently throughout the law and not interchangeably with other terms of similar meaning, as this can create confusion in interpretation of the law.

3.5 Definitions of other terms

Legislative documents use a variety of technical terms, which may have different contextual meanings in different settings and countries. To remove any ambiguity and help with the interpretation of legislation, these terms should be precisely defined in the legislative document. Examples from Mental Health Acts of two countries are given below.

Examples of definitions

Pakistan
Patient **means a person who is under treatment and care.**

Psychiatric facility **means a hospital, ward, clinic, nursing home, day-care institution, half-way house, whether in public or private sector, involved in the care of mentally disordered persons.**

Place of safety **means a Government run health facility, psychiatric facility, or residence or any suitable relative who is willing to temporarily receive the patient.**

(Ordinance No VIII of 2001, Pakistan)

Zimbabwe
Patient **means a person (a) who is mentally disordered or intellectually handicapped; or (b) concerning whom proceedings under this Act are considered necessary to determine whether or not he [or she] is mentally disordered or intellectually handicapped.**

Institution **means any mental hospital which the Minister, by notice in the Gazette, has declared to be an institution for the purposes of this Act.**

Reception order **means an order issued by a magistrate under section eight or twenty-six for the removal of a patient to, and his reception and detention in, an institution or in single care.**

(Mental Health Act of 1996, Zimbabwe)

The examples above reveal the disparity that exists in the level of specificity of definitions for any term. Definitions also sometimes make reference to the country's other legislative documents. Ultimately, the precise definitions of these terms depend on the local social, cultural, medical and legal contexts. Once again, it is important that the term that has been adopted and defined be used consistently throughout the law so as to avoid confusion in interpretation of that law.

Definition of "mental ill health" and other terms: Key issues

- **Legislation may use a broader definition when dealing with rights and a narrower definition when considering involuntary admission and treatment.**

- **Countries may prefer to include or exclude people with mental retardation from the substantive provisions of mental health legislation. It is important, however, to bear in mind that persons with mental retardation can, and sometimes do, also suffer from mental disorder. Many of the rights that require reinforcement through legislation are the same for people with mental retardation as for people with other mental disorders.**

- **Legislation must ensure that mental disorders are not presumed on the basis of:**
  - **(i) political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status;**
  - **(ii) family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community;**
  - **(iii) merely having a background of past treatment or hospitalization.**

- **Legislation should precisely define all technical terms that are used in order to remove any ambiguity and help with the interpretation of law.**

- **Once a particular term has been chosen and defined, it is important that it be used consistently throughout the law, and not interchangeably with other terms of similar meaning.**

4. Access to mental health care

Legislation can play an important role in improving access to mental health care (see also Chapter 1, subsection 3.5). Improving access means increasing availability of services, improving financial and geographical accessibility, and providing services that are acceptable and of adequate quality. This section discusses a framework for addressing these issues with a view to lowering access barriers in many countries.

MI Principles: Access to mental health care

Principles 1 (Fundamental Freedoms and Basic Rights) and 8 (Standards of Care) of the MI Principles are concerned with access to high quality care. Principle 1 establishes the right of all persons to the best available mental health care as part of the health and social care system. Principle 8 establishes the right to receive mental health care that is appropriate to a person's needs and protects that person from harm.

4.1 Financial resources for mental health care

In some legislative frameworks or countries it may be possible to include specific provisions for the resources and funding of mental health services. Where this is possible, it is advisable to indicate where resources should be spent, thereby enabling adequate provision in areas such as community mental health care and prevention and promotion programmes.

Most mental health legislation does not deal with funding directly. This is left to the domains of budget and policy. This does not mean, however, that legislation cannot directly influence financial allocations.

Examples of four ways in which legislation can direct funding are by stipulating the need for:

- *Equality with physical health* – In many countries, mental health lags behind physical health in care standards. It is possible for legislation to declare that people with mental disorders should be treated on the basis of equality with people with physical health problems. A law may state, for example, that persons with mental health disorders should have the right to receive treatment under the same quality and standards as individuals receiving other types of medical treatments. Without mentioning finances directly, this seemingly simple and innocuous statement can serve to force the authorities to allocate additional resources to mental health in order to meet the legislative requirement of equality in levels of mental health care with those of physical health care. Similarly, in private sector care, following the above legislative statement, health insurance companies may be required to apply equitable funding principles for people with mental and physical health problems. This does not currently occur in many countries.

- *Additional funding* – Where legislation states a service requirement, there is a legal obligation for this to be carried out. For instance, if a law specifies that people with acute mental disorders who seek voluntary care *must* be treated in a general hospital, provision must be made by the State for this to occur. Similarly, if a particular right is legislated that affects a public health institution (e.g. the right to privacy), the onus is on the authorities to ensure that the necessary infrastructure and resources are available to put this right into effect.

- *Redirecting funding* – Legislation may determine a different way of providing mental health care from the prevailing norm or legal statute. For example, whereas previous legislation may have directed that most people receive care in psychiatric institutions, a new law may assert that the majority should receive mental health care within their local communities. Without making any financial statement as such, the legislation implies that a financial shift from hospitals to the community should take place.

- *Funding of statutory bodies* – When legislation states that a structure such as a mental health review board or a review tribunal be set up, this becomes statutory and the authorities *must* establish such a body. However, before such legislation is passed, the appropriate ministry should ensure, by means of whatever mechanisms pertain in its country, that additional funding is available for the review bodies. If this is not agreed to, the authorities run the risk of possibly having to allocate funds dedicated to mental health services for the establishment of the statutory structure, thereby undermining mental health service delivery.

It is therefore easy to see why legislators are cautious about each clause of legislation and its potential financial implications before passing a bill into law.

4.2 Mental health in primary care

Consistent with the principle that mental health benefits should be put on an equal footing with general health benefits, countries can formulate legislation that ensures the introduction of mental health interventions into primary care. In low-income countries with acute shortages of mental health professionals, delivering mental health services through general health care is the most viable strategy for improving the access of underserved populations to mental health care. Integrated care can also help to reduce the stigma associated with seeking help from vertically structured mental health services, thus further improving accessibility.

It is clear, however, that legislation alone will not give effect to provisions unless the necessary infrastructure and personnel have been prepared and put in place. For example, staff need to be trained to deal with mental disorders, and medication must be available.

Example: Mental health in primary care

The Albanian Law on Mental Health (1991) states:

Article 5: Mental health care for persons with mental disorders is provided by psycho-social care services, *the primary health care service through the family physician* and, in particular, by the psychiatric medical service, which includes emergency treatment, ambulatory service, hospital care, rehabilitation houses, community health care and psychosocial services through a psycho-sociologist and social worker. (Emphasis added)

(Law on Mental Health of 1991, Albania)

4.3 Allocating resources for underserved populations

Within countries, there are disparities in service provision. These disparities may be geographical (people in certain areas may have little access to mental health services) or segmental (certain populations, e.g. minority groups within society, may have reduced access to culturally appropriate mental health services). Legislation can help to reduce these disparities by laying down criteria for needs-based allocation of services. (Section 17 below describes how legislation may be used to benefit minors, women, minorities and refugees.) Laws can also simply state that mental health care must be provided equitably (see box on Objectives in the South African law on mental health care in section 2 above).

4.4 Access to medications and psychosocial interventions

Psychotropic drugs are crucial for the treatment of certain mental disorders, and play an important role in secondary prevention. However, even basic psychotropic drugs are frequently not available in many countries. Legislative action can help improve the availability of drugs at the primary and secondary care level. Legislation can also help improve access to medication in countries where few or no psychiatrists exist, for instance, by permitting general practitioners and other medical specialists with the appropriate training to prescribe psychotropic drugs.

Drug supply is a problem in many developing countries and with regard to many conditions. Nevertheless, legislation can ensure that psychiatric medication is at least as available and accessible as medication for other medical conditions. It can do this by including a provision on "equality with physical health" (described above) and/or by specifically stating that adequate provision must be made for psychiatric medication on a country's essential drugs list, as has been done in Brazil (Order of Service No 1.077, 2001).

Medication alone is not enough in the treatment of most mental disorders. Other psychosocial interventions such as counselling, specific psychotherapies and vocational rehabilitation are equally important. Improving access to such interventions requires policy initiatives as well as legislative action. In Tunisia, for example, the law states, "Any person suffering from a mental disorder shall have the right to appropriate medical care and physical treatment as well as, to the extent possible, instruction, training, and rehabilitation that will aid him to develop his capacities and skills." (Law on Mental Health, 1992, Tunisia).

4.5 Access to health (and other) insurance

In many countries, individuals need health insurance to obtain health care. Legislation in such countries should contain provisions to prevent discrimination against people with mental disorders in obtaining adequate health insurance for the care and treatment of physical and mental health problems from public and private health insurance providers. In the United States of America (USA), the Mental Health Parity Act (1996) prevents health insurers from discriminating in their capping of annual limits on mental health benefits in comparison to benefits for redress of physical injuries (see also subsection 4.1 above and comments on equity with physical health).

Recent tendencies of health insurance companies are to deny coverage based upon a patient's genetic profile. Article 6 of the *Universal Declaration on the Human Genome and Human Rights* provides that "No one shall be subjected to discrimination based on genetic characteristics that is intended to infringe or has the effect of infringing human rights, fundamental freedoms and human dignity."

To contravene such practices, the United States Congress, for example, passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, which forbids insurers from denying applicants health insurance coverage based upon genetic tests that demonstrate a predisposition to develop certain mental or physical disorders.

In some countries, people with mental disorder find it difficult to obtain insurance, such as income or mortgage protection insurance. As with medical insurance, such discrimination may require protection by the law.

4.6 Promoting community care and deinstitutionalization

Legislation has a major role in promoting community-based care for mental disorders and reducing involuntary admissions to mental health facilities – particularly long-stay admissions to mental institutions. Legislation can put into operation the principle of "least restrictive alternative" (providing treatment in settings and in a manner which is the least intrusive while meeting treatment needs).

Legislation may require that admission to hospital be allowed only if it can be shown that community-based treatment options are not feasible or have failed. For example, as early as 1978, Italy legislated that " … the proposal for compulsory health treatment can envisage hospitalization care only if mental disturbances are such as to require urgent therapeutic intervention, if these interventions are not accepted by the patient, and *if there are not the conditions and the circumstances for taking immediate and timely health care measures outside the hospital"* (emphasis added) (Voluntary and Compulsory Health Treatments, Law No 180, 1978, Italy).

Twenty years later, and referring not just to compulsory admissions, the law in Portugal stated, "The provision of mental health care is undertaken primarily at community level, so as to avoid the displacement of patients from their familiar environment and to facilitate their rehabilitation and social integration" (Mental Health Law 36, 1998, Portugal).

The law in Brazil simply states that a person has the right "to be treated, preferably in community mental health facilities" (Mental Health Law No 10.216, 2001 Brazil), while in Rio Negro (Argentina) the law states, "Hospitalization shall be a last resort, all other treatment options having been exhausted … In all cases, length of stay shall be as short as possible." Referring to previously hospitalized patients, this law states "recovery of their identity and dignity and respect for patients with mental disorders, translated into their reintegration in the community, is the ultimate aim of this Act and all actions prescribed by it". (Promotion of Health Care and Social Services for Persons with Mental Illness Act 2440, 1991 Rio Negro, Argentina.). Such a provision requires that health authorities responsible for mental health services establish a range of community-based facilities of adequate quality and accessible to persons with mental disorders. If this is not done, there is recourse to a court of law.

Mental health legislation can thus promote the development of community-based treatment facilities in countries or areas where there are few or none available. A number of countries stipulate which community services must be made available. In Jamaica, for example, the law states, "The community mental health service shall undertake the provision of

- a) services to outpatient psychiatric clinics in health centres and general hospitals;
- b) rehabilitation services for persons after their discharge from a psychiatric facility;
- c) supervised home care and support for persons with mental disorders; and
- d) services for the promotion of mental health" (Mental Health Act, 1997, Jamaica).

Another means of promoting community-based care and rehabilitation is by having laws that prohibit involuntary admissions for periods longer than is absolutely necessary in the circumstances (see subsection 8.3 below). In some highly exceptional circumstances, it may be necessary to continue involuntary admissions for longer periods than is usually required, but then it has to be conclusively demonstrated that the original conditions that led to the involuntary admission are still evident. The absence of aftercare facilities cannot generally be adequate justification for continued involuntary admission. Aftercare and rehabilitation services are an integral part of mental health care and treatment, and therefore it is important that legislation include provisions for developing such services as part of promoting access to care.

Access to mental health care: Key issues

- **Improving access to mental health care is an important function of legislation. This entails increasing the availability of services, improving financial and geographical accessibility, and providing services that are acceptable and of adequate quality.**
- **In some countries it may be possible to include specific provisions for the allocation of resources and funding of mental health services. Where this is possible, it is advisable to indicate where resources should be spent, thereby enabling adequate provision in areas such as community mental health care and prevention and promotion programmes.**
- **Most mental health legislation does not deal with funding directly. Laws can, nevertheless, influence allocation of resources; for example, by including a provision related to the need for equity with physical health, specifying new service requirements which may necessitate additional funding or the redirecting of existing funds, and/or stating the need for the establishment of mental health review boards or tribunals.**
- **Legislation can promote the introduction of mental health interventions into primary health care settings, thereby increasing access to care for underserved populations, and reducing the stigma associated with mental disorders.**
- **By laying down criteria for needs-based allocation of services, mental health law can help reduce geographical and segmental disparities in service provision.**
- **Legislation can also improve access to psychotropic drugs by, for example: including a provision concerning equity with physical health; specifically stating that adequate provisions must be made for psychiatric medications on the country's essential drugs list; and permitting general health practitioners and other medical specialists with appropriate training to prescribe these medications.**
- **Mental health law should also promote access to psychosocial interventions such as counselling, different psychotherapies and vocational rehabilitation.**
- **Aftercare and rehabilitation services are an integral part of mental health care and treatment, and therefore it is important that legislation include provisions for developing such services as part of promoting access to care.**
- **In countries that have public or private health insurance schemes, legislation should ensure that people with mental disorders are able to obtain adequate insurance coverage for the treatment of both mental and physical conditions.**
- **By putting into effect the principle of "least restrictive alternative", legislation can promote community-based care for mental disorders and reduce involuntary admissions to mental health facilities, particularly long-stay admissions to mental institutions.**

5. Rights of users of mental health services

This section discusses important rights of users of mental health services that should be formally protected by legislation. Some of these rights (e.g. confidentiality) are not specific to users of mental health services; they apply equally to users of other health services. Persons with mental disorders, however, may require special and additional protection in view of a history of human rights abuses, stigma and discrimination and, at times, due to the peculiarities of mental disorders. People with mental disorders are sometimes treated as "non-persons", akin to the way children – or worse, animals – are treated. They are often considered to lack adult decision-making capacity, which results in a total disregard for their feelings and human dignity.

The user rights discussed below apply equally to users of all types of mental health services. A number of mental health laws specify the rights of people with mental disorders (e.g. Brazil, Lithuania, Portugal, the Russian Federation, South Africa, The former Yugoslav Republic of Macedonia and many others). In this section, some, though clearly not all, of the most important rights are highlighted and discussed.

5.1 Confidentiality

MI Principles: Confidentiality

The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected.

(Principle 6, MI Principles)

Persons with mental disorders have the right of confidentiality of information about themselves and their illness and treatment; such information should not be revealed to third parties without their consent.

Mental health professionals are bound by professional codes of conduct that generally include rules for confidentiality. All professionals involved in the care of persons with mental disorders have a duty to prevent any breach of confidentiality. It is important that all members of the mental health team be aware of the rules that bind them to maintaining confidentiality. Authorities in charge of mental health facilities should also make sure that adequate processes are in place to safeguard the confidentiality of persons with mental disorders. This means having an effective system in place so that only authorized individuals have access to patients' clinical notes or other data-recording mechanisms such as electronic databases.

Mental health legislation may also protect confidentiality by providing for sanctions and penalties for breaches of confidentiality, either by professionals or mental health facilities. Wherever possible, remedies other than legal prosecution, such as education of the person and appropriate administrative procedures, should be used where there has been disregard for patients' confidentiality. Nonetheless, in certain exceptional cases criminal sanctions may be necessary.

There are a few exceptional instances when confidentiality may be breached. Legislation may specify the circumstances when information on mental health patients may be released to other parties without the prior consent of the user. These exceptions may include situations such as life-threatening emergencies or if there is likelihood of harm to others. The law may also wish to cover circumstances such as prevention of significant morbidity or suffering. However, the information disclosed should be limited only to that required for the purpose at hand. Also, when courts of law require the release of clinical information to judicial authorities (in criminal cases, for example), and if the information is pertinent to the particular case, mental health professionals are obliged to provide the information required. There are other complicated issues concerning the need to maintain confidentiality and the need to share certain information with primary care-givers who are often family members (discussed in section 6 below). Legislation may ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to release information.

5.2 Access to information

Persons with mental disorders should have a statutory right to free and full access to their clinical records maintained by mental health facilities and mental health professionals. This right is protected by general human rights norms, such as Article 19 of the ICCPR and the MI Principles.

MI Principles: Access to information

1. A patient … shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

(Principle 19(1) and (2), MI Principles)

It is possible that in exceptional situations, revealing clinical records of a person may put the safety of others at risk or cause serious harm to that person's mental health. For example, clinical records sometimes contain information from third parties, such as relatives or other professionals, about a severely disturbed patient, which, if revealed to that patient at a particular time may cause a serious relapse or, worse still, cause the patient to do harm to himself or herself or to others. Many jurisdictions therefore give professionals the right (and duty) to withhold such parts of records. Normally, withholding information can only be on a temporary basis, until such time as the persons are able to deal with the information rationally. Legislation may ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to withhold information.

Patients and their personal representatives may also have the right to request that their comments be inserted in the medical records without in any way altering the existing records.

Legislation (or regulations) may outline the procedure for patients to exercise their right of access to information. This may include:

- the procedure for making an application for access to information;
- who is permitted to make such an application;
- the duration of time in which the mental health facility must make such records available upon receipt of the application;
- professionals who should review the records before they are made available to the patient and/or their personal representatives and certify which parts should not be made available (if any), and their reasons for this;
- when only partial records are given to the patients and/or their personal representative, the reasons for not providing the full record should be conveyed to them;
- set out the exceptional circumstances when access to information may be denied.

It is also important that health facilities have a staff member available to review and explain the information in the patient's file or record to the patient and/or legal representative.

5.3 Rights and conditions in mental health facilities

Persons with mental disorders residing in mental health facilities are often subject to poor living conditions, such as lack of or inadequate clothing, poor sanitation and hygiene, insufficient and poor quality food, lack of privacy, being forced to work, or being subject to physical, mental and sexual abuse from other patients and staff (see Chapter 1, subsection 3.2). Such conditions violate internationally agreed norms for rights and conditions in mental health facilities.

MI Principles: Rights and conditions in mental health facilities

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

(a) Recognition everywhere as a person before the law;

(b) Privacy;

(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;

(d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

(a) Facilities for recreation and leisure activities;

(b) Facilities for education;

(c) Facilities to purchase or receive items for daily living, recreation and communication;

(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

(Principle 13, MI Principles)

5.3.1 Environment

Patients admitted to mental health facilities have the right to be protected from cruel, inhuman and degrading treatment as set out in Article 7 of the International Convention on Civil and Political Rights (ICCPR).

The provision of a safe and hygienic environment is a health concern, and critical to a person's overall well-being. No individual should be subject to unsafe or unsanitary conditions when receiving mental health treatment.

Some institutions lack adequate food and clothing for the residents, are unable to provide adequate heat or warm clothing in the winter, have rooms or wards which are not organized to prevent injury, lack adequate health care and facilities to prevent the spread of contagious diseases, and may not have adequate facilities to maintain a minimum standard of sanitation and hygiene. The shortage of staff may lead to practices whereby patients are forced to perform maintenance work (labour) without pay or in exchange for minor privileges. Such practices constitute inhuman and degrading treatment and are in breach of Article 7 of the ICCPR.

The MI Principles state that the environment in mental health facilities must be as close as possible to that of normal life. This includes facilities for leisure, education, religious practice and vocational rehabilitation.

Legislation (or accompanying regulations) should set out minimum conditions to be maintained in mental health facilities to ensure an adequately safe, therapeutic and hygienic living environment. Legislation can also include provisions for a "visiting board" to visit the facilities in order to ensure that these rights and conditions are being respected and upheld (see section 13 below). It is important that the law stipulate the actions the visiting board can take if conditions are not met, because if they are not given legal powers, such boards can merely become a co-opted part of an abusive system.

5.3.2 Privacy

Privacy is a broad concept limiting how far society can intrude into a person's affairs. It includes information privacy, bodily privacy, privacy of communications and territorial privacy. These rights are frequently violated with regard to people with mental disorders, particularly in psychiatric facilities. For example, patients may be forced to live for years in dormitory-like wards or "human warehouses" that provide little private space. Facilities such as cupboards for storage of personal belongings may be lacking. Even when patients have a single or double room, staff or other patients may be able to violate their personal space.

Legislation may make it mandatory for the physical privacy of patients to be respected and for mental health facilities to be structured to make this possible. However, this may be difficult in low-income countries with resource limitations; in such instances, the previously established principle of parity with other health care should be a first step. Even with parity, problems are likely to persist. This is because conditions in many general hospitals in developing countries are far below acceptable privacy standards, and because conditions in chronic care situations (where privacy is the most problematic) need to be very different from those in acute care. Clearly, the privacy requirements in a facility that is akin to a person's home are very different from those required for a short-term hospital stay.

In countries where there are large numbers of people in institutional care and large numbers of individuals in wards, it is necessary to move towards privacy objectives and measure the progressive realization of these rights. For example, in institutions where several people share a room, even the provision of a private room in which to entertain is a step towards the realization of greater privacy rights. Moreover, if adequate services are provided in the community, deinstitutionalization may in itself become a means towards many people obtaining greater privacy through discharge from crowded and impersonal hospital conditions.

However, it is important to note that in mental health facilities the right to privacy does not mean that, in particular circumstances such as those involving a suicidal patient, that person cannot be searched or continually observed for his or her own protection. In these circumstances, the limitation on privacy needs to be carefully considered against the internationally accepted right.

5.3.3 Communication

Patients, especially those admitted involuntarily, have the right to communication with the outside world. In many institutions, intimate meetings with family, including one's spouse and friends, are restricted. Communication is often monitored, and letters opened and sometimes censored. Legislation can ban such practices in mental health facilities. However, as with confidentiality and access to information (discussed above) there may be certain exceptional circumstances in which communication too needs to be restricted. If it is reasonably demonstrated that failure to restrict communications would be harmful to the patient's health or future prospects, or that such communications would impinge on the rights and freedoms of other people, then it may be reasonable to restrict those communications. For example, when a patient makes repeated unpleasant telephone calls or sends letters to another person, or when a patient with a depressive illness writes and intends to send a letter of resignation to an employer. Legislation can set out the exceptional circumstances, as well as stipulating the right of people to appeal these restrictions.

5.3.4 Labour

Legislation can ban the use of forced labour in mental health facilities. This includes situations where patients are forced to work against their wishes (for example, due to staff shortages within the facility), or are not appropriately and adequately remunerated for work performed, and where patients are made to perform the personal work of the institution's staff in return for minor privileges.

Forced labour should not be confused with occupational therapy. Nor should it be likened to situations where, as part of a rehabilitation programme, patients must make their own beds or cook food for people in their facility. However, there are certain grey areas, and any legislation should strive to provide as much clarity on these issues as possible.

5.4 Notice of rights

Although legislation may provide many rights to persons with mental disorders, they are frequently unaware of their rights and thus unable to exercise them. It is therefore essential that legislation include a provision for informing patients of their rights when interacting with mental health services.

MI Principles: Notice of Rights

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

(Principle 12(1) and (2), MI Principles)

Legislation can ensure that patients are given information about their rights on admission to a mental health facility, or as soon after the admission as the patient's condition permits. This information should include an explanation of what these rights mean and how they may be exercised, and be conveyed in such a way that patients are able to understand it. In countries where various languages are spoken, the rights should be communicated in the person's language of choice.

An example of a rights document – *Your Rights as a Client or Patient,* of the Connecticut Department of Mental Health & Addiction Services – is presented in Annex 6. Annex 7 is a summary of a patients' rights document given to all mental health patients in Maine, USA.

It must be emphasized, however, that the levels of literacy and understanding of technical terms and procedures are critical, and the examples provided may be inappropriate in many countries. Nonetheless, countries can develop pamphlets, posters and tapes, for example, or use other mechanisms that are easily understood and reflect the rights of people in their own country. Legislation may make provisions for communicating these rights to personal representatives and/or family members in the case of patients who lack the capacity to understand such information.

Rights of users of mental health services: Key issues

Confidentiality

- Legislation must ensure patients' rights to confidentiality are respected.
- Legislation should specify that all information obtained in a clinical context (i.e. in the context of care and treatment in any setting) is confidential and that all concerned have a responsibility to maintain confidentiality. This would necessarily include all persons within facilities and services providing care and treatment to people with mental disorders.
- Legislation may provide for penalties and sanctions for wilful breach of confidentiality by professionals and/or mental health facilities.
- Confidentiality provisions of legislation must apply equally to information stored in electronic/digital format, including national and regional databases, as well as resource book records containing personal information about persons with mental disorders.
- Legislation may outline the exceptional circumstances when confidentiality may be legally breached. These could include:
  - a) life threatening emergencies when the information is urgently needed to save lives;
  - b) significant likelihood of serious harm or injury to the person concerned or to others;
  - c) prevention of significant morbidity and suffering;
  - d) in the interests of public safety;
  - e) when ordered by courts to do so, (in criminal cases, for example).
- Legislation could provide that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to release information.

Access to information

- Legislation should ensure that people with mental disorders have the right to free and full access to their clinical records.
- Legislation should also specify the exceptional circumstances when access to this information may be restricted (when revealing clinical records may put the safety of others at risk, or cause serious harm to the person's mental health).
- The withholding of information should only be temporary, until such time as the person is more able to rationally deal with the information.
- Legislation could stipulate that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to withhold information.
- Patients and their personal representatives may also have the right to request that their comments be inserted in the medical records without in any way altering the existing records.
- Legislation (or regulations) may outline the procedure for patients to exercise their right of access to information
- It is also important that health facilities have a staff member available to review and explain the information that is in the patient's file or record to the patient and/or legal representative.

Rights and conditions in mental health facilities

Legislation should guarantee patients in mental health facilities protection from cruel, inhuman and degrading treatment. In particular, legislation may specify that:

a) there is provision of a safe and hygienic environment;
b) adequate sanitary conditions are maintained in the facilities;
c) the living environment should include facilities for leisure, recreation, education and religious practice;
d) adequate provision is made for vocational rehabilitation (this would help patients to prepare for community living once they leave the facility);
e) a right to interaction with members of the same and opposite sex;
f) people's environment is structured so that patient's privacy is protected as far as possible;
g) the patients have free and unrestricted communication with the outside world, including receiving visits, letters and other communications from friends, family and others (any exceptional situations in which communication could be restricted should be stated in the law);
h) patients must not be forced to undertake work they do not wish to do, and when they do take up work, this should be appropriately remunerated.

Notice of rights

- **Legislation should include a provision for informing patients of their rights at the earliest possible time, when interacting with mental health services. Notifying them of their rights should take place within the shortest delay possible.**
- **This information should be conveyed in such a way that patients are able to understand it.**
- **Legislation may also make provisions for communicating these rights to personal representatives and/or family members in the case of patients who lack the capacity to understand such information.**

6. Rights of families and carers of persons with mental disorders

The roles of families or other carers of people with mental disorders vary significantly from country to country and from culture to culture. Nonetheless, it is common for families and carers to assume many responsibilities for looking after persons with mental disorders. These include housing, clothing and feeding them, and ensuring that they remember to take their treatment. They also make sure these persons avail of care and rehabilitation programmes and assist them in following through with these. They often bear the brunt of the person's behaviour when he or she is ill or relapses, and it is usually the caregivers/family members that fundamentally love, care and worry about the person with the mental disorder. Sometimes they too become targets of stigma and discrimination. In some countries, families and carers also carry the legal responsibility for third-party liability arising from actions of persons with mental disorders. The important role of families needs to be recognized in legislation.

Family members and carers need information about the illness and treatment plans to be better able to look after their ill relatives. Legislation should not arbitrarily refuse information merely on grounds of confidentiality – though the extent of an individual's right to confidentiality is likely to vary from culture to culture. For instance, in some cultures a patient's refusal to allow information to be released to family members or carers would need to be fully respected, while in others the family may be regarded as a unified, structured unit, and confidentiality may extend to culturally determined members of that family. It is likely, in these situations, that patients themselves are more accepting of the need to provide family members with information. In countries where there is more emphasis on the individual, as opposed to the family, it is more likely that the individual himself/herself may be less inclined to share information. Many variations and gradations are possible depending on culturally accepted practices. One position could be, for example, that family members who have ongoing responsibility for the care of a patient may receive some information required for the accomplishment of their supportive role in the patient's life, but not about other clinical or psychotherapeutic issues.

The right to confidentiality is not in dispute, however. In legislation, this right should be interpreted at the country level taking local cultural realities into account. In New Zealand, for example, under the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999, Section 2, " … the legislative powers must be exercised or the proceedings conducted: a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, *whanau, hapu, iwi*,[1] and family group; b) with proper recognition of the contributions those ties make to the person's well-being; and c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs."

Families can play an important role in contributing to the formulation and implementation of a treatment plan for the patient, especially if the patient is incapable of doing it alone. The Mauritian law states that "the patient … or next of kin may participate in the formulation of the treatment plan" (Mental Health Care Act, Act 24 of 1998, Mauritius).

Legislation can also ensure involvement of families in many aspects of mental health services and legal processes. For example, family members may have the right to appeal against involuntary admission and treatment decisions on behalf of their relative, if the latter lacks the capacity to do so himself/herself. Similarly, they may be able to apply for the discharge of a

[1] *Whanau* (extended family groups), *hapu* (sub-tribes, formed of several whanau), and *iwi* (tribes, made up of a number of hapu).

mentally ill offender. Countries may also choose to legislate that family groups should be represented on review bodies (see subsection 13.2.1 below).

Legislation can also ensure that family members are involved in the development of mental health policy and legislation, as well as mental health service planning. In the United States, Public Law 99-660, the Health Care Quality Improvement Act (1986), mandates that each state should establish a "planning council" that must consist of at least 51% users and relatives. This planning council is to be responsible for the creation and ongoing monitoring of an annual state-wide service system plan that must be approved by the council.

An exhaustive coverage of all situations where families' involvement becomes necessary is impossible. Instead, legislation can codify the principle that family members and family organizations are important stakeholders in the mental health system, and may therefore be represented in all forums and agencies where strategic decisions regarding mental health services are made.

Families and carers of people with mental disorders: Key issues

- **It is common for families and carers to assume major responsibility for looking after persons with mental disorders, and legislation needs to reflect this.**
- **Legislation should not arbitrarily refuse information merely on the ground of confidentiality – though the extent of an individual's right to confidentiality is likely to vary from culture to culture.**
- **Families and carers can play an important role in contributing to the formulation and implementation of a treatment plan for the patient, especially if the patient is incapable of doing this alone.**
- **Legislation can ensure that families and carers have access to the support and services they require in caring for a person with a mental disorder.**
- **Legislation can ensure involvement of families and carers in many aspects of mental health services, as well as the legal processes such as involuntary admission and appeal.**
- **Legislation can also ensure that family members and carers are involved in the development of mental health policy and legislation, as well as mental health service planning.**

7. Competence, capacity and guardianship

Most persons with mental disorders retain the ability to make informed choices and decisions regarding important matters affecting their lives. However, in those with severe mental disorders, this ability might be impaired. In these circumstances, legislation must have suitable provisions that allow managing the affairs of people with mental disorders in their best interests.

Two concepts that are central to decisions about whether or not a person may make choices concerning various issues are "competence" and "capacity". These concepts affect treatment decisions in civil and criminal cases, and the exercise of civil rights by persons with mental disorders. Legislation may therefore need to define capacity and competence, state the criteria for determining them, lay down the procedure for assessing them, and identify the actions that need to be taken when there is a finding of lack of capacity and/or competence.

7.1 Definitions

There is a tendency to use the terms "capacity" and "competence" interchangeably in relation to mental health; however, they are not the same. Generally, capacity refers specifically to the presence of mental abilities to make decisions or to engage in a course of action (see subsection 3.3 concerning the concept of "mental incapacity"), while competence refers to the legal consequences of not having the mental capacity.

In these definitions, “capacity” is a health concept, whereas “competence” is a legal concept. Capacity refers to individual levels of functioning, and competence to their impact on legal and social standing. For example, a person may lack mental capacity due to a serious mental disorder, and this may result in being found not competent to make financial decisions.

This distinction between capacity and competence is not universally accepted. In some legal systems, incapacity is used to mean legal incapacity, such as when minors below a certain age are not allowed to exercise certain rights or privileges. Competence, on the other hand, is a legal term applied to individuals who cannot understand the nature and purpose of the decision to be taken. In these cases, both the terms can be viewed as legal concepts.

This Resource Book uses the distinction between capacity as a health concept and competence as a legal concept when discussing issues relating to capacity and competence.

7.2 Assessment of incapacity

Ordinarily, there is a presumption of capacity and, consequently, of competence. Thus, a person is assumed to be capable and competent to make decisions unless proven otherwise. The presence of a major mental disorder does not in and of itself imply incapacity in decision-making functions. Hence, the presence of a mental disorder is not the overall determining factor of capacity, and certainly not of competence.

In addition, despite the presence of a disorder that may affect capacity, a person may still have the capacity to carry out some decision-making functions. Capacity and competence are thus function-specific. Therefore, because capacity may fluctuate from time to time, and is not an “all or nothing” concept, it needs to be considered in the context of the specific decision or function to be accomplished.

Some examples of specific capacities (which differ from country to country) are the following:

7.2.1 Capacity to make a treatment decision

The person must have the ability to: (a) understand the nature of the condition for which the treatment is proposed; (b) understand the nature of the proposed treatment; and (c) appreciate the consequences of giving or withholding consent to treatment.

7.2.2 Capacity to select a substitute decision-maker

The person must have the ability to: (a) understand the nature of the appointment and the duties of the substitute decision-maker; (b) understand the relationship with the proposed substitute; and (c) appreciate the consequences of appointing the substitute decision-maker.

7.2.3 Capacity to make a financial decision

The person must have the ability to: (a) understand the nature of the financial decision and the choices available; (b) understand the relationship to the parties to, and/or potential beneficiaries of, the transaction; and (c) appreciate the consequences of making the financial decision.

A finding of lack of capacity should be time-limited (i.e. it will have to be reviewed from time to time), because a person may regain some or complete functionality over time, either with or without treatment of the mental disorder.

7.3 Determining incapacity and incompetence

Determination of *incapacity* may be made by a health professional, but a judicial body would determine *incompetence*. Capacity is the test for competence, and people should be judged as lacking competence only if they are actually incapable of making specific kinds of decisions at a specific time.

Mental health legislation (or other relevant legislation) can lay down the procedure for determining a person's competence. For example:

a) As competence is a legal concept, a judicial body would determine this.
b) Ideally, a legal counsel should routinely be made available to a person whose competence is in question. Where a person is unable to afford a counsel, legislation may require that counsel be provided to the beneficiary free of charge.
c) Legislation should ensure there is no conflict of interest for the counsel. That is, the counsel representing the concerned person should not also be representing other interested parties, such as the clinical services involved in the care of the concerned person and/or the family members of the concerned person.
d) Legislation may have provisions to appeal to a higher court against the decision by the concerned person, the counsel, family members or clinical team.
e) Legislation should contain a provision for automatic review, at specified periodic intervals, of the finding of lack of competence.

In less developed countries it may not be possible to immediately legislate for all these requirements; however, depending on the resources available, as many of these as possible may be included in legislation.

7.4 Guardianship

In certain circumstances where, due to a mental disorder, persons are unable to make important decisions and are incapable of managing their lives, it is important to appoint another person who is able to act on their behalf and in the best interest of the person. In the New South Wales Guardianship Act (No 257 of 1987) a "person in need of guardianship means a person who has a disability and who, by virtue of that fact, is totally or partially incapable of managing his or her person". Although the concerned person can apply for guardianship, it is most often a family member, or others who care for the person with a mental disorder, who identify the need for guardianship and who make the necessary application for an assessment to determine whether a guardian should be appointed.

Whether or not to appoint a guardian is a complex decision, and consideration must be made within the context of the rights of persons to have as much control of their own lives as possible. Appointing a guardian does not imply that the person loses all decision-making powers, their ability to act for themselves in all circumstances and their dignity. For example, in the New South Wales Guardianship Act (No 257 of 1987), everyone exercising functions under the Act are obliged, among other things, "to take cognisance of the welfare and interests of persons under guardianship; [and to ensure] that the freedom of decision and freedom of action should be restricted as little as possible; that persons should be encouraged, as far as possible, to live a normal life in the community; that the views of persons should be taken into consideration; that the person's family relationships and cultural and linguistic environments should be recognised; that such persons should, as far as possible, be self-reliant in matters relating to their personal, domestic and financial affairs and should be protected from neglect, abuse and exploitation."

Other alternatives to guardianship that could be considered in certain situations include power of attorney and advanced directives (see also the discussion on proxy consent for treatment in subsection 8.3.6 below).

MI Principles: Guardianship

Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

(Principle 1(6), MI Principles)

Whether a guardianship provision should be part of mental health law or have a separate law is another decision for individual countries to make. In Australia, for example, there is a detailed separate Guardianship Act (Guardianship Act, No 257 of 1987, Australia), whereas in Kenya the Mental Health Act (The Mental Health Act, 248 of 1991, Kenya) includes a section on guardianship.

If individuals are considered legally not competent and/or unable to manage their own affairs, legislation needs to make provisions for the appointment of a person or persons (guardian/trustee) to look after their interests. Since the finding of lack of competence is a legal issue, appointment of a guardian should be made by a judicial body.

Legislation may state the procedure to be followed for appointment of a guardian, the duration of such appointment and a process for review of the decision, as well as delineating the duties and responsibilities of the guardian. Legislation may, in addition, determine the extent and scope of the decision-making powers of the guardian. In many countries, the power of guardians is limited to only those subjects or areas in which a person is shown to truly lack legal competence. These laws strive to permit individuals with mental disorders to retain the ability to make most decisions about themselves, even when they cannot make all such decisions. Moreover, legislation may be designed specifically to pursue the best interests of the individual and to encourage the person to develop his/her capacities to the greatest extent possible (for example, see the New Zealand Protection of Personal and Property Rights Act, 1988).

Specifying the penalties if guardians fail to perform their duties would strengthen legislation. Legislation may also give the affected person the right to a judicial review of the decision to appoint a guardian. Lastly, legislation should contain provisions and procedures for discharge from guardianship when the affected person regains competence in the future.

Competence, capacity and guardianship: Key issues

Competence and capacity

- Legislation may need to define capacity and competence, state the criteria for determining them, lay down the procedure for assessing them, and identify the actions that need to be taken when there is a finding of lack of capacity and/or competence.
- Generally, capacity refers specifically to the presence of mental abilities to make decisions or to engage in a course of action, while competence refers to the legal consequences of not having the mental capacity.

- The presence of a major mental disorder does not in and of itself imply incapacity in decision-making functions, and is therefore not the overall determining factor of capacity or competence.
- Despite the presence of a disorder that may affect capacity, a person may still have the capacity to carry out some decision-making functions.
- Because capacity may fluctuate from time to time, and may improve partially or fully in time, it needs to be related to the specific decision or function to be accomplished.
- Determination of incapacity may be made by a health professional, but a judicial body would determine incompetence.
- Capacity is the test for competence, and people should not be judged as lacking competence only because they are incapable of making specific kinds of decisions at a specific time.

Guardianship

Legislation may:

a) Determine the appropriate authority for appointment of a guardian. This may be the judicial body making the decision regarding competence (see above) or a separate judicial body such as a higher court.
b) Lay down the procedure for appointment of a guardian.
c) Specify the duration of the appointment.
d) Delineate the duties and responsibilities of the guardian.
e) Specify the penalties – civil, criminal or administrative – for failure of the guardian to perform the statutory duties.
f) Determine the extent and scope of the decision-making powers of the guardian. Any order must be tailored to ensure that it best suits the interests of the person who is subject to it. Through this, individuals with mental disorders can retain the ability to make most decisions about themselves, even when they cannot make all such decisions.
g) Make provision for patients to appeal against the appointment of a guardian.
h) Make provision for the review of guardianship and a provision for discharge from guardianship if the patient recovers competence with or without treatment.

8. Voluntary and involuntary mental health care

8.1 Voluntary admission and voluntary treatment

Free and informed consent should form the basis of the treatment and rehabilitation of most people with mental disorders. All patients must be assumed initially to have capacity and every effort should be made to enable a person to accept voluntary admission or treatment, as appropriate, before implementing involuntary procedures.

MI Principles: Informed consent

No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 [of the present principles].

(Principle 11(1), MI Principles)

To be valid, consent must satisfy the following criteria (MI Principle 11, see Annex 3):

a) The person/patient giving consent must be competent to do so, and competence is assumed unless there is evidence to the contrary.
b) Consent must be obtained freely, without threats or improper inducements.
c) There should be appropriate and adequate disclosure of information. Information must be provided on the purpose, method, likely duration and expected benefits of the proposed treatment.
d) Possible pain or discomfort and risks of the proposed treatment, and likely side-effects, should be adequately discussed with the patient.
e) Choices should be offered, if available, in accordance with good clinical practice; alternative

modes of treatment, especially those that are less intrusive, should be discussed and offered to the patient.

f) Information should be provided in a language and form that is understandable to the patient.
g) The patient should have the right to refuse or stop treatment.
h) Consequences of refusing treatment, which may include discharge from the hospital, should be explained to the patient.
i) The consent should be documented in the patient's medical records.

The right to consent to treatment implies also the right to refuse treatment. If a patient is judged as having the capacity to give consent, then refusal of such consent must also be respected.

If admission is needed, legislation should aim to promote and facilitate voluntary admission to a mental health facility, after obtaining informed consent. This objective can be met either by (i) specifically stating that people requiring mental health services should be provided with those services – including admission when required, (ii) or simply by omission, thus regarding mental health in the same way as any other disorder or illness. There are advantages and disadvantages to these alternatives. With the former, by stating the right to treatment and admission, the law obviates any ambiguity with regard to whether or not people with mental disorders can be treated/admitted voluntarily. It also offers the opportunity for patients to assert that they are indeed acting voluntarily. Given the evidence of past neglect and low levels of uptake of mental health care, such an approach may encourage more people to obtain care and treatment.

MI Principles: Voluntary admission and treatment

Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

(Principle 15(1), MI Principles)

On the other hand, segregating mental health issues from other health problems can stigmatize users, and it weakens the argument that mental disorders should be treated in the same way as other health problems. If voluntary mental health care and treatment are not specifically mentioned in legislation, they will be regarded in the same way as other health care.

Voluntary admission brings with it the right to voluntary discharge from mental health care facilities. However, legislation relating to discharge is complicated by the fact that many jurisdictions empower authorities to override this right to leave under certain circumstances. The MI Principles state that patients not admitted involuntarily have the right to leave the facility at any time unless the criteria for involuntary admission are met.

Legislation should permit authorities to prevent self-discharge by voluntary patients only if all the conditions that warrant involuntary admission are met. All the procedural safeguards of involuntary admission should apply. It is recommended that legislation incorporate a right for voluntary patients to be informed at the time of admission that they may only be denied the right to leave if they meet conditions for an involuntary admission at the time when they wish to discharge themselves.

A problem which sometimes arises is when patients who lack the capacity to consent are “voluntarily” admitted to a hospital simply because they do not protest against the admission (see also subsection 8.2). One example of this would be a patient who is admitted “voluntarily” but has no understanding of either the fact or the purpose of the admission. Another group of patients that runs this risk of so-called “voluntary” admission is those with mental retardation. Other people may “accept” treatment or admission without protest merely because they are intimidated or because they do not realize they have the right to refuse. In these cases, their lack of protest should not be construed as consent, since consent must be voluntary and informed.

The concept of "voluntary" precludes the use of coercion; it implies that choices are available and that the individual has the ability and right to exercise that choice. One or all of these conditions would be violated in the examples given above. In Brazil, the law states that "A person who requests voluntary internment or who consents to internment shall be required to sign, at the time of his or her admission, a declaration signifying that he or she has chosen this regime of treatment" (Mental Health Law No 10.216 of 2001, Brazil).

Voluntary admission & voluntary treatment: Key issues

- **Where a person needs inpatient treatment, legislation should support voluntary admission and every effort shall be made to avoid involuntary admission.**
- **If the law permits the authorities to retain voluntary patients when they attempt to leave, this should only be possible if the criteria for involuntary admission are met.**
- **On admittance to the mental health facility, voluntary patients may be informed of the fact that mental health professionals of the facility may exercise the authority to prevent their discharge should they meet involuntary admission criteria.**
- **Voluntary patients must be treated only after obtaining informed consent.**
- **Where the patient has the capacity to give informed consent, such consent is a prerequisite for treatment.**

Given the fact that in many countries not all persons who have been admitted as voluntary patients are strictly voluntary, legislation may make provision for an independent body (see section 13) to periodically review long-stay voluntary patients, assess their condition and situation and make appropriate recommendations.

8.2 "Non-protesting" patients

Legislation in some countries makes provision for users who are incapable, due to their mental health status, to give consent to treatment and/or admission, *but who do not refuse* mental health interventions. This would include people described in the previous section as not fulfilling the requirements as voluntary patients, but who also do not meet the criteria for involuntary admission (for example, people with severe mental retardation). While in some countries the "incapacity" legislation linked with comprehensive guardianship laws are able adequately to deal with people with mental disorders who are unable to give consent but do not refuse admission/treatment, other countries find it important to legislate in this area. The purpose of this category is to provide "non-protesting" patients with safeguards, while at the same time providing necessary admission and treatment to people *unable to give informed consent*. It has the important advantage of ensuring that people who are not resisting treatment are not incorrectly made either involuntary or voluntary patients; it also helps prevent a potentially huge increase in the number of people being incorrectly admitted as involuntary patients.

The criteria for being allowed admission and/or treatment are usually less stringent than in the case of involuntary users. This makes it possible for users who are unable to give informed consent – but who require treatment and admission for their (mental) health – to receive necessary care and treatment even if, for example, they are not a safety risk to themselves or to others. The "need for hospitalization" is sometimes regarded as a sufficient criterion. This, or a criterion such as "required for a person's health", is often less demanding than, for example, the criteria for involuntary admission (see subsection 8.3.2 below). The person making the application for care of a non-protesting patient is usually a close relative or a person who has the interest of the user at heart. The use of "surrogates" for non-protesting patients is common in a number of countries. If users object to their admission or treatment they must immediately stop being regarded as "non-protesting" and the full criteria for determining involuntary admission and treatment must be applied.

It is crucial that the rights of non-protesting patients be protected in a similar manner as those of involuntary users. For example, an assessment of capacity and suitability may need to be undertaken, and agreed, by more than one practitioner. Non-protesting patients should, like

involuntary users, qualify for mandatory automatic review procedures. This may include initial confirmation of their status as well as ongoing periodic assessments to determine whether their condition has changed. If, following their admission/treatment, they regain the capacity to make informed decisions, they must be removed from this status. Moreover, non-protesting patients should have the right to appeal their position. Non-protesting patients will also enjoy all other rights afforded to other patients, such as the right to notification of their rights, to confidentiality, to adequate standards of care and other rights (see section 5 above).

The fundamental principles of "least restrictive environment" and "in the best interest of the patient" must similarly be applied to non-protesting patients.

Countries that have provision in legislation for non-protesting patients include Australia, which has a section for "informal treatment of patients incapable of consenting" (Mental Health Act, 1990, New South Wales, Australia), and South Africa, which makes provision for "assisted users" in its Mental Health Care Act (2002). In different legislation, care for non-protesting patients may be for inpatients only or may also apply to the treatment of outpatients.

Non-protesting patients: Key issues

- **Legislation in some countries makes provision for users who are incapable, due to their mental health status, to give consent to treatment and/or admission, *but who do not refuse* mental health interventions.**
- **The criteria for being allowed admission and/or treatment are usually less stringent than in the case of involuntary users (criteria may be, for example, the "need for hospitalization" or "required for a person's health")**
- **If users object to their admission or treatment, they must immediately stop being regarded as "non-protesting" and the full criteria for determining involuntary admission and treatment must be applied. Similarly, if, following their admission/treatment, they regain the capacity to make informed decisions, they must be removed from this status.**
- **It is crucial that the rights of non-protesting patients are protected in a similar manner to those of involuntary users (for example, the right to assessment of capacity, to automatic review procedures, the right to appeal their status).**
- **Non-protesting patients should also enjoy all other rights afforded to other patients, such as the right to being informed of their rights, to confidentiality, to adequate standards of care and other rights.**

8.3 Involuntary admission and involuntary treatment

Involuntary, or compulsory, admission to mental health facilities and involuntary treatment are controversial topics in the field of mental health as they impinge on personal liberty and the right to choose, and they carry the risk of abuse for political, social and other reasons. On the other hand, involuntary admission and treatment can prevent harm to self and others, and assist some people in attaining their right to health, which, due to their mental disorder, they are unable to manage voluntarily.

Several international human rights documents, such as the MI Principles (1991), European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and The Declaration of Hawaii (1983), accept the need, at times, for involuntary admission and treatment of persons with mental disorders. However, it is important to stress that involuntary admission and treatment is required only for a minority of patients who suffer from mental disorders; in many instances where patients are admitted and treated involuntarily, if humane treatment and a proper opportunity for voluntary care were provided, involuntary admission and treatment could be reduced further.

It is acknowledged that some user and advocacy groups, such as MindFreedom Support Coalition International, are vehemently opposed to the idea of involuntary treatment, including the involuntary administration of psychotropic medicines, under any circumstances.

The key issue for mental health legislation in this regard is to outline circumstances when involuntary admission and involuntary treatment are appropriate, and to lay down suitable procedures. To ensure that rights are adequately protected, this section of legislation usually requires a fairly detailed exposition of the legal processes, and hence can be somewhat lengthy.

It is not the purpose of this Resource Book to be prescriptive about involuntary admission and treatment. Rather, it emphasizes recognition for global and cultural differences and, similarly, with regard to involuntary admission and treatment, it stresses that different cultures, traditions, economies and human resources are pertinent. But the principles of involuntary admission and treatment are important, and frameworks can be developed to assist countries to take locally appropriate legislative decisions.

MI Principles: Involuntary admission and treatment

1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

- **(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or**
- **(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.**

2. In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

(Principle 16 (1) and (3), MI Principles)

8.3.1 Combined versus a separate approach to involuntary admission and involuntary treatment

Mental health legislation may combine involuntary admission and involuntary medical treatment into one procedure or it may treat them as separate (see subsection 8.3.7, fig. 1).

Under the "combined" approach, once patients are admitted involuntarily, they may be treated involuntarily without having to undertake a separate procedure for sanctioning treatment. Some family groups, professionals and others have argued that the purpose of involuntary admission in most instances is to reverse a deteriorating clinical condition. It is asserted that there is no purpose in admission to hospital if no treatment is provided. In fact, in Portugal, the law states that "compulsory detention may *only* be determined in cases where it is deemed to be the *only* way of guaranteeing that the detained patient is submitted to treatment…" (emphasis added) (Mental Health Law No 36, 1998, Portugal) and in Pakistan, the law refers only to "admission for treatment"(Mental Health Ordinance for Pakistan, 2001). It is possible, of course, that a patient may not require medication, but may benefit from less intrusive therapies (such as psychotherapy, support groups or occupational therapy). Nonetheless, within the single approach, whether actually provided for or not, medical treatment *can* be given if admission is approved.

This does not imply that in the combined approach the patient cannot play any part in the treatment plan. For example, the Albanian law states that a person admitted to a psychiatric institution without consent should be "treated with the necessary medical procedures"; it further states that the person or his/her legal representative "has the right to complete information on the therapeutic treatment proposed, including knowing about the side effects and *what alternatives are available"* (emphasis added) (Law on Mental Health, 1991). Even with involuntary users subject to a single, combined process, it is good practice for the practitioner to always try and get cooperation and approval for treatment from the patient.

Under a fully "separate" approach, the admission and treatment procedures are independent of each other. First, the person is assessed for involuntary admission, then, if an involuntarily admitted patient requires involuntary treatment, the treatment need has to be assessed and a separate procedure for sanctioning such treatment is necessary (see subsection 8.3.7, fig.1).

Many individuals and organizations, especially user groups, object to combining involuntary admission and involuntary treatment and argue that a person's consent or refusal to admission and to treatment, are separate issues. Persons may require involuntary admission but not involuntary treatment, or, indeed, involuntary treatment without having to be placed outside their homes or communities. Moreover, it is argued that capacity is issue-specific, in that a person who is judged to be lacking capacity to make decisions regarding admission to a mental health facility may still retain the ability (capacity) to make decisions regarding treatment. It is agued that involuntary treatment violates fundamental human rights principles. For example, General Comment 14 to Article 12 of the ICESCR provides that the right to health includes the right to be free from non-consensual medical treatment. It is further argued that it is possible that an independent authority, for example a court or a review board, may commit a person to a psychiatric facility due to a mental illness, but this same authority, or a separate one, may find that the person has not lost his/her capacity to make treatment decisions. Assessment to determine incapacity to consent to treatment is thus necessary. Furthermore, advocates of a separate approach argue that the provision of two independent procedures for invoking involuntary admission and involuntary treatment ensures an extra layer of rights protection for persons with mental disorders.

On the other hand, advocates of the combined approach contend that with the separate approach there is a risk that if too much time elapses between the two processes, treatment can be seriously delayed, with detrimental effects for the individual concerned, as well as, possibly, to health care workers and other patients if the person is highly aggressive. In addition, due to the unavailability of human and financial resources in many low-income countries, it can be difficult to institute two separate procedures for involuntary admission and involuntary treatment. The "combined" approach does not contradict MI Principle 16(2), which recommends that "Involuntary admission or retention shall initially be for a short period as specified by domestic law for *observation and preliminary treatment* pending review of the admission or retention by a review body" (emphasis added).

Another possible variation of the combined and separate approaches, that could incorporate the advantages of both, is to consider the *need* for admission and treatment separately, but to combine the *processes* for determining and sanctioning them. In other words, the same practitioner(s), and possibly the same review body (or independent authority), that assesses the need for admission may also (in the same session) assess whether the person has the capacity to consent to treatment, and whether involuntary treatment is indeed required. This could lead to a range of different outcomes (discussed in subsection 8.3.5).

The following subsections discuss the criteria and procedure for involuntary admission and treatment. Where a "combined" procedure is utilized, i.e. treatment is provided (as required) as an integral part of involuntary admission and treatment, it should be "read into" admission. In other words, if admission is permitted, then treatment is automatically permitted, though it should never be given unless clinically required. Where treatment is to be provided as a

"separate" process from admission, the criteria and process for *admission* are largely the same as under the "combined" procedure, but involuntary *treatment* is considered separately.

8.3.2 Criteria for involuntary admission

Presence of a mental disorder

First and foremost – and common to all human-rights-oriented mental health legislation that deals with involuntary admission – there should be proof of the presence of a mental disorder as defined by internationally accepted standards. However, the type, severity and degree of a mental disorder qualifying for involuntary admission varies in different jurisdictions. Some countries allow involuntary admission only for specific mental disorders such as psychotic illness; others mention "severe mental disorder (illness)", while still others use the broader definition of mental disorder as the qualifying criteria for involuntary admission. A crucial issue for national legislation is to determine whether specific conditions should be included or excluded from involuntary admission. The more contentious diagnoses include mental retardation, substance abuse and personality disorder (see section 3 above). Choices in this regard will reflect the values of a particular country or community.

Serious likelihood of immediate or imminent danger and/or "need for treatment"

The two most often utilized – and probably also the most important – grounds for authorizing involuntary admission of persons with mental disorders are "serious likelihood of immediate or imminent danger " and "the need for treatment".

- *Serious likelihood of immediate or imminent danger* – This criterion can be applied in the best interests of the patients themselves to prevent harm to themselves, or for the safety of others. Preventing harm to self, to carers, families and society in general is an important obligation of the State, and thus it is often a key element of legislation (for information on predicting dangerousness, see Livesley, 2001; Sperry, 2003).

- *Need for treatment* – This criterion, like the dangerousness/safety criteria, solicits a great deal of controversy. There are a number of organizations and individuals, including users of mental health services and user groups, who object to this criterion. The MI Principles (Principle 16) state that involuntarily admission may be considered if, "in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility…."

  This principle usually includes the concurrent presence of a number of factors. First, the illness must be "severe" (issue of definition); secondly, it must be proved that there is "impaired judgement" (issue of capacity); and thirdly, there must be reasonable grounds to suspect that failure to admit the person will lead to serious deterioration in his/her condition or prevent administering appropriate treatment (prediction of treatment issue).

Admission should include a therapeutic purpose

Persons should be admitted involuntarily only if there is a therapeutic purpose to the admission. This does not necessarily mean that medication must be provided, as a wide range of rehabilitative and psychotherapeutic approaches may be implemented. A lack of therapeutic success does not imply a lack of therapeutic purpose, and involuntary admission can be justified if the person is receiving therapeutic care, even if the available treatments are not able to completely cure the person's condition. A person requiring purely custodial care should not be kept in a psychiatric facility as an involuntary patient.

When applying the above criteria, it is also important to consider the principle of "the least restrictive environment". In other words, a person may not be admitted if other, less restrictive alternatives, such as community care, can be utilized.

8.3.3 Procedure for involuntary admission

Mental health legislation usually outlines the procedure to be followed for involuntary admission. This procedure will vary from country to country. The following section (as with other sections of this Resource Book) should be read as broad guidelines rather than as recommendations.

Who should conduct the assessment?

As an additional safeguard to protect the rights of those being detained involuntarily, the MI Principles recommend that two independent *medical practitioners* who examine the patient separately and independently conduct the assessment. This is an important principle. However, in low-income countries with a scarcity of psychiatrists and general medical professionals, and even in some developed countries, this is often not possible or is deemed impractical, and other viable alternatives may be reasonably legislated. For example, other accredited mental health practitioners (such as psychiatric social workers, psychiatric nurses and psychologists) may need to be trained and accredited, as has been done in South Africa. In most Canadian provinces, there is only one physician in the community who authorizes a short-term (24–72 hours) admission. Thereafter, an independent physician examines the person in hospital, and if the physician does not consider a longer retention necessary the person is discharged.

There are no established rules with regard to how many practitioners must examine a person before he/she is admitted or treated or on what their qualifications must be. *Multiple examinations* by *more qualified* people may well provide the greatest protection to patients, but if legislating and enforcing this means that other patients who need care are not treated because the scarce resources are being used in assessing one person – or persons are not assessed at all because they come from a region where there are no or not enough qualified practitioners as legislated – then clearly this does *not* provide better protections.

Moreover, ostensibly, more qualified professionals may be less able to do mental health status examinations than those assumed to be less qualified. For example, in many developing countries medical doctors have had very little training and experience in mental health, whereas certain psychiatric nurses are highly skilled and experienced. On the other hand, many psychiatric symptoms are manifestations of an underlying physical illness, and examination by at least one medical doctor is important. Locally appropriate solutions are clearly more important than any rules described in this Resource Book. Nonetheless, the standards of independence, and having two assessments, one of which is by a qualified practitioner, should always apply.

If a second assessment absolutely cannot be undertaken prior to an initial admission due to circumstances within a country, it should occur on admission and prior to treatment being administered. If there is a discrepancy between the first and the second assessment, a third independent practitioner must examine the person and make recommendations, following which a majority recommendation should be instituted.

Who should make the application?

The issue of who should make the application for involuntary admission is a further difficult and much debated area. In some countries, based on the recommendations of a mental health practitioner, either a family member, close relative or guardian, or another State-appointed person (e.g. in the United Kingdom, a social worker), makes an application to the designated mental health facility (either a mental hospital or a psychiatric ward in a general hospital) to admit the patient to the facility. In other countries, the application for admission is made even before the medical examination, and the examination takes place on the basis of the application.

In some cases, certain families believe it is their prerogative to make the decision on whether and when a family member needs involuntary care and treatment, and that they should have a say on whether and when outside help is needed. In yet other countries, family members are not involved in the application at all because it is felt that most families do not wish to run the risk of later being blamed by the family member with a mental disorder for committing them for admission and treatment. Such differences reflect different cultures and different processes adopted by countries, and none of the options can be considered the only "correct" one.

Where should the patient be admitted?

Countries will need to make decisions regarding where involuntary patients are to be admitted. Wherever possible, like other health admissions, this should be as near to the patients' homes as possible. Facilities in general hospitals may be developed to accommodate most involuntary patients. However, given the fact that a minority of involuntary patients may be aggressive or difficult to handle, certain facilities may need to have the required level of security to be able to accommodate these patients. In any event, the mental health facility should be accredited as providing adequate and appropriate care and treatment before being permitted to admit involuntary patients.

Who should review the proposal and continued admission?

Most countries utilize an independent authority such as a review body, tribunal or a court to confirm involuntary admission based on medical/psychiatric/professional expertise, as outlined above (see also section 13 below). The independent authority's decision should not be influenced by instructions from any source whatsoever. As with the issues mentioned above, resources and local conditions should determine what kind of review body is needed and the procedures to be followed. Again, countries will need to balance priorities and rights. For example, despite the fact that most involuntary admissions are not categorized as being "emergencies" (see subsection 8.4), given the criteria for involuntary admissions (above), any delays in having a patient admitted and treated should be avoided. An appropriate balance is needed between the right to prevent harm to self or others, on the one hand, and to be treated (if such treatment is needed) or have the right to refuse treatment on the other.

In some countries it may not be possible to have the independent authority review each case prior to a person's admission. Rather than delay admission, the law may provide a specified time frame (which must be short) in which the case must be reviewed. As soon as the review body makes its decision, the relevant action should be implemented. There should then be ongoing, automatic, mandatory and regular reviews of status.

In practice, most involuntary admissions are brief, lasting days or a couple of weeks, with most patients showing good recovery and/or no longer meeting the requirements for involuntary admission. There is little reason, in most instances, to continue the involuntary admission beyond this period. Patients may either recover sufficiently to be discharged, or be well enough to be able to make their own decisions to voluntarily continue the placement. In some countries, legislation does not require a review by the review body for involuntary admissions lasting less than a specified period of time. For example, this initial time period is restricted to 72 hours under South African legislation (Mental health Care Act, Act 17, 2002). Low-income countries with scarce human and financial resources may see advantages to this approach, as the review mechanism does not consume a disproportionate amount of resources to the detriment of service provision. This particular approach is also in keeping with MI Principle 16(2) which recommends that "Involuntary admission or retention shall initially be for a short period as specified by domestic law for *observation and preliminary treatment* pending review of the admission or retention by a review body" (emphasis added).

Where possible, the independent authority should give patients an opportunity to state their views and opinions regarding involuntary admission (including whether they believe they are

being incorrectly admitted or where they would choose to be admitted), and these should be taken into account when making decisions. Furthermore, the independent authority should consult family members (and others close to the patient), the health practitioners involved and/or a legal representative (if any) appointed by the patient.

The law can ensure that patients are informed immediately of the grounds for involuntary admission, and that this is also conveyed promptly to the patients' legal representatives and family members as appropriate.

Moreover, an important element to be incorporated into legislative provisions on involuntary admission is the right to appeal to quasi-judicial and judicial bodies. Legislative sections dealing with involuntary admission should include this right and set out the process to be followed – for patients, their families and/or legal representatives – for appeal to a mental health review body and/or a court against the initial detention.

Involuntary admission: Key issues

- **Involuntary admission is generally permitted only if *all* the following criteria are met and the patient is refusing voluntary admission:**
  - **a) there is evidence of a mental disorder of specified severity, and;**
  - **b) there is a serious likelihood of immediate or imminent harm to self or others, and/or a deterioration in the patient's condition if treatment is not given,**
  - **c) admission includes a therapeutic purpose, and;**
  - **d) this treatment can only be given by admission to a mental health facility.**

- **Procedure to be followed for involuntary admission:**
  - **a) Two accredited mental health practitioners (one of whom ideally should be a medical doctor) should certify that criteria for involuntary admission are fulfilled and recommend involuntary admission.**
  - **b) An application for involuntary admission should be made in accordance with local culture and conditions.**
  - **c) The mental health facility should be accredited as providing adequate and appropriate care and treatment, and therefore permitted to admit involuntary patients.**
  - **d) An independent authority (review body, tribunal or court) should authorize involuntary admission. This should be done as soon as possible after an application is made or, if not possible, as soon as possible after admission; legislation should lay down the time frame required for such a review. The person should be entitled to a legal representative at the hearing.**
  - **e) Patients, their families and legal representatives should be informed immediately of the grounds for involuntary admission and of the patient's rights.**
  - **f) Patients, their families and/or their legal representatives should have a right to appeal to a review body and/or a court against involuntary admission.**

- **There needs to be a provision for regular, time-bound review of involuntary admissions by an independent review body.**

- **Patients must be discharged from involuntary admission when they no longer fulfil the criteria for involuntary admission. Voluntary treatment may follow.**

The procedures for discharging a person from involuntary admission and treatment should be as flexible as possible to ensure that a person is not retained for any period longer than is necessary. Continued admission is only justified upon the persistence of the mental disorder of a severity and form that prompted the involuntary admission. If involuntary admission is no longer warranted, the patient may be discharged without further care, either by a doctor or a professional as determined by law, or by the review board if it has considered the case. If patients so choose, they may be transferred to voluntary status to continue care and treatment

as an inpatient or outpatient. This implies that there is a need for a statutory process for reviewing cases at regular intervals. Where a patient is involuntarily detained for a longer period than recommended, the right to appeal against this decision should be allowed at prescribed intervals.

To facilitate this procedure, it is useful for countries to have standardized forms which must be filled in at various stages (see Annex 8 for examples of such forms).

8.3.4 Criteria for involuntary treatment (where procedures for admission and treatment are separate)

There is considerable overlap between the criteria for involuntary admission and involuntary treatment. The main difference, however, is that, regarding *treatment*, the person has to be found to lack the capacity to make informed decisions. Treatment without consent should be considered only when all of the following conditions are met:

1. A determination that a patient has a mental disorder has been made in accordance with international medical standards.
2. The patient lacks the capacity to give or withhold informed consent to the treatment proposed.
3. Treatment is necessary to:
   (i) bring about an improvement in the patient's mental disorder; and
   (ii) prevent deterioration of the patient's mental state; and/or
   (iii) protect the patient from self harm; and/or
   (iv) protect others from significant harm.

Treatment without consent and without the authorization of a legally constituted body should be instituted only, and strictly, in emergencies, and only for the duration of the emergency (see subsection 8.4).

8.3.5 Procedure for involuntary treatment of admitted persons

There are a number of different ways in which a treatment process – as distinct from the admission process – may be applied. The treatment decision may be independent in terms of:

a) *time* – involuntary treatment is assessed only after the patient has been admitted;
b) *criteria* – mental health status that requires involuntary admission is different from the capacity to decide treatment; and
c) *professional and authorizing power* – different people, with different skills, are involved in deciding who needs to be involuntarily admitted and who requires involuntary treatment.

Each of these may provide added protections to the user, but, as with admission, these processes should not be allowed to delay treatment unduly as this may also constitute a violation of human rights.

In situations with fewer resources, it is still possible to separate the *criteria* for involuntary admission and involuntary treatment, but the *same person(s)* should conduct the assessment for treatment at the same time as assessing for admission.

Whether part of a combined or separate process, involuntary treatment should always be proposed by a suitably qualified and accredited mental health practitioner. Which professional category this is will depend on country resources and situations. As with admission, a second independent, accredited mental health practitioner, who has independently examined the patient and reviewed the entire medical and treatment records of the patient, may be utilized to confirm the treatment plan. Practitioners making treatment decisions may only do this within their professional scope of practice. It is important to emphasize once again that the designated professionals need to have the requisite training, competence and expertise to perform this role – and legislation should stipulate these criteria.

Based on the above recommendations, the treatment plan – as with admission recommendations – may be sanctioned by an independent authority (this may be the review body). The independent authority may be required to verify that the patient does indeed lack the capacity to give consent to treatment, and (under some legislations) that the proposed treatment is in the best interests of the patient. As with admissions, this independent authority may be quasi-judicial or judicial. The key point is that the independent authority is different from the individual(s) proposing the treatment, and is made up of people with the requisite skills and knowledge to judge the competence of the patient.

Although in some situations this body will be different from the body that authorizes the admission, this may not be possible in all situations. Where only a single body is available, its members would need to bear in mind the differing admission and treatment criteria. The authority could then decide on a range of options, for example, that a person must be involuntarily admitted but cannot be medically treated without his/her consent, that the patient be both admitted and treated, or that neither involuntary admission nor treatment is permissible.

Where the same authority assesses for both admission and treatment, an opportunity is created for recommending treatment in the community (i.e. compulsory treatment without admission) – if that is an option for the country (see subsection 8.3.7 below). Another variation on independent sanctioning of involuntary treatment is to specify certain treatment modalities that require a separate review process. For example, treatment using depot psychotropic medications may require a separate procedure for sanctioning its use, but not for administering oral medication.

When involuntary treatment is recommended, whether as part of a “combined” or “separate” approach, it is essential that the patient be protected from any undue harm and that the proposed treatment should aim to benefit the patient. In general, treatment should always be applied in response to a recognized clinical symptom, have a therapeutic aim, and be likely to entail a real clinical benefit – and not only have an effect on the administrative, criminal, family or other situation of the patient. Involuntary treatment must meet national and/or international treatment guidelines for the particular mental health condition – whichever offers the most protection and safeguards against abuse.

Involuntary treatment must not be given for longer than is necessary, and should be systematically reviewed by the treating health practitioner and periodically by an independent review body. In some statutes, a maximum time limit for treatment may be stipulated. One of the key aims of the proposed treatment must be to restore the patient’s capacity, and when this occurs involuntary treatment should be stopped. In many cases, voluntary treatment will then commence. Where a time limit is stipulated, involuntary treatment must not extend beyond the sanctioned limit or beyond the restoration of the patient’s capacity – *whichever happens earlier.*

Legislation can encourage professionals to engage patients and/or their families (or others concerned) in the development of the proposed treatment plan, even if the treatment is being imposed involuntarily. Patients and those caring for them must be informed immediately of their rights when patients are being involuntarily treated.

Patients and their families and/or personal representatives must have a right to appeal to a review body, tribunal and/or court against the imposition of involuntary treatment. Once again, it is useful to have standardized forms for the process of appeal to a review body (see Annex 8 for an example of such a form).

Example: Successful appeal of an admitted patient against involuntary treatment in Ontario, Canada

In Ontario, Canada, Professor Starson was admitted to hospital after he was found not criminally responsible for making death threats, and the Review Board ordered his detention for 12 months. The attending physician proposed medical treatment for his bipolar condition. Starson refused to consent to the treatment on the basis that medication dulled his mind and diminished his creativity, but the attending physician found him not capable of deciding whether to accept or reject medical treatment. Starson applied to the Consent and Capacity Board to review the physician's decision. The Board confirmed the physician's decision. However, the decision of the Board was subsequently overturned on judicial review by the Superior Court. This decision was in turn referred to the Court of Appeal, which upheld the lower court's decision. The case went to the Supreme Court of Canada, the country's highest court. In June 2003, the Supreme Court upheld the decision of the Ontario Court of Appeal.

In terms of the Ontario Health Care Consent Act (see Sec. 2.3) a person must be able to understand the information that is relevant to making a treatment decision, and must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one.

The Court found that the Board had misapplied the statutory test for capacity as well as being incorrect in its finding that Professor Starson failed to appreciate the consequences of his decision.

This case demonstrates the important principles that:

- admission without a person's consent does not necessarily imply that he/she is incapable of making treatment decisions;
- tests determining capacity are open to interpretation;
- by allowing appeals to higher authorities, initial decisions on treatment can be reversed;
- the integrity and inviolability of a person is a critical human rights principle.

(Starson v. Swayze, 2003, SCC 32)

When periodically reviewing involuntary treatment, the independent authority must ensure that grounds for continuing involuntary treatment persist. Where a time for allowing involuntary treatment has been stipulated and treatment beyond this time is required, the process of sanctioning treatment must be repeated. The mere refusal of treatment by a patient should not be considered as adequate grounds for resanctioning involuntary treatment.

Involuntary treatment: Key issues

- The criteria for involuntary treatment must be met before treatment is administered.
- Procedure to be followed for involuntary treatment:
  - a) The treatment plan should be proposed by an accredited mental health practitioner having sufficient expertise and knowledge to undertake the proposed treatment.
  - b) A second independent accredited mental health practitioner should be required to agree to the treatment plan.
  - c) An independent authority (review body) should meet as soon as possible after involuntary treatment has been recommended to review the treatment plan. It should meet again at set intervals to assess the need for continued involuntary treatment.
  - d) Where the sanction for involuntary treatment is for a limited period, continued treatment can only be administered if the sanctioning process is repeated.
  - e) Involuntary treatment should be discontinued when patients are judged to have recovered their capacity to make treatment decisions, when there is no longer a need for treatment or when the sanctioned time has elapsed – whichever happens earliest.
  - f) Patients and their families and/or personal representatives should be immediately informed of involuntary treatment decisions being made and, as far as is feasible, they should be involved in developing the treatment plan.
  - g) Once involuntary treatment is sanctioned, patients, families and personal representatives must be informed of their rights to appeal to a review body, tribunal and/or court against the involuntary treatment decision.

Note that the above procedure does not apply to emergency situations, special treatments or research, which are discussed below.

8.3.6 Proxy consent for treatment

Certain jurisdictions provide for the appointment of a personal representative, a family member or a legally appointed guardian who has the right to give consent to treatment on the patient's behalf. Clearly, proxy consent can only be considered in situations where a person's lack of capacity to consent to treatment has been established.

"Proxy" consent in many circumstances is a form of involuntary treatment. Any proxy or surrogate should be bound by a "substituted judgement" standard in making decisions for a person without capacity. That is, surrogates should make the decision they believe the incapacitated person would have made if that person had the capacity to make the decision. Where the person never had capacity – such as certain people with mental retardation – the standard merges with a "best interest" standard. Even then, however, surrogates should strive to learn about the person's particular situation so that they can make the decision that is closest to their perception of the known wants and needs of the incapacitated person.

There are advantages to proxy decisions by family members; they are the most likely to have the patients' best interests at heart and to be familiar with the patient's own values. Simultaneously, it should be acknowledged that "proxy" decisions – particularly when they happen to be made by family members – might not be truly independent. Conflicts of interest can occur in families, and family members may equate their best interests with the patient's best interests. Safeguards incorporated in rules governing involuntary treatment should therefore also apply to proxy consent; e.g. patients should have the right to appeal even in circumstances of proxy consent.

In some countries' legislation, provision is made for an "advance directive", whereby persons with a mental disorder may, during periods when they are "well", determine what they find acceptable or unacceptable for periods when they are unable to make informed decisions. They may also determine who should make decisions on their behalf at times when they cannot make informed decisions (see Annex 9 for an example of New Zealand's advance directives for mental health patients).

A recent study has shown that the negotiation of a joint crisis plan among patients and mental health teams, including the preparation of advance directives specifying treatment preferences, can result in reduced involuntary admissions in patients with severe mental disorders (Henderson, 2004).

More problematic is when a person with a mental disorder specifies advance refusal of treatment. Some mental health professionals are reluctant to accept that such an advance refusal should apply in a later situation when a patient meets the criteria for involuntary treatment, and where honouring the advance refusal of treatment would deprive a seriously ill patient of needed treatment, or where patients could do harm to themselves or others.

Proxy consent to treatment: Key issues

- **Proxy consent may be given to a personal representative, a family member or a legally appointed guardian who has the right to give consent to treatment on the patient's behalf.**
- **Rules governing involuntary treatment "by proxy" should incorporate safeguards. For example, patients should have the right to appeal.**
- **"Advance directives" give patients an opportunity to make decisions for themselves during periods when they are able to give informed consent for periods when they are not so capable. If a law provides for the use of advance directives or other forms of substitute decision-making, it should define such terms clearly and consistently.**

8.3.7 Involuntary treatment in community settings

MI Principles: Treatment in the least restrictive environment

Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

(Principle 9(1), MI Principles)

Based on the principle of least restrictive alternative, some countries have enacted legislation that permits involuntary treatment of patients residing in community settings. The community setting is regarded as usually less restrictive than a hospital (although highly restrictive living conditions and intrusive medical interventions that can be part of community orders are sometimes more restrictive than, for example, a short stay in hospital).

Examples of less restrictive settings would generally include outpatient treatment, day hospital treatment, partial hospitalization programmes and home-based treatment. There are other reasons why some countries have made provision for involuntary treatment in the community. First, professionals and others are concerned about the occurrence of a "revolving door" situation, whereby persons with mental disorders undergo involuntary admission and treatment, stop medication on discharge and relapse, leading to an ongoing cycle of involuntary admission and treatment. Secondly, there is a fairly common public – as well as professional – perception that deinstitutionalization has failed in many countries, and that the number of persons with mental disorders in the community poses a public risk (Harrison, 1995; Thomas, 1995).

Some countries have community supervision orders that require individuals to reside at a specified place and attend specified treatment programmes (such as counselling, education and training). They also grant the individuals access to mental health professionals at their homes, but do not include having to submit to medication without consent. Other countries have enacted community treatment orders that include a provision for involuntary medical treatment.

New Zealand has revised its mental health legislation to accord with the least restrictive principle. Under the Mental Health (Compulsory Assessment and Treatment) Act, Sec. 28(2), when a court has ruled that the certification criteria (for involuntary treatment) have been met "the court shall make a community treatment order unless the court considers that the patient cannot be treated adequately as an outpatient, in which case the court shall make an inpatient order." Such legislative provisions aim to promote community-based treatment rather than an outmoded institutional admissions framework. Certain other countries have introduced the concept of conditional leave, based on the principle of the least restrictive alternative, in order to aid community reintegration of patients who have received involuntary treatment in hospital settings.

At this juncture, the evidence base for the effectiveness of compulsory community supervision and/or treatment orders is still rather new. Such orders appear to decrease rehospitalization and total hospital days when they are accompanied by intensive community-based treatment, which requires a substantial commitment of manpower and financial resources (Swartz et al., 1999).

Community supervision and treatment legislation should be introduced only in the context of accessible, quality community-based mental health services that emphasize voluntary care and treatment as the preferred option. There is a significant risk that compulsory community supervision could cause mental health services to rely on compulsion for providing community-based care, rather than focusing on making such services acceptable to users and investing efforts and resources in engaging users in such services voluntarily.

Critics – particularly those from groups representing users – have argued that compulsory supervision and treatment orders amount to "institutionalization" within the community, and they are strongly opposed to such measures being taken.

Legislators and others considering compulsory community treatment need to ensure that this approach does not undermine the purposes of deinstitutionalization and many of the gains made in the humane treatment of persons with mental disorders over the past five decades.

As in cases of involuntary admission and treatment, where community orders are implemented they must be regularly reviewed and the orders revoked when the criteria are no longer met. Furthermore, people subject to involuntary care in the community should also have the right to appeal their status.

Involuntary care in the community should be considered as an alternative option to involuntary admission in a mental health facility, rather than as an alternative to voluntary community care. The criteria for involuntary treatment described above should therefore prevail in all instances of involuntary care and treatment.

Community-based involuntary care: Key issues

- **Community-based involuntary treatment (community treatment orders) and community supervision orders can represent a generally less restrictive alternative to inpatient involuntary treatment. The procedural requirements for community-based supervision should be similar to those for hospital-based involuntary treatment orders (as outlined above).**
- **Community-based supervision and treatment legislation should be introduced only in the context of accessible, quality community-based mental health services that emphasize voluntary care and treatment as the preferred option.**
- **As in cases of involuntary admission and treatment, where community orders are implemented they must be regularly reviewed and the orders revoked when the criteria are no longer met.**
- **People subject to involuntary care in the community should have a right to appeal their status.**
- **Involuntary care in the community should be considered as an alternative option to involuntary admission in a mental health facility, rather than as an alternative to voluntary community care.**

Figure 1. Procedure for combined involuntary admission and treatment

(in this figure, wherever involuntary admission is mentioned, involuntary treatment is also assumed)

Patient is evaluated for involuntary admission; all criteria are carefully evaluated

Person does not meet the criteria; can only be admitted voluntarily

Person meets criteria for involuntary admission; application is made for admission by family member, personal representative or State-appointed person

Assessment may include determining whether the person would be more effectively treated in hospital or in the community

Independent review body thorougly reviews application

Involuntary admission not granted; patient may not be admitted/must be discharged immediately

Involuntary admission authorized

Patient to retain the right to be involved in treatment plan and to evidence-based options

Patient/family member/personal representative may appeal decision

Appeal considered by court, tribunal or other authorized independent body

As soon as patient no longer meets involuntary criteria, status must return to voluntary

Appeal upheld

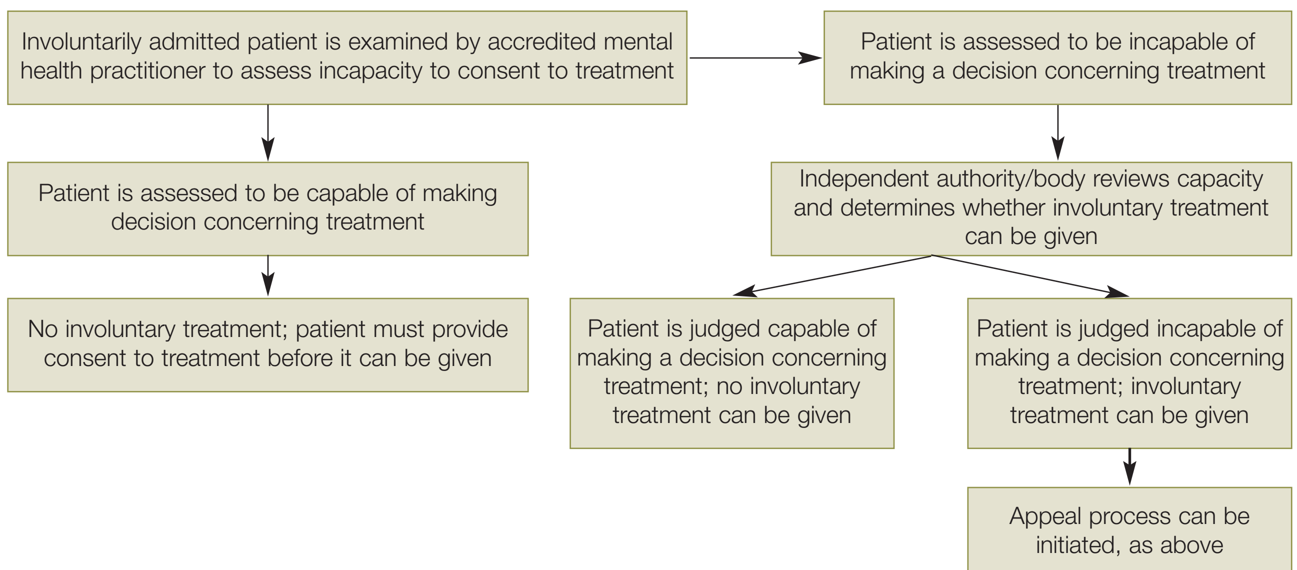
Appeal denied

Patient must be discharged immediately

Involuntary admission authorized

In case of a separate procedure for involuntary treatment

(Where admission and treatment are separate, the above procedure should be undertaken, followed by the following procedure for involuntary treatment)



8.4 Emergency situations

There will be situations when urgent involuntary admission and/or urgent involuntary treatment may be needed. Actively suicidal patients or acutely disturbed patients who are violent or aggressive are examples. Here it may not be feasible or reasonable to expect compliance with substantive procedures for involuntary admission and treatment. Legislation must therefore provide for such emergency treatment with sufficient safeguards. The assistance of the police may also be required in certain situations (see section 14 below).

Legislation should define what constitutes an emergency. In most jurisdictions, an emergency situation is one in which there is *immediate and imminent* danger to the health and safety of the person concerned and/or others. To be considered an emergency, it must first be demonstrated that the time required to comply with substantive procedures would cause sufficient delay and lead to harm to the concerned person or others. In such situations, legislation can permit immediate involuntary admission to hospital and/or immediate involuntary treatment based on an assessment carried out by a qualified medical and/or other accredited mental health practitioner operating within their scope of practice. Emergency admission and/or treatment should not be prolonged, but allowed only for a short period of time. During this time, if it appears that the person may require further involuntary care, the substantive procedures for involuntary admission or treatment should be undertaken. In many countries, emergency admission or treatment is not permitted beyond 72 hours, as this gives sufficient time to meet all the requirements for compliance with substantive involuntary procedures. Emergency treatment should not include ECT, depot neuroleptics and irreversible treatments such as psychosurgery or sterilization procedures.

8.4.1 Procedure for involuntary admission and treatment in emergency situations

The patient should be examined by a qualified practitioner to determine whether an emergency exists. In particular, the practitioner should be able to justify involuntary admission, given the nature of the emergency.

When the person is admitted for treatment to an accredited mental health facility, treatment should be administered according to a treatment plan drawn up and supervised by a qualified medical or mental health practitioner (who, ideally, should be different from the practitioner certifying admission and/or treatment).

If the person requires involuntary admission/treatment beyond the prescribed emergency time frame, procedures for such admission and/or treatment (see section 8.3 above) should be initiated and completed within a specified time period. If the patient does not fit the criteria for involuntary admission/treatment, or if the procedures for keeping/treating the person as an involuntary patient are not completed, the person should be discharged immediately after the emergency has ended. Admitted patients who do not fit the criteria for involuntary admission/treatment after an emergency admission, but who may still benefit from treatment, should be regarded as voluntary users and only treated with their informed consent.

If a person is discharged from emergency involuntary admission and not granted involuntary admission and/or involuntary treatment, it would be inappropriate to reapply emergency powers immediately to readmit the person unless there is a substantive change in the nature of the emergency, requiring the use of such emergency powers. The purpose of this provision is to prevent misuse of emergency powers to indefinitely prolong involuntary admission or involuntary treatment.

Patients' family members, and/or personal representatives should be immediately informed of the use of emergency powers. And they should have the right to appeal to a mental health tribunal, review body and the courts against such emergency admission and treatment.

Emergency situations: Key issues

- To be an emergency, it must first be demonstrated that the time required to follow substantive procedures would cause considerable delay, resulting in harm to the concerned person or others.
- In an emergency, involuntary admission and treatment should be permitted on the assessment and advice of a qualified medical or other appropriate practitioner.
- Emergency treatment must be time-limited (usually no longer than 72 hours), and substantive procedures for involuntary admission and treatment, if necessary, must be initiated as soon as possible and completed within this period.
- Emergency treatment should not include:
  - > depot neuroleptics
  - > ECT
  - > sterilization
  - > psychosurgery and other irreversible treatment.

- Procedure for emergency admission and treatment:

A qualified practitioner should examine the person and certify that the nature of the emergency requires immediate involuntary admission and treatment.

a) A treatment plan should be drawn up under the supervision of a medical or mental health professional.
b) Procedures for involuntary admission and/or involuntary treatment should be initiated immediately if it is assessed that the person is likely to require involuntary care beyond the stipulated time limit for emergency treatment.
c) It is inappropriate to reapply emergency powers when a patient has been released following completion of the procedure for involuntary admission, unless there is a substantial change in the nature of the emergency.
d) Patients' family members, personal representatives and/or a legal representative should be immediately informed of the use of emergency powers.
e) Patients, their families and/or personal representatives have the right to appeal to a mental health tribunal and courts against emergency admission and treatment.

9. Staff requirements for determining mental disorder

There is international consensus that clinically qualified experts must base their assessment of mental disorder on objective evidence.

Legislation (or regulations) should
- define the level of experience and skills required to determine mental disorder; and
- delineate the professional groups permitted to do so.

9.1 Level of skills

There should be a system of accreditation by which practitioners who are part of the process of determining mental disorder are independently accredited as having demonstrable competence in this task. This accreditation should be:
- codified in law;
- require the accredited professional to have achieved a level of competence established by the relevant professional organization or certifying body;
- require the accredited professional to understand relevant mental health legislation.

In countries where it is not possible to achieve all of these requirements, it must be stipulated in the law that a process be put in place to guarantee that practitioners who determine who has mental disorders have the competence to do so.

9.2 Professional groups

Which professional group may make a judgement about the presence or absence of a mental disorder must be determined within countries, and must be linked to questions of availability, accessibility, affordability, training and competence of various professional groups. In some developed countries, only a psychiatrist (a medical doctor with special training in mental health and mental disorder, and certified as such) is qualified to undertake this exercise, while in others, general practitioners are considered competent. The MI Principles are silent on this issue, noting only "in accordance with internationally accepted medical standards". The European Commission of Human Rights, on the other hand, has accepted that medical evidence may come from a general practitioner rather than a psychiatrist *(Schuurs v. the Netherlands, 1985)*.

In many low-income countries with a scarcity of psychiatrists and general practitioners, it may be appropriate to designate other mental health practitioners, such as psychologists, psychiatric social workers and psychiatric nurses, as competent to determine mental disorders. Where this is permitted, legislation (or accompanying regulations) should clearly specify the level of knowledge, experience and training required for such accreditation.

Staff requirements for determining mental disorders: Key issues

- **Legislation (or regulations) should outline the following:**
  - **define the level of experience and skills required to determine mental disorder;**
  - **delineate the professional groups permitted to do so.**

- **A system of accreditation needs to exist whereby practitioners who are involved in the process of determining mental disorder are recognized as having demonstrable competence in this task.**

- **Which professional group may make a judgement about the presence or absence of a mental disorder must be determined within countries. In countries with a scarcity of psychiatrists and general practitioners, it may be appropriate to designate other mental health practitioners as competent to determine mental disorders. Where this is permitted, legislation (or accompanying regulations) should clearly specify the level of knowledge, experience and training required for such accreditation.**

10. Special treatments

Countries may decide to enact legislation to protect people against abuses in the use of certain treatments such as major medical and surgical procedures, ECT, psychosurgery or other irreversible treatments. Some countries may also need to specifically ban certain interventions if they are being unjustifiably utilized as treatments for mental disorders. Sterilization as a treatment for mental illness is an example of this. In addition, the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent.

MI Principles: Sterilization

Sterilization shall never be carried out as a treatment for mental illness.

(Principle 11(12), MI Principles)

10.1 Major medical and surgical procedures

MI Principles: Major medical or surgical procedures

A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

(Principle 11(13), MI Principles)

Major medical or surgical procedures on patients with mental disorders should generally only be performed after obtaining free and informed consent. The ethical standards governing these treatments should apply both to non-mental-health patients and mental health patients alike. If a patient lacks the capacity to give informed consent, legislation may permit such procedures only under exceptional circumstances and with adequate safeguards.

Medical and surgical procedures without consent may be permitted if they are deemed to be life saving, and if delay due to waiting for restoration of the patient's capacity to consent would put that patient's life at risk. In rare cases of mental illness or profound mental retardation, where the patient's lack of capacity to consent is likely to be permanent, medical and surgical interventions may also be necessary without consent. In these situations, the proposed medical or surgical treatment may be authorized either by an independent review body or, in countries where the law permits, a proxy consent by a guardian, relative or personal representative. In other instances, medical and surgical treatment must be delayed until the patient's mental state improves to a point where he/she has the capacity to make a treatment decision.

Where emergency medical and surgical treatment is necessary to save a patient's life or prevent irreparable deterioration in his/her physical health, a person with a mental disorder should be entitled to the same treatment available to other persons without mental disorders who are not able to consent (e.g. unconscious patients). Legislation governing emergency medical and surgical treatment given without consent to all persons should thus also cover persons with mental disorders. Medical services carry the responsibility of providing and justifying the appropriateness of such emergency medical and surgical treatment.

10.2 Psychosurgery and other irreversible treatments

MI Principles: Psychosurgery and other intrusive and irreversible treatments

Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

(Principle 11(14), MI Principles)

Psychosurgery and other irreversible mental health treatments generally should not be permitted to be performed on people unable to give informed consent. In view of the irreversible nature of certain treatments, legislation may provide an additional level of protection to consenting patients by making it mandatory that an independent review body, or similar safeguard, sanction the treatment. The review body (or other safeguarding structure) should interview the patient, ensure that the patient has the capacity to give, and has in fact given, informed consent, and review the patient's medical/psychiatric history and records. The review body/safeguard must be

satisfied that the proposed intrusive treatment is in the best interest of the patient. Patients should also be made aware of all risks as well as short- and long-term effects of the proposed treatment.

10.3 Electroconvulsive therapy (ECT)

Although significant controversy surrounds electroconvulsive therapy (ECT) and some people believe it should be abolished, it has been and continues to be used in many countries for certain mental disorders. If ECT is used, it should only be administered after obtaining informed consent. And it should only be administered in modified form, i.e. with the use of anaesthesia and muscle relaxants. The practice of using unmodified ECT should be stopped.

There are no indications for the use of ECT on minors, and hence this should be prohibited through legislation.

Special treatments: Key issues

- **Sterilization is not a treatment for mental disorder, and having a mental disorder should not be a reason for sterilization (or abortion) without informed consent.**
- **Ethical standards that govern major medical and surgical procedures that are applicable to all patients should also be applied to persons with mental disorders.**
- **Major medical and surgical procedures should be performed only with informed consent, except under exceptional circumstances. In these circumstances, proposed medical or surgical treatment should either be authorized as involuntary treatment by an independent review body or by proxy consent.**
- **Emergency medical and surgical treatments for people with mental disorders should be treated in the same manner for all patients who need such emergency treatment without consent.**
- **Psychosurgery and other irreversible treatments should not be permitted as involuntary treatment, and, as additional protection, all such treatment should be reviewed and sanctioned by an independent review body.**
- **ECT should be administered only after obtaining informed consent. Modified ECT should be utilized. Legislation should prohibit the use of ECT on minors.**

11. Seclusion and restraint

The terms "seclusion" and "restraint" may need to be defined in legislation, as there can be various interpretations of what is meant by these terms. Moreover, there may be different types of seclusion and restraints that may apply in different circumstances.

Legislation should discourage the use of restraints and seclusion in mental health facilities. To facilitate this, countries will need to develop their mental health infrastructure, as it is often a lack of resources that encourages staff to use these interventions. To protect against abuse, legislation may outline the exceptional circumstances when these procedures are permitted. Restraints and seclusion may be allowed when they are the *only* means available to prevent immediate or imminent harm to self or others, and then used for the shortest period of time necessary. They may only be authorized by an accredited mental health practitioner. If used, there needs to be ongoing active and personal contact with the person subject to seclusion or restraint, which goes beyond passive monitoring. Legislation may ensure that restraints and seclusion are used as procedures of last resort when all other methods of preventing harm to self or others have failed. In particular, legislation must ban the use of restraints and seclusion as a form of punishment.

MI Principles: Seclusion and restraint

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

(Principle 11(11), MI Principles)

All episodes of physical restraint and seclusion should be recorded in a register that is made available to the review body for its perusal and for identification of facilities that may be abusing these interventions. Information should include details of the circumstances leading to restraint and seclusion, the duration, and the treatment given to bring about a speedy termination of the restraint or seclusion.

Where possible, there should be a legislative requirement to immediately inform patients' families and/or personal representatives when patients are subjected to seclusion or restraint procedures.

Seclusion and restraint: Key issues

- **Seclusion and restraint may be permitted by legislation when they are the only means available to prevent immediate or imminent harm and danger to self and others.**
- **Seclusion and restraints must be used for the shortest period of time (lasting minutes or a few hours).**
- **One period of seclusion and restraint should not be followed immediately by another.**
- **There needs to be ongoing active and personal contact with the person subject to seclusion and restraint, which goes beyond passive monitoring.**
- **Legislation should ban the use of seclusion and restraints as punishment or for the convenience of staff.**
- **Legislation should also promote infrastructure and resource development so that seclusion and restraints are not used due to such deficiencies.**
- **Procedure for exceptional use of seclusion and restraints:**
  - **a) They should be authorized by an accredited mental health practitioner;**
  - **b) The mental health facility should be accredited as having adequate facilities for undertaking such procedures safely;**
  - **c) The reasons and duration of seclusion and restraint and the treatment given to ensure speedy termination of these procedures, should be entered in the patients' clinical records by the mental health professional authorizing these procedures.**
- **Records of all seclusion and restraint should be recorded in a register, which is accessible to a review body.**
- **Patients' family members and/or their personal representatives may need to be immediately informed when patients are subjected to seclusion or restraint.**

ICCPR: Clinical and experimental research

No one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subject without his free consent to medical or scientific experimentation.

(Article 7, International Covenant on Civil and Political Rights (ICCPR))

Article 7 of the ICCPR (1966) prohibits clinical and experimental research without informed consent. This Article is an important part of the ICCPR and has been designated as one of the provisions that is non-derogable; it can never be limited even under conditions of national emergency. The UN Human Rights Committee has made it clear that "Article 7 (of the ICCPR) allows no limitation … no justification or extenuating circumstances may be invoked to excuse a violation of Article 7 for any reasons". Article 7 therefore prohibits research on subjects who lack the capacity to consent.

On the other hand, MI Principle 11 states that, "clinical trials and experimental research shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose".

The *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, prepared by the Council for International Organizations of Medical Sciences (CIOMS, 2002), allows biomedical research with proxy consent, or consent from a properly authorized representative, involving individuals who are incapable of giving informed consent. Where informed consent cannot be obtained, an ethics review committee should approve the permission (Guideline 4). Guideline 15 of the CIOMS guidelines (2002) specifically outlines criteria to be fulfilled when conducting research involving persons with mental disorders (see box below).

CIOMS Guidelines: Research

Research involving individuals who by reason of mental or behavioural disorders are not capable of giving adequately informed consent

Before undertaking research involving individuals who by reason of mental or behavioural disorders are not capable of giving adequately informed consent, the investigator must ensure that:

- **such persons will not be subjects of research that might equally well be carried out on persons whose capacity to give adequately informed consent is not impaired;**
- **the purpose of the research is to obtain knowledge relevant to the particular health needs of persons with mental or behavioural disorders;**
- **the consent of each subject has been obtained to the extent of that person's capabilities, and a prospective subject's refusal to participate in research is always respected, unless, in exceptional circumstances, there is no reasonable medical alternative and local law permits overriding the objection; and**
- **in cases where prospective subjects lack capacity to consent, permission is obtained from a responsible family member or a legally authorized representative in accordance with applicable law.**

(Guideline 15, Research involving persons with mental and behavioural disorders, International Ethical Guidelines for Biomedical Research Involving Human Subjects, 2002)

The MI Principles and CIOMS Guidelines thus allow research involving persons who are lacking capacity to consent if: i) the research is necessary to promote the health of the population represented; ii) this research cannot instead be performed on persons who have the capacity to consent; and iii) adequate procedural safeguards are followed.

It has been argued that although the ICCPR is legally binding on the governments that have ratified it, whereas the CIOMS Guidelines and the MI Principles are not, in certain circumstances it could be advantageous for people affected by particular conditions to allow research or experimentation without consent, where this involves minimal risk of harm to the person; for example, people with conditions (whether current or likely to present in the future) where *all* affected are unable, due to their condition, to give informed consent. In such circumstances, the consequence of not undertaking research with this group may be a reduced likelihood of ever finding treatments or interventions that could cure or prevent the condition.

If countries do decide to legislate in favour of research or experimentation involving persons unable to give informed consent, the CIOMS guidelines should be carefully followed.

Clinical & experimental research: Key issues

- **Informed consent for participation in clinical or experimental research must be obtained from all patients who have the capacity to consent. This is applicable to both voluntary and involuntary patients.**

In countries where clinical and experimental research is permitted with patients who are unable to consent, legislation should include the following safeguards:

1. **When patients are lacking capacity to give informed consent, they may participate in clinical and experimental research, provided that proxy consent is obtained from legally appointed guardians and/or family members and/or personal representatives, or by obtaining consent from an independent review body specifically constituted for this purpose.**
2. **Participation of patients who are lacking capacity to consent, by obtaining consent from proxies or an independent review body, should only be considered when:**
   - **a) this research cannot be performed on patients who are capable of giving consent;**
   - **b) the research is necessary to promote the health of the individual patient and the population represented;**
   - **c) adequate procedural safeguards are followed.**

13. Oversight and review mechanisms

Most modern mental health legislation contains statutory safeguards providing for the creation of review bodies to protect the human rights of persons with mental disorders. Such bodies fall into two broad categories: (i) oversight and review of the processes regarding people who are admitted/treated involuntarily; and (ii) oversight and review of the well-being of people with mental disorders, within and outside mental health facilities. The former is a judicial or quasi-judicial function. The latter, although it may be provided in law, and penalties for not carrying out its instructions enforced in some instances, does not operate as a "court" that can impose restrictions on the liberty of individuals or decide that involuntary patients should be discharged, for example. In many countries these two bodies are completely independent of each other, have members with different expertise and have unique powers and functions; however, in other countries one body may be legislated to carry out the full range of functions.

Whether one or two bodies are set up, independence is crucial. All review bodies should make decisions purely on the merits of the situation before them, and should not be influenced by political or departmental pressures or by health service providers.

Legislation should make provision for the composition, powers and resources of these authoritative bodies. It is also necessary to decide whether to have a body with national jurisdiction or to have a number of review bodies functioning at local, district or regional levels based on existing administrative boundaries.

13.1 Judicial or quasi-judicial oversight of involuntary admission/treatment and other restrictions of rights

Most countries employ an independent authority such as a review body, tribunal or court to sanction involuntary admission and treatment based on medical/psychiatric/professional expertise. This is an important function since, although the examining accredited health professional decides whether a person meets the criteria for involuntary admission/treatment, it is generally the prerogative of a judicial or quasi-judicial authority to rule on whether persons can be admitted/treated against their will. In many jurisdictions, courts are the preferred option to carry out this function due to their easy accessibility and unambiguous legal status. However, the position of the courts in a number of countries has been questioned, as some have merely become a "rubber stamp" for the medical decision. Judges or magistrates often make their decisions in the absence of the patient, their representative or witnesses, and confirm the medical recommendation without applying independent thought and analysis to the process.

An alternative to a court procedure is the establishment of an independent and impartial court-like body with a judicial function. Such a body is established by law to determine matters within its competence and to make binding decisions on such matters. The fact that it is specifically established for this purpose, and is comprised of specially selected members with expertise, is believed, in certain countries, to make this a more competent body for the purpose than a court.

The exact functions of this judicial or quasi-judicial body with regard to involuntary admission and treatment are likely to vary from country to country and may, in some jurisdictions, complement rather than replace the role of the court. The following, however, are important roles for such a body:

Assess each involuntary admission/treatment – Many legislative frameworks are categorical that every case of a person recommended for involuntary admission/treatment should appear before the review body. The persons concerned should be represented by a legal counsel and should be allowed the opportunity to state their position. They, as well as the authorities seeking involuntary admission/treatment, should call witnesses as required. The review body has the power to endorse or override, after careful consideration, any involuntary committal/treatment.

It has been argued that in countries with fewer resources it may not be possible for a review body to consider each case in person, and that a "paper review" may be conducted for some of the more straightforward cases. However, the review body would conduct hearings on all the more contentious cases, or where there is a particular reason for holding a full hearing.

Entertain appeals against involuntary admission and/or involuntary treatment from patients, families and/or personal representatives. As a basic human right, even in countries with fewer resources, all patients must be informed of their right to appeal, and all appeals must be heard within reasonable time frames (see Annex 8 for an example of an appeal form). The review body must have the right to overturn involuntary admission and treatment decisions that have come to it on appeal.

Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients) at periodic intervals to ensure that patients are not held in hospital for longer than is necessary for their protection and treatment. Review bodies may also be given the power to discharge a patient if they deem the patient to be wrongly held.

Regularly monitor patients receiving treatments against their will. Except in emergency situations, the review body should implement a procedure for authorizing or disallowing continued treatment of involuntary patients without their consent. The review body should also monitor involuntary treatment given in the community (for example, community supervision and treatment orders).

Authorize or prohibit intrusive and irreversible treatments such as all cases of psychosurgery and electroconvulsive therapy (ECT). Even though these treatments should be undertaken on a voluntary basis, a review body can, nevertheless, protect patients from unnecessary treatments, by sanctioning or prohibiting them after due consideration of the merits.

Where jurisdictions include non-protesting patients, the review body would also be required to carry out most of the above functions with this group of patients.

Appeals against the decisions of a review body should be allowed to go directly to the courts.

13.1.1 Composition

Countries will determine the composition and number of representatives of the quasi-judicial body based on the functions assigned to it and the availability of human and financial resources. Nonetheless, given the legal and health considerations that a quasi-judicial body has to deal with, it is probably advisable that, at the least, an experienced legal and an experienced health professional be appointed. In addition, at least one "non-professional" person may need to be represented to reflect a "community" perspective. In view of the gravity of the decisions that the body will be making, respected individuals with "wisdom" would also seem appropriate.

Example: Review body composition

In New South Wales (Australia) the members of the Mental Health Review Tribunal are to be appointed from:

- **a) barristers and solicitors;**
- **b) psychiatrists;**
- **c) persons having, in the opinion of the Governor, other suitable qualifications or experience, including at least one person selected from a group of persons who are nominated by consumer organizations.**

(New South Wales Mental Health Act 1990)

13.2 Regulation and oversight body

A number of oversight and regulatory tasks are required to promote the human rights of people with mental disorder. These might include the following:

Conduct regular inspections of mental health facilities – The independent body may undertake regular inspections of all mental health facilities at periodic intervals, and conduct additional visits, as deemed necessary, without any prior notice (sometimes called a visiting board). During such visits, it should have unrestricted access to all parts of the health facility and patients' medical records as well as the right to interview any patient in the facility in private. During such visits, representatives need to inspect the quality of living facilities as well as the documentation in medical records, and also personally interview voluntary as well as involuntary patients admitted to the facility. Such visits provide the review body and its representatives with the necessary means to satisfy requirements that persons within the facility are receiving the treatment and care they need, that their human rights are not being violated, and that the mental health facilities are implementing the safeguards contained in mental health legislation. Legislation should lay down the procedures to be followed and the penalties if violations are found.

Periodically receive and review copies of unusual incident reports and death records from mental health facilities to permit review of institutional practices.

Guidance on minimizing intrusive treatments, such as seclusion and restraint – The review body should establish guidelines for authorizing such procedures and ensure that the guidelines are being followed. This protection must be available to both involuntary and voluntary patients.

Maintain statistics on, for example, the percentage of patients admitted and treated involuntarily, the duration of involuntary admission and involuntary treatments, use of intrusive and irreversible treatments, seclusion and restraints, physical comorbidities (especially epidemics that could be indicative of poor hygienic or nutritional conditions in the institution), suicide, and natural or accidental deaths.

Maintain registers of facilities and professionals accredited for admission and treatment of those with mental disorders, and outline and enforce minimum necessary standards for such accreditation.

Report directly to the appropriate government minister(s) with responsibility for mental health legislation.

Make recommendations to the minister(s) with regard to improvements required, either through amendments to the legislation or to the code of practice.

Publish the findings on a regular basis as specified by the legislation.

13.2.1 Composition

To provide effective protection, a minimum composition may include professionals (e.g. in mental health, legal and social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates, and lay persons. In some countries it may be appropriate for religious authorities also to be given representation. Women and minority groups should receive adequate representation. The number of persons serving on the oversight and regulations body, and the breadth of representation, will largely depend on the resources available. In a combined approach, adequate representation from both the quasi-judicial and regulation and oversight bodies would need to be accommodated.

13.2.2 Additional powers

The mental health review body/bodies should have statutory powers to enforce compliance with the provisions of mental health legislation. In addition to those described above these powers may include:
- granting accreditation to professionals and mental health facilities (although professional accreditation may alternatively lie with statutory professional councils);
- the power to withdraw accreditation from facilities and professionals for non-compliance with legislation;
- the power to impose administrative and financial penalties for violations of legislative norms; and
- the power to close facilities which persistently violate human rights of persons with mental disorders.

13.3 Complaints and remedies

Patients as well as their family members and personal representatives should have the right to complain about any aspect of care and treatment provided by mental health services.

To ensure the protection of users' rights, while at the same time being fair to service providers, a complaints procedure should be based on a set of guiding principles. These may differ from one situation to the next, but some of the most important values are:
- consultation with increased openness and transparency
- quality enhancement
- impartiality
- accessibility
- speed and responsiveness
- courtesy
- accountability

- confidentiality
- independent advocacy
- humane care and treatment
- transparent process.

Legislation should outline the procedure for submission, investigation and resolution of complaints. An effective complaints procedure should be written in simple language and be prominently displayed so that mental health care users or their families are informed of its relevance, applicability, and how and where to lodge a complaint. The procedure should define the time from the occurrence of the incident within which a complaint can be made, and specify a maximum period within which the complaint must be responded to, by whom and how. In the event of a user not being satisfied with the outcome of a grievance, the complaints procedure should also specify the next or higher level to which the matter can be referred. An initial complaint, ideally, should first be made to the health facility, and if unresolved, to the oversight body.

It may be appropriate to appoint an ombudsperson with the authority to receive and investigate complaints against mental health services. If appointed, that person should forward a report of its investigations, along with recommendations, to the oversight body for appropriate action, and penalties if necessary. The review body should set in place a procedure to prevent retribution against patients filing complaints.

13.4 Procedural safeguards

Patients should have the right to choose and appoint a personal representative and/or a legal counsel to represent them in any appeals or complaints procedure. Patients should also have access to the services of an interpreter if necessary. The State should pay for the services of such counsel and/or interpreter for patients who do not have the financial means to pay for such services.

Patients (and their counsel) should have the right to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedure. They should also have the right to request and produce an independent mental health report and any other relevant reports, as well as oral, written or other evidence during the complaints or appeals procedure. In addition, patients and their counsel should have the right to request that a particular person be present at a complaints or appeals procedure, if that presence is deemed relevant and necessary.

Patients and their counsel should have the right to attend and participate in all complaints and appeals hearings. The decisions arising out of the hearings should be expressed in writing and copies given to patients and their counsel. When publicizing the decisions of the complaints or appeals hearings, due consideration should be given to respecting the privacy of the patient and other persons, and to the need for preventing serious harm to the patient's health or putting the safety of others at risk. Additionally, patients and their counsel should have the right to judicial review of such decisions.

Review bodies: Key issues

An independent review body (or bodies) should be set up to protect the human rights of persons with mental disorders. Countries may have separate bodies dealing with quasi-judicial and other regulatory and oversight issues, or a combined structure.

- **The functions of the quasi-judicial body with respect to involuntary admission/treatment or other patients admitted or receiving treatment without consent should include assessing each involuntary admission/treatment, entertaining appeals, reviewing the cases of patients admitted on an involuntary basis at periodic intervals, regularly monitoring patients receiving treatments against their will, and authorizing or prohibiting intrusive and irreversible treatments.**

- **Functions of a regulatory and oversight body may include conducting regular inspection of mental health facilities; regular monitoring of patients' welfare and well-being; providing guidance on minimizing intrusive treatments; keeping records and statistics; maintaining registers of accredited facilities and professionals; publishing reports; and making recommendations directly to the relevant minister regarding their findings.**

- **The composition of review bodies will depend on the functions assigned and on whether two separate bodies or a single body is chosen. A quasi-judicial body may consist of at least one legal and one health practitioner as well as an appropriate community representative. A regulatory and sanctioning body may include professionals (mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons.**

- **The mental health review body should have statutory powers to enforce compliance with the provisions of mental health legislation.**

- **Appeals against the decisions of a review body should be allowed to be made directly to the courts.**

- **Patients as well as their family members, personal representatives and advocates should have the right to complain to the review body about any aspect of care and treatment provided by mental health services.**

- **Legislation should outline the procedure for submission, investigation and resolution of complaints.**

- **Patients should have the right to choose and appoint a personal representative and/or a legal counsel to represent them in any appeals or complaints procedure. They should also have the right to access copies of their records and to attend and participate in hearings.**

14. Police responsibilities with respect to persons with mental disorders

Legislation can assist in ensuring a constructive and helpful role for the police with respect to people with mental disorders.

14.1 Powers of the police

The police have a primary responsibility for maintaining public order. At the same time, they also have a duty to protect and respect the rights of persons who are vulnerable on account of a mental disorder, and to act in a caring and compassionate manner. Legislation often requires the police to intervene in situations where the behaviour of persons with mental disorders represents a danger to themselves or to the public. Examples of such situations include the following:

- Entering private premises, arresting a person and taking that person to a place of safety when there are reasonable grounds to suspect that person represents a danger to self or others. In this case, the police should obtain a warrant prior to entering the premises. In an emergency, where the health and safety of the individual and/or those around him/her are at risk unless immediate action is taken, provision may be made in legislation for the police to act without a warrant.

- Taking a person subject to involuntary admission to a designated mental health facility. For example, this would apply to a person who needs to be taken to a mental health facility following an assessment by a mental health professional in a hospital emergency room that he/she requires involuntary admission. Another example is a person on conditional release who fails to observe the conditions of the release and thus may need to be taken back to a mental health facility.

- Taking an involuntary patient absent without leave from a mental health facility, back to that facility.

14.2 Responding to calls for assistance

In emergency situations, family members or carers sometimes witness and/or are caught in highly aggressive or out-of-control behaviour. Legislation should allow them the possibility to alert the police to the situation so that the police can intervene if necessary. In such a situation, the police should have discretion to decide whether or not there is immediate and imminent danger, and whether the person may be acting in this manner due to a mental disorder. In this situation, police or emergency personnel must also have quick access to a mental health professional service for advice.

Health professionals or others working in health facilities may also require the assistance of the police in certain circumstances. In these situations, the police would not have discretion to evaluate whether or not the person has a mental disorder.

14.3 Protections for persons with mental disorders

Legislation may place restrictions on the activities of the police to ensure protection against unlawful arrest and detention of persons with mental disorders. These include the following:

14.3.1 Place of safety

If a person is picked up by the police for causing public disorder that is suspected to be related to that person's mental health, police powers may be restricted to taking the person to a place of safety for an assessment of that person's condition by a qualified mental health practitioner. However, if the person is a known psychiatric patient, and does not appear to need treatment and care, the police may simply return the person to his or her home.

A "place of safety" could include a designated mental health facility, a private place (e.g. a psychiatrist's office) or other secure location. The police do not have the legal authority to detain the person in a prison facility (or in police custody) under these circumstances. However, where it is impossible to immediately take the person to a place of safety, such as may occur in some developing countries, the legislation should determine a short time frame in which the police may retain custody of a person suspected of having a mental disorder. Once the police have taken the person to a place of safety for assessment, the person is no longer considered to be in police custody and cannot be subsequently detained. Problems may occur with police powers of this type if the place of safety cannot (or will not) take the person in for assessment (e.g. because the place of safety does not have appropriate personnel available to conduct the assessment or does not have room for the person). Clearly, such situations indicate the need for the health sector to provide sufficient resources for mental health services. (see Chapter 2 subsection 4.1)

If a person has been arrested for a criminal act, and the police have a reasonable suspicion that the person suffers from a mental disorder, such a person should be taken to a place of safety for assessment by a mental health professional. In situations where a person represents a danger to himself/herself or to others, he/she should be taken to a secure mental health facility for assessment. Following assessment, if no mental disorder is detected, the police would have the power to take the person back into detention or custody, if appropriate.

14.3.2 Treatment options

Following the mental health assessment, if the person is deemed to require treatment he/she should be offered the opportunity to enter a programme (as an inpatient or outpatient, as appropriate). The full implications of his/her condition and the advantages and disadvantages of different treatment options should be explained to the patient. If the person refuses admission/treatment, he/she must be discharged unless the criteria for involuntary admission/treatment (described above) are met – in which case the relevant processes should be followed. Whether a person has been brought in by the police, a family member or anyone

else, the due procedures for involuntary admission and treatment should be observed (see subsection 8.3 above).

14.3.3 Detention period

The period of holding a person for an assessment should not be excessive. Legislation can mandate procedures requiring an assessment within a specified time period (e.g. 24–72 hours). If the assessment has not occurred by the end this period, the person should be released.

14.3.4 Prompt notification

The police should promptly inform persons who are detained in their custody prior to being sent for an assessment as to why they are being detained and what will be happening to them. Under certain circumstances, a family member or other designated representative may also be notified of such a detention, with consent from the detainee.

14.3.5 Review of records

Records of all incidents in which a person has been held on suspicion of mental disorder may be passed on to a review body or independent monitoring authority (see section 13 above).

Police responsibilities and duties: Key issues

There are several situations when the police will have cause to interact with people with mental disorders and mental health services. In each case, the police are duty-bound to respect and protect the rights of people with mental disorders, and to act in a caring and compassionate manner.

a) ***In public places*** **– If the police have reasonable grounds to suspect mental disorder in a person arrested for causing public disorder, the law may require the police to take the person to a place of safety for assessment by a mental health professional. Assessment must be completed expeditiously (e.g. within 24–72 hours of the initial detention).**

b) ***In private premises*** **– Police should obtain a warrant issued by a court for entry into private premises and detention of any person suffering from a severe mental disorder who is likely to cause significant harm to self or others. A family member or an independent authority such as a social worker may request a warrant from the court. Persons detained in this way should immediately be taken to a place of safety for assessment by a mental health professional. Assessment must be completed expeditiously (e.g. within 24–72 hours of the initial detention). The police may need to bypass the warrant requirement under very urgent circumstances, where there is imminent danger and immediate police action is necessary.**

c) ***Persons arrested for criminal acts and in police custody*** **– If the police have reasonable grounds to suspect a person who has been arrested for criminal acts of having a mental disorder, legislation may require the police to take such a person to a place of safety for assessment by a mental health professional. In that case, the police would continue to have the power to detain such a person after his/her removal to a place of safety.**

d) ***Persons admitted involuntarily to a mental health facility*** **– The police have a duty to take to a designated mental health facility any person who has been involuntarily admitted to a mental health facility by due process of law. This would apply, for example, to a person found to require involuntary admission after assessment by a mental health professional in a hospital emergency room, or a person requiring involuntary admission to a mental health facility due to failure to comply with conditional release requirements.**

e) ***Persons admitted involuntarily who are absent without leave from a mental health facility*** **– The police have a duty to find and return such persons to the mental health facility from where they have been absent without leave.**

15. Legislative provisions relating to mentally ill offenders

Legislative provisions relating to mentally ill offenders are a highly complex area covering both the criminal justice and forensic mental health systems. There are wide variations in policy and practice in different countries, and forensic mental health is often part of the criminal code (or criminal procedure) rather than of mental health law.

The criminal justice system is charged with protecting the public, punishing criminals, and administering the laws in a fair and just manner. Police, prosecutors and the courts should conduct themselves in a way that protects the rights, not only of the victims of crime but also of particularly vulnerable populations, including persons with mental disorders. One important goal of the criminal justice system should be to ensure that no one with a mental disorder is inappropriately held in police custody or in a prison. At present, this goal is not often achieved. Far too many people with mental disorders are prosecuted and imprisoned, often for relatively minor offences. There is increasing worldwide concern about people with mental disorders being incarcerated in prisons, rather than being cared for in mental health facilities. In some countries, there are as many individuals with schizophrenia in prison as there are in all the hospitals (Torrey, 1995).

The large numbers of persons with mental disorders incarcerated in prisons is a by-product of, among other things, unavailability or reduced availability of public mental health facilities, implementation of laws criminalizing nuisance behaviour, the widespread misconception that all people with mental disorders are dangerous, and an intolerance in society of difficult or disturbing behaviour. Furthermore, some countries lack legal traditions that promote treatment (as opposed to punishment) for offenders with a mental disorder.

Prisons are the wrong place for people in need of mental health treatment, since the criminal justice system emphasizes deterrence and punishment rather than treatment and care. Where correctional facilities do emphasize rehabilitation, they are usually inappropriately equipped to assist people with mental disorders. Unfortunately, prisons have become de facto mental hospitals in a number of countries. Prisoners with severe mental disorders are often victimized, intentionally or unintentionally.

Mental health legislation can help to prevent and reverse this trend by diverting people with mental disorders from the criminal justice system to the mental health care system. Legislation should allow for such a diversion at all stages of the criminal proceedings – from the time a person is first arrested and detained by the police, throughout the course of the criminal investigations and proceedings, and even after the person has begun serving a sentence for a criminal offence.

Legislation can play an important role at various stages of the criminal proceedings. As mentioned earlier (section 14 above), where minor "crimes" such as public disturbance are committed by people suspected of having a mental disorder, it is preferable for the police to immediately take such persons to treatment centres rather than have them subject to criminal proceedings.

Laws governing mentally ill offenders – often part of criminal procedure rather than mental health legislation – vary considerably among countries. The following section should thus be read in close conjunction with existing legal processes in a country, and be adapted and adopted accordingly. What never varies, however, is the principle that people with mental disorders should be in appropriate facilities where suitable treatment is available.

The following are the different "stages" at which an arrested person can be diverted towards mental health admission and treatment as found in different legislative statutes.

- Pre-trial stage
- Trial stage
- Post-trial (sentencing) stage
- Post-sentencing (serving sentence in prison) stage

As mentioned, not all of these stages exist in all countries and variations do occur. Countries should adopt whatever is most appropriate for their circumstances.

15.1 The pre-trial stages in the criminal justice system

15.1.1 The decision to prosecute

In most countries, the police and/or prosecutors decide whether to prosecute a person for a particular offence. Legislation or administrative regulations can specify criteria for making decisions about whether – or in what circumstances – a person with a mental disorder will be prosecuted or diverted to the mental health system. These criteria should create a presumption against prosecution and in favour of treatment. The following factors should be taken into account:

- the gravity of the offence;
- if the person has previously been under psychiatric treatment, and for how long; for example, if a person has a treatable mental disorder, prosecutors may decide that continued treatment is preferable to prosecution;
- the person's mental state at the time of the offence;
- the person's current mental state;
- the likelihood of harm to the person's mental health as a result of prosecution;
- the interest of the community in pursuing a prosecution (i.e. the risk posed by the person to the community).

By foregoing prosecution in favour of voluntary treatment for persons with mental disorders who do not pose a serious public safety risk, the police and prosecutors can benefit the individual and society. Persons with mental disorders would not be subjected to unnecessary stigma, and they could begin necessary treatment immediately instead of being trapped in the criminal justice system.

15.2 The trial stage in the criminal justice system

Once a decision has been made to proceed with criminal charges, there are two processes applicable to a person with a mental disorder. The first is if the person is unfit to stand trial and the second is if the person cannot be held criminally responsible for his/her actions at the time of committing the offence. In some cases there can be an overlap, in that the person who suffered from a mental disorder at the time of the offence remains so to the time of trial.

15.2.1 Fitness to stand trial

The law in most countries requires that a person be physically and mentally fit to stand trial. Generally, mental fitness is measured according to whether the person is able to (i) understand the nature and object of the legal proceedings; (ii) understand the possible consequences of the proceedings; and (iii) communicate effectively with legal counsel.

If a decision is made to prosecute a person, and there are reasonable grounds to suspect that the accused may suffer from a mental disorder, the court must request a mental health assessment by a qualified mental health professional, usually, but not always, a psychiatrist. Often this takes place before the trial starts, but it can take place at any point during the trial. Preferably, the assessment should take place at a designated mental health facility or other place of safety pursuant to a court order. The maximum length of time in which a psychiatric observation should take place should be specified, in order to ensure that the person is not detained unnecessarily and that the trial is not unreasonably delayed. A number of countries specify a limit of 30 days. If a person is subsequently found unfit to stand trial by virtue of a severe mental disorder, criminal proceedings may not commence until the person regains fitness. In such cases, the law should empower the court to transfer the person to a mental health facility for treatment. Moreover, such a person should have the right to appeal against any continued confinement.

For minor offences, the court could dismiss or stay the criminal charge while the person completes inpatient or outpatient treatment. For example, dismissal or suspension of the criminal charge would be desirable if the accused is clearly in need of treatment by virtue of a severe mental disorder, and does not represent a danger to self or others. When the offence is serious and/or the accused represents a danger to self or others, the court may order admission to a designated mental health facility for treatment.

Safeguards need to be in place to protect the rights of persons with mental disorders so that they do not languish in mental health facilities for longer than is necessary. Legislation should make provisions for regular review of the individual's placement by the court, for example by asking for a regular psychiatric report. Furthermore, all persons accused of criminal charges who are detained in a mental health facility pending their trial have the same rights, procedures and safeguards as persons who have been admitted involuntarily. Accordingly, they must also have the right to seek judicial review of their detention by an independent review body such as a tribunal or court of law.

15.2.2 Defence of criminal responsibility (mental disorder at time of offence)

Countries around the world have legislation to determine the level of criminal responsibility attributable to an accused person. This legislation states that the mental condition of the accused at the time of the offence has a significant bearing on whether the accused will be subject to criminal responsibility.

A court may find that the accused could not have met the requirements to establish a guilty mind *(mens rea)*, if the accused is able to demonstrate that:

1. his/her mental faculties were impaired by virtue of a mental disorder at the time of the offence; and
2. such a disorder was severe enough to render the person partially or totally incapable of satisfying the elements required to establish criminal responsibility.

Legislation should stipulate that persons who did not have sufficient capacity at the time of the offence be admitted to an appropriate facility. This approach supports the goal of favouring treatment options over punishment for offenders in need of mental health care.

Under these circumstances, courts may find the accused to be "not responsible due to mental disability" (NRDMD).[1] This concept is familiar in many countries under varying terminology. Legislation can define the criteria necessary to obtain a NRDMD verdict.[2] Such a verdict should apply to any persons with a mental disorder serious enough to impair their reasoning, comprehension or self-control at the time the offence was committed. In the case of such a verdict, the court may decide to release the person back into the community or order admission/treatment. National legislation varies considerably with regard to such admissions and discharges. In some countries a person must be discharged unless the trial court or other judicial body finds that the person meets all of the criteria for involuntary admission and follows the appropriate procedural requirements to involuntarily commit the person. In other countries there may be a specific legal category (different from involuntary patients) for persons admitted on the grounds of NRDMD. For example, in Australia they are called forensic patients; in Mauritius, security patients; and in South Africa, State patients.

[1] The term NRDMD is analogous to other terms such as "not guilty by reason of insanity" (NGRI) used in some countries, and to a lesser extent "guilty but insane". NRDMD is a less stigmatizing term for the concept that persons do not have criminal responsibility for their actions because of the contributory role played by their mental distability. Some commentators believe that the "guilty but insane" verdict is punitive and unfair to persons with serious mental illness. It is also conceptually problematic because if the requisite criminal intent is not established, the person cannot logically de found "guilty".

[2] This definition should be broader than the insanity test under the McNaughten Rules. Many countries still employ the McNaughten Rules, which allow for defence on the grounds of a mental disorder only if the accused did not know what (s)he was doing when (s)he commited the offence, or if (s)he was aware of the act, but did not know that the act was wrong. However, many severely mentally ill people are able to comprehend that what they are doing is wrong, but their cognition is highly distorded due to a serious mental disorder. Therefore some have argued that even the most severely metally ill people are considered "sane" under the McNaughten Rules, so that in many systems they are sent to prison inappropiately. According to this argument, persons who can reason, but lack self-control due to a serious mental disorder, should be able to obtain a verdict of "not responsible due to a mental disability" (NRDMD).

Nonetheless, similar to other non-criminal persons with mental disorders, persons who are detained after a NRDMD verdict have the right to regular and periodic review of their detention and the right to receive appropriate treatment and care in a therapeutic environment. In addition, persons admitted because they were not criminally responsible may well have the capacity to make treatment decisions.

Sufficient improvement in the person's mental state should lead to release from detention. In some countries it may be permitted that a health practitioner discharge a person admitted as a mentally disordered offender. However, in other countries only a judge or other judicial authority can order such a discharge. It is important, however, that the patient, family members and others be allowed to make an application for discharge. For a specified period of time it may be reasonable to require a discharged person to follow community-based treatment with enforced compliance, on condition of returning to hospital if a relapse occurs or if the person is not adhering to the agreed treatment plan. However, enforced community-based treatment is likely to be subject to opposition from some user groups. Countries will have to make their own decisions concerning this issue.

15.3 Post-trial (sentencing) stage in the criminal justice system

In some countries, a person with a mental disorder may not have met the criteria of being unfit to stand trial or of being mentally disordered at the time of the offence, yet, having been found guilty by the court, they may still be diverted to the mental health care system during the sentencing stage. This can be achieved through non-custodial sentences (i.e. probation orders and community treatment orders), or through custodial sentences served in a mental health facility (i.e. hospital orders). The hospital order could refer to an open facility or to a more secure facility, depending on the risk posed to the public.

15.3.1 Probation orders and community treatment orders

Legislation should allow for and encourage the use of non-custodial sentences for minor offences by individuals with mental disorders as a substitute for incarceration in prison. Courts in some countries already have the authority to make probation orders or community treatment orders on the condition that such persons continue to be treated by mental health services. Community treatment orders (CTO) allow persons with mental disorders to live in the community subject to certain conditions, including that they:

- reside at a specified place;
- participate in treatment and rehabilitative activities including counselling, education and training;
- grant mental health professionals access to their homes;
- report regularly to a probation officer; and
- submit to involuntary psychiatric treatment, where appropriate.

15.3.2 Hospital orders

Hospital orders are another means of ensuring that a person who has been found guilty receives the necessary mental health treatment. Legislation that provides for a hospital order allows the court to send offenders with a mental disorder to a hospital for treatment in lieu of incarceration, if at the time of sentencing they need hospital care.

The hospital order should not be for a duration longer than the sentence would have been. If the court and the mental health professionals in the hospital feel that the person needs additional treatment after the sentence would have expired, they must justify continued hospitalization through normal involuntary admission procedures.

Offenders with mental disorders who are placed in a mental health facility, pursuant to a hospital order, have the same rights to periodic review by an independent review body (e.g. a tribunal or court of law) as all other involuntarily admitted patients.

15.4 The post-sentencing (serving sentence in prison) stage

At times, an accused may develop a mental disorder following incarceration. Legislation or administrative arrangements should contain provisions for adequate care and treatment of prisoners' mental disorders. The law must provide for transfer of prisoners with severe mental disorders to a mental health facility for treatment if they cannot be adequately treated within the prison. In many countries, prisons have specially designated hospital units where prisoners are transferred if they are deemed to be ill. A review body should monitor such units to ensure that the quality and availability of care are equivalent to services found in non-custodial mental health facilities. Legislation must also ensure that such hospital units are under the direct supervision of qualified mental health personnel, and not the prison authorities.

Prisoners placed in prison hospital units or transferred to other mental health facilities are entitled to protection of their rights, and should enjoy the same protections afforded to other persons with mental disorders. In particular, such offenders have the right to consent or refuse treatment. If involuntary treatment is deemed necessary, the proper procedures for authorization of involuntary treatment must be followed. Important rights include, among others, the right to be protected from inhuman and degrading treatment, and participation in research only with valid informed consent and protection of confidentiality. Any prisoners transferred from prison to a hospital and then back to prison should have the time spent in hospital counted as part of their sentence.

Furthermore, such prisoners can only be detained in the hospital for the duration of their sentence. On expiry of their sentence term, if further involuntary admission is justified by their mental state, they may only be detained under the civil provisions of the mental health legislation. In addition, prisoners in such treatment facilities have the same right to be considered for parole as they would if they were not under treatment for mental disorders. Appropriate information on their case and treatment might, in accordance with law, be made available to the parole authorities on a need-to-know basis or with the consent of the prisoner.

15.5 Facilities for mentally ill offenders

One of the difficulties in keeping mentally ill offenders out of prison is that many countries do not have appropriate facilities to house people regarded as "criminal and dangerous". As a result, those with mental disorders are not only forced to stay in prison, but also are deprived of the necessary treatment there. Provisions for secure mental health facilities may need to be legislated. Legislative criteria can identify the levels of security required for patients, and these levels should be reviewed regularly. In addition, no patient should stay in a hospital under a greater level of security than is necessary.

In summary, mental health legislation can and should provide a framework for treatment and support rather than punishment. Such a framework should also allow persons with mental disorders to be transferred from the criminal justice system to the mental health system at any stage. By implementing protections in the criminal justice system for people with mental disorders, and only incarcerating them under very rare circumstances, legislation can help to protect public safety and simultaneously provide for humane treatment of offenders with mental disorders, allowing them to receive appropriate care and rehabilitation.

The following web sites provide information on UN principles and rules concerning prisoners, including those who are mentally ill:
http://www.unhchr.ch/html/menu3/b/h_comp36.htm
http://www.unhchr.ch/html/menu3/b/h_comp34.htm

Mentally ill offenders: Key issues

The criminal justice system should prefer treatment to incarceration, where possible, for criminal offenders with mental disorders. The structure of the criminal justice system should allow for diversion of offenders to treatment programmes at all stages of the criminal trial process.

1. *Prosecution* – Prosecutors should consider the following factors when deciding whether to prosecute an individual with a mental disorder: the gravity of the offence; the person's psychiatric history, mental state at the time of the offence, and present mental state; the likelihood of detriment to the person's health; and the community interest in prosecution.

2. *Trial stage:*
   a) Fitness to stand trial – The law requires the mentally fit to stand trial. The ability of the accused to understand the legal proceedings and the consequences of the proceedings, and to communicate effectively with counsel need to be assessed. A person found to be unfit for trial might have charges dropped or stayed while he/she undergoes treatment. Persons detained in a mental health facility pending their trial have the same rights as other people subject to involuntary admission, including the right to judicial review by an independent review body.

   b) Defence for criminal responsibility – Persons found to have inadequate capacity at the time of the offence should be treated rather than incarcerated. Most courts allow a defence of "not responsible due to mental disability" (NRDMD) if the person's reasoning, comprehension or self-control were impaired at the time of the offence. A person found to be NRDMD might be released once the mental disorder sufficiently improves.

3. *Post-trial (sentencing) stage*:
   a) Probation orders – Persons with mental disorders may receive treatment through non-custodial probation orders and community treatment orders, which allow treatment in the community under certain conditions. A person who does not fulfil the designated conditions may be recalled to a custodial facility to complete treatment.
   b) Hospital orders – Treatment may be offered through a hospital order (i.e. a custodial sentence served in a mental health facility). A person subject to a hospital order may not be detained for treatment for a period longer than what would have been imposed by the sentence, unless subsequent involuntary admission procedures are followed. Persons subject to hospital orders have a right to periodic review of their detention by an independent review body.

4. *Post-sentencing (serving sentence in prison) stage:*
   a) Transfer of prisoners – A person who develops a mental disorder after incarceration may be transferred to a prison hospital unit or another secure mental health facility to receive mental health treatment. Prisoners so transferred have rights similar to other involuntarily confined persons, such as the right to consent to treatment, to confidentiality and to be protected from inhuman and degrading treatment. Prisoners also have the right to be considered for parole. A prisoner may not be detained for treatment for a period longer than the sentence that would have been imposed, unless subsequent involuntary admission procedures are followed.

Facilities for mentally ill offenders
Provisions for secure mental health facilities may need to be legislated. Legislative criteria can identify the levels of security required for patients, and these levels should be reviewed regularly. No patient should stay in a hospital at a greater level of security than is necessary.

16. Additional substantive provisions affecting mental health

The welfare and well-being of people with mental disorders will be significantly enhanced by legislation that addresses the issues already discussed in this chapter: access; rights; voluntary and involuntary mental health care; review mechanisms and provisions related to mentally ill offenders. In addition, there are a number of other areas that are equally important in furthering mental health and well-being that can be effectively legislated, but which have been neglected historically. However, it is not possible to cover every issue in this Resource Book, and to discuss the full complexity of each point, but the following are pointers to areas that may be included in national legislation. In many countries these may be contained in legislation other than a specific mental health law.

16.1 Anti-discrimination legislation

Legislation should protect people with mental disorders from discrimination. In many instances, countries have antidiscrimination, and even affirmative action, legislation for the protection of vulnerable populations, minorities and underprivileged groups. Such legislation can also be made applicable to persons with mental disorders by specifically including them as beneficiaries in the statute. Alternatively, if general antidiscrimination legislation does not provide them with adequate protection, antidiscrimination provisions for people with mental disorders can be specifically included in mental health legislation. For example, in some countries people with mental disorders are not allowed to study in some schools, be in some public places, or travel in aeroplanes. Specific legislation may be required to rectify this.

As another legislative alternative, if, for example, a country has a Bill of Rights or other rights document, it should specify the grounds on which it is unlawful to discriminate, and this should encompass people with mental disorders. The New Zealand Bill of Rights Act (1990) for example, prohibits discrimination on the grounds of disability among other things.

16.2 General health care

Persons with mental disorders may need legislative protection for their interaction with the general health care system, including access to treatment, quality of treatment offered, confidentiality, consent to treatment and access to information. Special clauses can be inserted into general health care legislation to emphasize the need for protection of vulnerable populations such as those with mental disorders and those who lack the capacity to make decisions for themselves.

16.3 Housing

Legislation could incorporate provisions for giving persons with mental disorders priority in State housing schemes and subsidized housing schemes. For example, the Finland Mental Health Act states, “In addition to adequate treatment and services, a person suffering from a mental illness or some other mental disorder must be provided with a service flat and subsidized accommodation appropriate to the necessary medical or social rehabilitation as separately decreed” (Mental Health Act, No. 1116, 1990, Finland).

Such provisions may not be possible in some countries, but, at the very least, people with mental disorders should not be discriminated against in the allocation of housing. Legislation can also mandate governments to establish a range of housing facilities such as halfway homes and long-stay supported homes. Legislation should include provisions to prevent geographical segregation of persons with mental disorders. This may require specific provisions in appropriate legislation to prevent discrimination in location and allocation of housing for persons with mental disorders.

16.4 Employment

Legislation could include provisions for the protection of persons with mental disorders from discrimination and exploitation in employment and equal employment opportunities. It could also promote reintegration into the workplace for people who have experienced a mental disorder, and ensure protection from dismissal from work solely on account of mental disorder. Legislation could also promote "reasonable accommodation" within the workplace, whereby employees with mental disorders are to be provided with a degree of flexibility in their working hours in order to be able to seek mental health treatment. For example, an employee could take time off to receive counselling and make up for that time later in the day.

The Rio Negro (Argentina) Act for the Promotion of Health Care and Social Services for Persons with Mental Illness (Act 2440, 1989) states that "the province shall ensure that appropriate measures to ensure access to work, which is a decisive factor in the recovery of persons with mental illness, are taken". It further decrees that a commission be established to examine the issue of work promotion, which will propose appropriate permanent measures to guarantee access to work for persons covered by the Act.

Laws can also contain provisions for establishing adequate funding of vocational rehabilitation programmes, provisions for preferential financing for income-generating activities by people with mental disorders residing in the community, and general affirmative action programmes to improve access to jobs and paid employment. Employment legislation can also provide protection to persons with mental disorders working in sheltered work schemes to ensure they are remunerated at a comparable rate to others and that there is no forced or coercive labour in such sheltered schemes.

Employment legislation that incorporates provisions concerning maternity leave, especially paid maternity leave, has proved effective as a health promotion tool in many countries. It allows new mothers to spend more time with their infants and facilitates the establishment of affective bonds, thus promoting good mental health for both infant and mother.

16.5 Social security

The payment of disability grants can represent a huge benefit for people with mental disorders, and should be encouraged through legislation. Where pensions are provided, disability pensions for persons with mental disorders should be paid at a similar rate as pensions granted to persons with physical disabilities. The social security legislation needs to be flexible enough to allow people with mental disorders to get back into employment, especially part-time employment, without losing the benefits of their disability pension.

16.6 Civil issues

Persons with mental disorders have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, The International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights.

Some of the key rights (often denied to people with mental disorders) that need to be protected are mentioned below. This is not an exhaustive list; it merely illustrates the wide range of rights that may need to be protected. However, some of these rights are subject to limitations based on a person's capacity at a given point in time.

- Right to vote
- Right to marry
- Right to have children and to maintain parental rights
- Right to own property

- Right to work and employment
- Right to education
- Right to freedom of movement and choice of residence
- Right to health
- Right to a fair trial and due process of law
- Right to sign cheques and engage in other financial transactions
- Right to religious freedom and practice

Additional substantive provisions relating to mental health: Key issues

There are a number of important areas of mental well-being that can be effectively legislated but which have been neglected historically. These include the following:

- **Legislation should protect people with mental disorders from discrimination.**
- **People with mental disorders may need legislative protection in their interaction with the general health care system, including access to treatment, quality of treatment offered, confidentiality, consent to treatment and access to information.**
- **Legislation can incorporate provisions for giving persons with mental disorders priority in State housing schemes and those granting subsidized housing.**
- **Legislation can mandate governments to establish a range of housing facilities such as halfway homes and long-stay, supported homes.**
- **Legislation can include provisions for the protection of people with mental disorders from discrimination and exploitation in employment and equal employment opportunities.**
- **Legislation can promote "reasonable accommodation" for employees with mental disorders, by providing them with a degree of flexibility in working hours, to enable them to seek mental health treatment.**
- **Employment legislation can provide protection to persons with mental disorders who are employed in sheltered work schemes to ensure that they are remunerated at a comparable rate to others, and that there is no forced or coercive labour in such sheltered schemes.**
- **Where pensions are provided, disability pensions for persons with mental disorders should be paid at a similar rate as pensions granted to persons with physical disabilities.**
- **People with mental disorders should retain the right to vote, to marry, to have children, to own property, to work and employment, to education, to freedom of movement and choice of residence, to health, to a fair trial and due process of law, to sign cheques and engage in other financial transactions, and to religious freedom and practice.**

17. Protections for vulnerable groups – minors, women, minorities and refugees

The need for specific legislation for minors, women, minorities and refugees affected by mental disorders would probably be unnecessary if practice showed that these vulnerable groups received adequate and nondiscriminatory treatment and services. However, in reality these groups are discriminated against and serious inequities do exist. The extent and form of these problems vary from country to country, and the specific issues that different countries need to address through legislation also differ. Nonetheless, no country is immune to discrimination against vulnerable groups, and thus some aspects of the following sections will be relevant for all countries.

17.1 Minors

Legislation protecting the human rights of children and adolescents should take account of their particular vulnerabilities. It should specifically aim to respect, protect and fulfil their rights, as laid out in the *UN Convention on the Rights of the Child* (1990) and other relevant international instruments.

In many countries there are no specialized mental health services for minors, and legislation can therefore play an important role in promoting the establishment of and access to such services.

Legislation should specifically discourage the involuntary admission of minors in mental health facilities. Hospitalization may be appropriate only when community-based alternatives are not available, are unlikely to be effective or have been tried and failed. If minors are placed in institutional settings, their living area must be separate from that of adults. The living environment in mental health facilities should be age-appropriate, and take into account the developmental needs of minors (e.g. provision of a play area, age-appropriate toys and recreational activities, access to schooling and education). While different countries will be able to fulfil these objectives to varying degrees, all countries should take positive steps towards realizing these objectives and consider allocating additional resources for this purpose.

Minors should have access to a personal representative to adequately represent their interests, especially when admitted to mental health facilities and throughout the course of such admission. In most instances, their personal representative would be a family member. However, where there is potential or real conflict of interest, there should be legal provisions for the appointment of another independent personal representative. In these cases, legislation may make the State responsible for remunerating such a personal representative.

Consent to treatment of minors also needs attention in legislation. Many jurisdictions use age (usually 18 years) as the sole criterion for determining a minor's right to consent or refuse consent. However, a significant number of minors, especially teenagers, have sufficient maturity and understanding to be able to consent or withhold consent. Legislation may contain provisions to encourage taking into consideration minors' opinions in consent issues, depending on their age and maturity.

Legislation may ban the use of irreversible treatment procedures on children, especially psychosurgery and sterilization.

17.2 Women

Stark gender inequalities and discrimination are a matter of fact in many societies around the world. Inequities and discriminatory practices can cause and exacerbate mental disorders in women. Women are often discriminated against in terms of access to mental health services for reasons such as lack of money and a perception of their lack of importance in society. Legislation may actively counter such inequalities and discrimination. *The Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), which defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination, represents a useful instrument to guide the development of legislation in this area.

Women who are admitted to mental health facilities should have adequate privacy. Legislation can ensure that all mental health facilities have separate sleeping facilities (single-sex wards) for women, and that such living facilities are of adequate quality and comparable to those provided to men. Legislation may also explicitly protect women from sexual abuse and physical exploitation by male patients and male employees of mental hospitals.

The post-partum period is a time of high risk of mental disorders for women. Treatment facilities for post-partum mental disorders should take into account the unique needs of post-partum women and provide adequate facilities for nursing mothers. In particular, if nursing mothers are admitted to a mental health facility they should not be separated from their infants. The mental health facility may have nursery facilities and skilled staff who can provide care to both mother and baby. Legislation can assist in achieving these goals.

Protection of confidentiality is of particular importance in societies where information concerning a woman can be used against her in some way. Legislation may specifically state that information regarding mental health matters in such situations is never released without the explicit consent of the woman concerned. Legislation should also encourage mental health professionals to take into account the pressures faced by women in many societies to consent to release information to family members.

In countries where women are detained in hospitals on social and cultural grounds it is necessary that legislation explicitly state the illegality of such a practice. Legislation should promote equal access to mental health services, including community-based treatment and rehabilitation facilities for women. Women should also have equal rights to men in relation to issues of involuntary admission and treatment. Legislation could insist that a review body undertake separate and specific monitoring of the proportion of women admitted involuntarily to mental health facilities in order to assess potential discrimination.

17.3 Minorities

Discrimination in the provision of mental health services to minorities takes many forms. For example:

- minorities may be denied access to community-based treatment facilities and be offered treatment in inpatient facilities instead;
- minorities have been found to have higher rates of involuntary admission;
- social and cultural norms of behaviour which may be different for minorities are sometimes interpreted as signs of mental disorders and lead to involuntary admission;
- minorities are more likely to receive involuntary treatment when in mental health facilities;
- the living environment of mental health facilities does not take into account the unique cultural and social needs of minorities;
- minorities with mental disorders are more likely to be arrested for minor behavioural problems leading to higher rates of contact with the criminal justice system.

Legislation may specifically provide protection against such discriminatory practices. For example, legislation could stipulate that a review body monitor involuntary admissions and involuntary treatment of minorities, ensure that accreditation criteria for mental health facilities include provision of culturally appropriate living environments, and monitor the provision of community-based treatment and rehabilitation services to minorities.

Example: Protecting the interests of women and minorities in Australia

To protect women and minorities, the Australian Mental Health Act states that the members of the Mental Health Tribunal "are to include 1 or more women and 1 or more persons of ethnic background".

(New South Wales Mental Health Act 1990)

17.4 Refugees

In some countries, refugees and asylum seekers often receive inappropriate treatment that causes or exacerbates mental disorders. However, they are not afforded the same mental health treatment as citizens of that country. This violates Article 12 of the ICESCR, which "recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

Legislation can stipulate that refugees are entitled to the same mental health treatment as citizens of the host country.

Protections for vulnerable groups: Key issues

- **Legislation protecting the human rights of children and adolescents should take account of their particular vulnerabilities.**
- **Legislation can promote the establishment of and access to specialized mental health services for minors.**
- **Legislation may actively discourage the involuntary admission of minors in mental health facilities.**

- **Minors must have access to a personal representative to adequately represent their interests, especially when admitted to mental health facilities, and throughout the course of such admission.**
- **Inequities and discriminatory practices can both cause and exacerbate mental disorders in women.**
- **Women should have separate sleeping facilities (single-sex wards), and their living facilities should be of adequate quality and comparable to the living facilities provided to men.**
- **In countries where women are detained in hospitals on social or cultural grounds, it is necessary that legislation explicitly state the illegality of such a practice.**
- **Legislation may specifically provide protection against discriminatory practices directed towards minorities. For example, legislation could stipulate that the review body must monitor involuntary admissions and involuntary treatment of minorities, and the provision of community-based treatment and rehabilitation services to minorities.**
- **Refugees should be afforded the same mental health treatment as citizens of the host country.**

18. Offences and penalties

A law is not written with the intention of prosecuting people who do not adhere to its provisions, but rather to guide and direct people in terms of what a (hopefully) democratically constituted legislature, after consultation and debate, has deemed necessary and appropriate for the country. When a law is transgressed, however, the criminal justice system of a country has the power to take actions to prosecute and punish offenders. This gives legislation a special position relative to, for example, a country's policy or strategic plans.

Like other issues that have been covered in this chapter, dealing with offences and penalties will vary from country to country. Nonetheless, in many countries, unless specific guidance is given in the law regarding the level and extent of penalties to be awarded for particular offences, the courts may be unable to act effectively when the law is transgressed. As a result, the law's potential to promote mental health may not be fully realized. The law should therefore specify the appropriate punishment for different offences, and may indicate the severity of penalties to be handed out for particular transgressions, taking account of the fact that not all transgressions are equally serious.

Examples: Offences and penalties

The following are illustrations of how different legislative systems provide for offences and penalties within their mental health law. These examples are for illustrative purposes only and it will be up to each individual country to determine the system for offences and penalties to be adopted for their national legislation.

Japan

In Japan, the law concerning the Mental Health and Welfare of the Mentally Disordered Person (Law 94, 1995) outlines a range of different penalties for various transgressions. For example:

- **A person to which any of the following items are applicable shall be punished with penal servitude for not more than three (3) years or a fine of not more than one million yen:**
  - **(i) a person who violates an order of discharge under paragraph 5 of Article 38.5;**
  - **(ii) a person who violates an order under paragraph 2 of Article 38.7;**
  - **(iii) a person who violates an order under paragraph 3 of Article 38.7.**

- **The administrator of a mental hospital, the designated physician, the member of the psychiatric review board [and various other people mentioned] shall be punished with penal servitude for not more than one year or a fine of not more than five thousand yen if he/she, without due cause, discloses a secret that has come to him/her in the course of execution of duties under this law.**

Kenya
The Mental Health Act (Act No 7, 1989) in Kenya lists a number of actions that are regarded as offences in terms of the Act. It then states:

> Any person who is guilty of an offence under this Act, or who contravenes any of the provisions of this Act or of any regulation made under this Act shall, where no other penalty is expressly provided, be liable on conviction to a fine not exceeding ten thousand shillings or to imprisonment for a term not exceeding twelve months or both.

Australia
In New South Wales, a system of "penalty units" is used. This precludes the need to regularly change every piece of legislation where a specific penalty is prescribed in order, for example, to keep up with inflation or other economic fluctuations. For instance, a maximum of 50 penalty units could be awarded for disclosure of information or refusing to obey or comply with an order, direction or decision of the review tribunal, a magistrate or the Psychosurgery Review Board, while a maximum penalty of 10 units is assessed for a person who operates a residential facility without a licence.

Chapter 3 Process: drafting, adopting and implementing mental health legislation

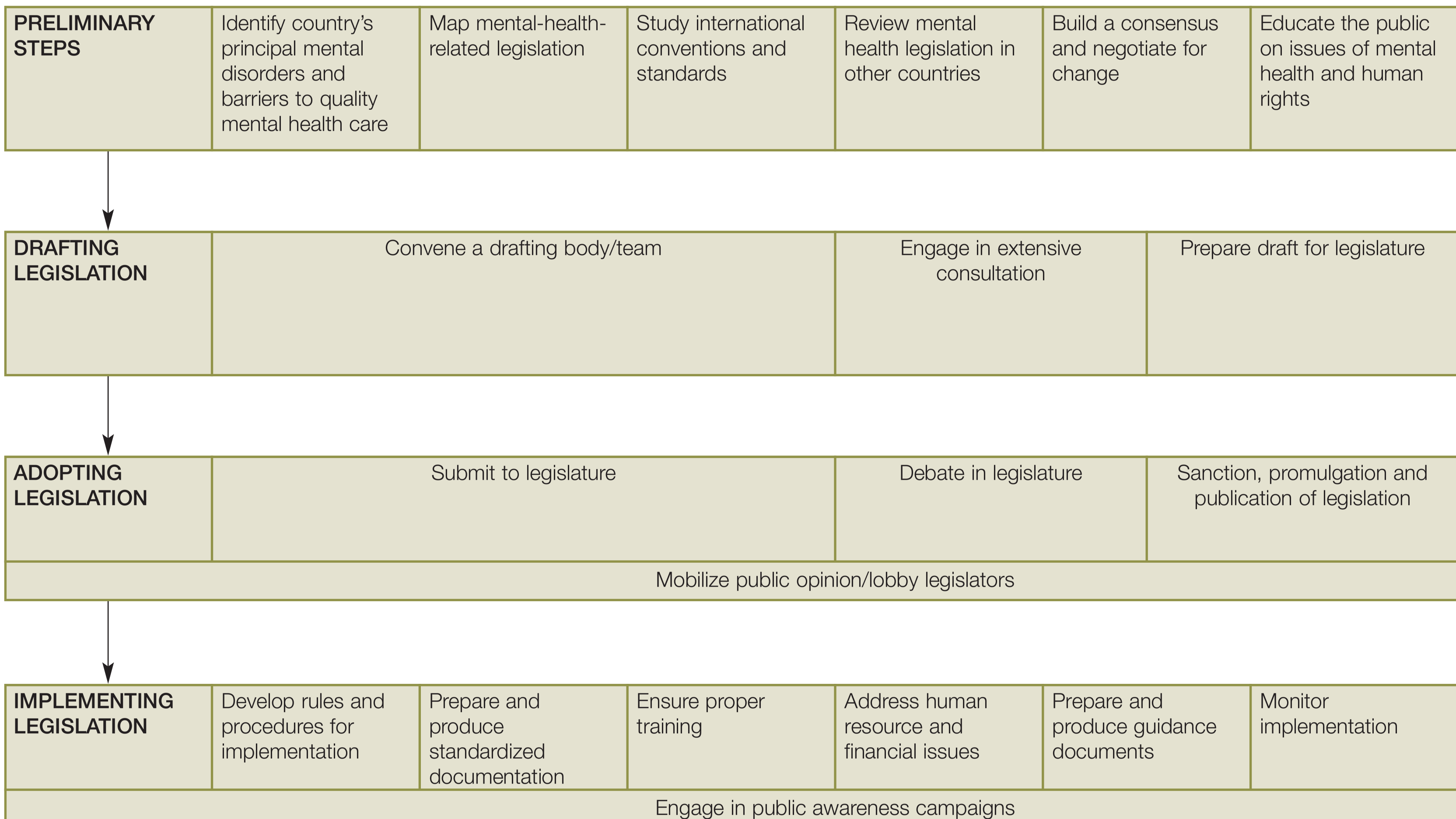
1. Introduction

This chapter covers the legislative process, starting from the drafting of mental health legislation to its effective implementation. The discussion focuses on the "how to" of mental health legislation relative to the "why" of Chapter 1 and the "what" (or content) of Chapter 2. It outlines the preliminary steps that may be taken by countries before embarking on the drafting process, as well as the steps for drafting, adopting and implementing mental health legislation. This chapter also provides country examples highlighting possible difficulties in – and solutions to – the process aspects of mental health legislation.

As with legislative content, the legislative process will depend on local norms and customs in countries for the drafting, adoption and implementation of legislation. Important practices are outlined and discussed here, but it should be pointed out that these are only guiding principles; each country will follow its own established legal processes and procedures.

Figure 2 outlines four stages that most countries will undertake in enacting legislation: preliminary steps, drafting legislation, adopting legislation and implementing legislation. This chapter discusses these steps.

Figure 2. Process of mental health legislation



2. Preliminary activities

Before embarking on drafting mental health legislation, there are a number of preliminary steps that can be useful in deciding the content of such legislation. These steps include:

1. Identifying the country's principal mental health needs and problems as well as existing and likely barriers to the implementation of mental health policies, plans and programmes.
2. Examining existing mental health law and/or identifying general laws that address mental health issues, looking at specific aspects that are lacking or in need of reform, and examining barriers and problems with respect to their implementation.
3. Studying those international human rights conventions and standards that include provisions related to mental health, and identifying governments' obligations for fulfilling the requirements of those instruments.
4. Studying components of mental health legislation in other countries, especially those with similar economic and political structures, and similar social and cultural backgrounds.
5. Building a consensus and negotiating for change.
6. Educating the public on issues of mental health and human rights.

In many countries it is the professionals in charge of mental health at the ministry of health who will have to initiate these preliminary activities. However, in some countries there are "law commissions" – or similar bodies whose mandate is to identify legal areas needing reform – that conduct necessary research and make recommendations for change. In other situations it is the legal unit within a ministry that is responsible for the development of all legislation.

In countries where user, family, advocacy or professional groups and organizations identify the need for mental health legislation (or a change to the existing law), it is incumbent upon them to advocate initiation of new legislation and explain why a law (or an amendment) is necessary.

Example: Initiating law reform in the Republic of Korea

In 1992 in the Republic of Korea, a group of young psychiatrists felt strongly about the need for an innovative mental health policy. They were strong advocates for human rights, deinstitutionalization and community-based mental health services. They interacted with government officials in the Ministry of Public Health and Welfare, and together they initiated the task of formulating a new mental health law. After two years of preparation and consultation, the Government completed a draft, which was presented to the National Assembly for deliberation. In December 1995, the new Mental Health Law was passed.

(Personal communication, Dr Tae-Yeon Hwang, Director, Department of Psychiatric Rehabilitation and Community Mental Health, WHO Collaborating Centre for Psychosocial Rehabilitation and Community Mental health, Yongin Mental Hospital)

2.1 Identifying mental disorders and barriers to mental health care

The first step is to obtain reliable information about mental disorders in the entire country, and variations in different regions and population groups (if these occur). The most reliable source of such information is community-based epidemiological studies. However, there is a paucity of good quality epidemiological data in many developing (and even in some developed) countries. When community-based epidemiological data is unavailable or unreliable, planners and policy-makers can collect information from other sources. For example:

a) Quantitative data from treatment settings can provide a rough estimate of the level of need for mental health services and prevalence of mental disorders. However, it is well known that only a small proportion of persons with mental disorders, and in need of mental health services, approach clinical services for help; but calculations can be done to estimate "true" prevalence (for further details, see Module on *Planning and Budgeting Services for Mental Health* (WHO, 2003a): http://www.who.int/mental_health/resources/policy_services/en/).

b) Qualitative information from focus group interviews and interviews with key informants can provide useful information at low cost (Arjonilla, Parada & Pelcastre, 2000).
c) In some cases, information obtained in one country can be applied to other countries with similar cultural and social characteristics.

It is also important to get a clear understanding of the barriers and obstacles to good quality mental health care. Legislation can be used to overcome or break down some of these barriers. The examples in the box below illustrate some of the barriers that can be tackled by legislative efforts, and identifies priority areas for legislation.

Examples of barriers and obstacles to good quality mental health care that legislation can help to overcome

- **A lack of mental health services in some areas or in the country as a whole.**
- **The cost of mental health care is unaffordable to many, and health insurance offers partial or no coverage for mental health treatments.**
- **The quality of care provided in mental hospitals is poor and the living conditions are inadequate, leading to human rights violations.**
- **Regulations and checks concerning involuntary admission and treatment are usually lacking, and this is often associated with loss of liberty.**
- **Stigma and discrimination associated with mental disorders negatively affect access to care, as well as the social integration of those suffering from mental disorders.**
- **Persons with mental disorders are denied basic civil, political, economic, social and cultural rights such as the right to social participation, cultural expression, voting, freedom of opinion, housing, employment and education.**
- **Mental disorders can affect people's ability to defend their own rights and to express their needs and interests.**
- **Some social conditions or cultural practices damage the mental health of some population groups.**
- **A lack of resources for mental health services and programmes.**

2.2 Mapping of mental-health-related legislation

Some countries have a long history of mental health legislation and mental-health-related legislation, while other countries may be developing such legislation for the first time. The "mapping" of existing legislation will therefore be very different. For countries with specific mental health laws, these laws will need to be carefully examined as a basis for new legislation. In addition, components of other laws, as they relate to mental health, need to be found and assessed. For countries with no specific mental health legislation, there are still likely to be laws that affect mental health which need to be identified and analysed.

Mapping of mental-health-related legislation is very helpful in providing an overview of the different laws that can contribute to achieving the objectives of mental health policies and programmes, and for assessing which laws may need to be changed. A systematic and critical review of existing legislation can help identify legal aspects that are lacking, or in need of reform, in order to protect the rights or ensure access to treatment of persons with mental disorders, as well as to facilitate promotion and prevention in the mental health field. Occasionally, it will be found that countries have adequate provisions in existing legislation, but that the problem really lies in their implementation. In these cases, there may be little need to alter, modify, amend or introduce new legislation.

The WHO Checklist on Mental Health Legislation, which is a companion to this Resource Book, is a useful tool that can be used to help determine the strengths and weaknesses of existing legislation and identify what provisions need to be considered for inclusion in a new law (see Annex 1).

Example: Mapping legislation in Samoa

In developing new mental health legislation in Samoa, 32 different Acts that were relevant to mental health were examined. These included the Citizenship Act (1972), Criminal Procedure Act (1972), Health Ordinance (1959), Komesina o sulufaiga (Ombudsman) Act (1988), Mental Health Ordinance 91961), Ministry of Women's' Affairs Act (1990), Pharmacy Act (1976) and Trustees Act (1975).

(WHO Mission Report, 2003)

2.3 Studying international conventions and standards

Countries that have ratified international human rights conventions have an obligation to protect, respect and fulfil the rights that are enshrined in those instruments through legislation, policy and other measures.

As discussed in Chapter 1, the *International Covenant on Civil and Political Rights* (ICCPR, 1966) and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR, 1966) represent two key international instruments that have been ratified by the majority of countries in the world. It is therefore important that these instruments be reviewed thoroughly when mental health legislation is being planned. Various international standards – though not legally binding – represent international consensus on accepted good practice standards, and provide a useful framework for developing and implementing legislation and policy on mental health. These include the *MI Principles, the Standard Rules, the Declaration of Caracas, the Declaration of Madrid* and the WHO *Mental Health Care Law: Ten Basic Principles* (see Chapter 1, sections 6 and 7).

2.4 Reviewing mental health legislation in other countries

Reviewing other countries' legislation related to mental health issues gives a good idea of the components generally included in legislation in different countries. While conducting such a review it is important to remember that many countries still have outdated legislation. The review should therefore focus on countries that have enacted progressive legislation that reflects international human rights standards and current knowledge in the area of mental health treatment and care. It should also critically examine the effect of legislation in improving the situation for those with mental disorders in those countries. Reasons for failure may include badly drafted legislation and implementation difficulties resulting from legislative provisions that do not take into account the practical realities in the country. A useful resource for accessing legislation from different countries is the *WHO International Digest of Health Legislation* (IDHL) online database (http://www.who.int/idhl).

An example of badly drafted legislation is a legislative provision that demands certification from at least two psychiatrists before compulsory admission to a hospital in countries where there are so few psychiatrists that this requirement is impossible to fulfil. Though the purpose of the provision is to provide adequate protection against compulsory admission, the result could be the opposite. In many cases, because the provision is impossible to carry out, it is simply ignored, and professionals and family members continue with existing and often inadequate practices for enforcing compulsory admission. In other instances, in seeking to comply with the law by trying to find two psychiatrists, a person who requires involuntary admission and treatment will receive no care; this can also be considered an abuse of human rights. A better option would be to demand certification by two mental health professionals at least one of whom must be a psychiatrist. Other mental health professionals could include psychiatric social workers, psychologists and psychiatric nurses, thus increasing the pool of mental health professionals available for certification and meeting the need for adequate protection of persons with mental disorders.

When examining another country's mental health law there may be social, economic and cultural variables or factors specific to that country. Certain provisions may therefore not be applicable in one's own country. For example, a country may restrict guardianship to members of a person's immediate family or refer to "the spouse" of a patient. This would be inappropriate in a country where an extended family has culturally determined rights with respect to a person or where polygamous marriages are allowed. Thus there may be a need to modify and adapt the provisions to suit the social, economic and cultural situation of that particular country.

Examples of obstacles and facilitating factors with respect to formulating mental health legislation

Obstacles	Facilitating factors
Tension between those in favour of an individual human-rights-based approach to legislation and those who emphasize public safety.	Formulating mental health law taking a needs-based approach (i.e. addressing user needs as well as the needs of society in general).
Tension between medical hegemony versus a human rights approach to legislation. That is, differences between people who believe that the medical professionals know what is best for a patient and those who believe the user knows best.	Formulating a mental health law from a user perspective, and through a participative process involving many sectors and disciplines.
Conflicts between those who favour mental health legislation solely concerning treatment and patients' rights and those who favour legislation relating also to promotion and prevention.	Appoint representatives from both interest groups to the drafting body.
Tension between the rights and responsibilities of families and the rights and responsibilities of users.	Workshops with representatives from families and user organizations to examine and discuss the key issues and interests of each group. Include both groups in the drafting body.
Resistance from psychiatrists who perceive provisions established in legislation and regulations as undermining clinical autonomy.	Seminars on patients' rights and medical ethics with the participation of experts in these areas.
Low priority to mental health legislation by government, parliament and sectors outside the health sector.	Empowerment of organizations of users, carers and other advocacy groups. Lobbying legislators and finding individual legislators who may be prepared to push for mental health legislation. For further details, see Module on *Advocacy for Mental Health* (WHO 2003b): http://www.who.int/mental_health/resources/policy_services/en/)
Resistance from the general public to human-rights-oriented legislation.	Information and education of the public.

The box above provides examples of certain obstacles and facilitating factors to the process of formulating mental health legislation. Each country will face particular obstacles specific to its situation and conditions, and the examples are by no means exhaustive.

2.5 Building a consensus and negotiating for change

The previous chapter provided guidance on the issues that should be included in new legislation and/or that should direct necessary amendments and modifications to existing legislation. However, a consensus needs to be built around these issues. The stakeholders include politicians and parliamentarians, policy-makers, government ministries (health, social welfare, law and finance), professionals (psychiatrists, psychologists, psychiatric nurses and social workers), family members of those with mental disorders, users and user groups, advocacy organizations, service providers, nongovernmental organizations, civil rights groups, religious organizations and congregations of particular communities. In some countries it may also be necessary to include community leaders and traditional healers in the process.

Consensus building and negotiation have an important role to play, not only in drafting the legislation but also in ensuring that legislation is implemented once it is adopted. A broad consensus is also necessary because mental health legislation cannot be embraced by any society unless misconceptions, misapprehensions and fears relating to mental disorders are addressed.

2.6 Educating the public on issues concerning mental health and human rights

Due to a lack of understanding of mental health issues among the general public, in many countries there is resistance, and sometimes opposition, to human-rights-oriented mental health legislation. There is also considerable stigma and discrimination against people with mental disorders. This may lead to public opposition to the legislation while it is being processed through the legislature, or even to an undermining of the legislation once it is passed.

It is important that the public be informed and educated about what a mental disorder is and what rights people with mental disorders are entitled to. This would greatly facilitate the process of drafting, adopting and implementing legislation.

Preliminary activities in drafting mental health legislation: Key issues

- **The process for new mental health legislation may be initiated by professionals responsible for mental health in a ministry, a law commission (or similar body), the legal unit within a ministry, an NGO, or by user, family, advocacy, professional or other group that identifies the need.**

- **Information about mental disorders, needs and barriers can be obtained from epidemiological studies, gathering quantitative information (e.g. from treatment settings), conducting qualitative studies (e.g. focus groups of users) or extrapolating from other countries with similar social and cultural characteristics.**

- **Barriers that can be addressed by legislation should be identified.**

- **Assessment of all legislation relevant to mental health should be undertaken and reviewed.**

- **International conventions and standards should be thoroughly studied to ensure that internationally accepted rights are included in the legislation.**

- **Careful examination of progressive laws of other countries, as well as consideration of the elements that made the implementation of these laws effective, can provide useful guidance for the development of a national law. However, the feasibility and applicability within any specific country must be carefully evaluated.**

- **The process of building a consensus for mental health legislation should begin as early as possible so that different views can be incorporated and subsequent implementation facilitated.**

3. Drafting mental health legislation

3.1 The drafting process

The process of drafting new legislation varies in different countries depending on the particular legislative, administrative and political structures. This Resource Book does not seek to interfere with these well-established mechanisms that are locally developed and accepted. A number of factors determine how often new legislation is drafted and by whom. It has been suggested that legislation should probably be reviewed every 5 to 10 years, but if there are problems with the content or implementation of the current law, then it should be reviewed as soon as possible. In some countries the law includes a "power to remove difficulties" that allows certain changes to be made – which are not fundamental in structure and effect, but which may be necessary to enable the legislation to better serve the purpose for which it was passed – without having to wait for the legislative process. The mental health law in India for example, states, "If any difficulty arises in giving effect to the provisions of this Act in any State, the State Government may, by order, do anything not inconsistent with such provisions which appears to it to be necessary or expedient for the purpose of removing the difficulty." (Article 97 of the Indian Mental Health Act, 1987).

In some countries, a specially constituted drafting committee is appointed by the legislature, or the relevant ministry is given the task of drafting the law; other countries have a law commission or a similar body that conducts this function (see section 2 above). In countries that lack well defined structures for drafting new legislation, the mental health section in the ministry can play an important facilitative role.

Example: The drafting process in Portugal and South Africa

In Portugal, following a National Conference of major stakeholders where a set of recommendations for new legislation was approved, the Ministries of Health and Justice nominated two working groups and charged them with writing the draft of new mental health legislation. One group worked on aspects related to mental health policy and patient rights, while the other group dealt with the regulation of compulsory treatment. This process took more than two years and involved extensive consultation with many different groups.

(Personal communication, Dr JM Caldas de Almeida, Regional Adviser for WHO Region of the Americas, 2003.)

In South Africa the need for new legislation was identified by the Department of Health, in part because a number of clauses of the existing legislation were seen as unconstitutional following the political change from apartheid to democracy. The Directorate responsible for Mental Health was mandated with coordinating a consultative and drafting process. The process, from conception to passage by Parliament, took approximately five years.

(Personal communication, Prof. M Freeman, Department of Health, South Africa, 2003)

The crucial point is not which body drafts the legislation, but rather, that there is significant and sufficient expertise contributing to the process to ensure that the bill produced is thorough, comprehensive, reflects a balance of competing (though reasonable) ideologies, has adequately considered all the available relevant information, and is able to produce a substantive draft appropriate to the local circumstances. Some countries may choose to appoint a committee

made up of a number of people who themselves are able to fulfil all the criteria and produce the draft. Other countries may appoint only one or two people to draft the legislation, with a mandate to draw on the skills of others with the relevant expertise and representing different interests to ensure that the above criteria are met. A mix of these models is also possible.

Such decisions will depend on factors such as the availability of expertise, costs of different approaches relative to funds available, and an assessment of which approach is likely to be most effective in that country. The scope of the proposed legislation will also determine the composition and breadth of consultation. For example, a country which chooses to have comprehensive legislation covering all issues of relevance to persons with mental disorders will require experts who can advise on aspects such as housing, employment, social benefits, welfare and justice.

In most countries, the drafting body will need to draw on the expertise of the following:

- a representative from the ministry of health, usually the professional in charge of mental health, who can chair the committee, coordinate the process or act as executive secretary;
- representatives from the other ministries involved (e.g. finance, education, employment, housing, social security and justice);
- mental health professionals;
- lawyers with expertise in mental health and other sectors;
- people (legal or other) with expertise in human rights;
- representatives of users, family and carers;
- nongovernmental organizations representing the interests of people with mental disorders;
- experts with experience of working with minorities and other vulnerable groups (e.g. women, children and the elderly);
- legislators with an interest in mental health issues.

Despite the inclusiveness proposed for this stage of development of the legislation, the draft produced should still be subjected to a number of further processes through which additional (or the same) stakeholders will have the opportunity to provide input and influence the final legislation (see subsection 3.3 below).

3.2 The need for consultation

Once legislation is drafted, it should be put forward for consultation to all the key stakeholders in the mental health field. Through the consultation process, potential weaknesses of the proposed legislation can be ironed out, conflicts with existing legislation and local customary practices rectified, issues that have been inadvertently left out can be added and solutions to practical difficulties in implementation can be corrected.

If well planned and executed systematically, consultation also has the potential to influence positively the adoption of the proposed legislation and its implementation, once enacted. Consultation provides an opportunity to raise public awareness about the needs of people with mental disorders and the prevention of such disorders. It also involves the community and thus enhances the visibility of the burden of mental disorders. All these factors increase the likelihood of effective implementation of the legislation once it is enacted.

3.3 Inviting consultation

In many countries there will be a statutory as well as a slightly less formal consultation process. Before legislation is submitted to the legislature, many countries publish a draft copy in a formal publication such as a government gazette. The public is then given a particular time frame (e.g. three months) for comment. All comments received must be carefully considered and appropriate changes made. However, at this point, extensive consultation should already have taken place. The following paragraphs deal with this non-statutory stage of the consultation process.

Consultation should be undertaken with users of mental health services, families of persons with mental disorders, advocacy organizations, NGOs, professional groups, governmental bodies and departments, service providers, community representatives and any others who will be directly or indirectly affected by the legislation. Many of these would already have been involved in the initial drafting, though this stage offers an opportunity for wider consultation. Each of these interest groups may include many subgroups that may have distinctly different perspectives. (See also, *Mental Health Policy and Service Guidance Package: Advocacy for Mental Health* (WHO, 2003b) at: http://www.who.int/mental_health/resources/policy_services/en/).

Within the government, the ministries responsible for health, welfare/social services, education, employment, justice, police, correctional services, finance, housing (and possibly others) are involved and need to be consulted. The exact division of responsibilities between government departments varies in different countries. In some countries the department of health will have jurisdiction over care and treatment aspects of the proposed legislation, while the needs for rehabilitation and prevention may be the responsibility of the department of welfare/social services. In other countries all these functions may fall under the department of health. Whichever framework is in place, consultation with both the health and welfare departments would be essential to avoid overlaps, duplication or conflicts. The department of finance would also need to be consulted, as the proposed legislation is likely to have financial implications for public and private service providers, and there are likely to be costs in setting up the regulatory and monitoring agencies. This department's support and commitment to the legislation is therefore crucial to ensure adequate financial provision for effective implementation of the legislation. Consultation would similarly be required with other government departments concerning those sections of the legislation relevant to them.

Professional groups, including psychiatrists, nurses, psychologists, psychiatric social workers, therapists, rehabilitation professionals and other professionals who interact with the mental health system will have day-to-day responsibility for implementing the provisions of mental health legislation. These groups are likely to be able to identify specific implementation difficulties in treatment and care practice. It is therefore essential that their views be taken into consideration when legislation is being drafted.

Users are the primary beneficiaries of the law and their input and involvement is crucial. In many countries, families are more often than not the primary care givers, and are therefore also directly concerned with such legislation. There is, at times, tension among user groups and groups representing family members of people with mental disorders in their orientation and ideological stance towards mental health treatment and legislation. It is important that the consultation process embrace all opinions in this regard. In some countries, especially those where user and family advocacy groups have been established for some time, and where an ethic of respect for the view of the patient is entrenched, it is relatively easy to get useful inputs from these groups. However, in many countries this can be a major difficulty. People with mental disorders often feel completely disempowered, and many come from disadvantaged communities where their opinions are generally not sought. The hegemony of doctors and other health professionals is also often an obstacle to getting users' and families' perspectives. The view that "doctor knows best" is extremely strong in many countries. The process of getting users' views is thus often far more complicated than simply requesting input; it may involve an intensive training and empowerment process before valuable feedback is received. It also often means going out to people, rather than waiting for people to come forward with their views.

The consultation process should also include the statutory agencies which will be involved in implementation of the mental health legislation. These include the police, prison officials and magistrates working on the ground, and not only national or "head office" people who may not be as closely in touch with everyday occurrences. Representatives of minority groups and other vulnerable groups should also be involved in the consultation process.

Other important groups that should be involved in consultation are politicians, legislators and other opinion makers. These groups can play a key role in the subsequent process of adoption and implementation of legislation. They can help raise awareness about mental health issues,

help in identifying potential difficulties in implementation at the community level, and give suggestions for corrective action at the drafting stage. Engaging legislators may also pre-empt possible disagreements that may arise later in the legislature, and allow drafters to make necessary modifications at an early stage.

Examples of key stakeholders to invite for consultation on proposed mental health legislation

- **Governmental agencies, including the ministries of health, finance, law, education, employment (labour), social welfare, justice, the police and correctional services and housing.**
- **Academic institutions and professional bodies representing professionals such as psychiatrists, psychologists, medical and psychiatric social workers, as well as psychiatric nurses and other professionals who interact with the mental health system.**
- **User group representatives and representatives of families and carers of persons with mental disorders.**
- **NGOs, including advocacy organizations representing the interests of people with mental disorders and their families.**
- **The private sector and NGOs providing care, treatment and rehabilitative services to persons with mental disorders.**
- **Politicians, legislators and opinion-makers.**
- **Law enforcement agencies such as the police and prison officials.**
- **Judicial authorities, including lawyers and legal representatives.**
- **Religious authorities.**
- **Organizations representing minorities and other vulnerable groups (such as women and children).**
- **Wider community groups, including civil rights groups, and associations such as employee unions, staff welfare associations, employer groups, resident welfare associations, religious groups and congregations of particular communities.**

Mental health legislation that aims to promote the community care of people with mental disorders cannot succeed without the active involvement of the wider community and those affected. This part of the consultation can present some of the greatest challenges. Community constituents are diffuse and widespread, and probably the most effective way of getting their opinions is through a broad approach. This could involve addressing questions of mental health in various kinds of civil rights groups, and in associations such as employee unions, staff welfare associations, employer groups, resident welfare associations, religious groups and congregations of particular communities. This method of obtaining community opinion may yield more specific feedback than the more global method of a national public consultation. The broad-based description of "public consultation" very often hides the fact that the consultation is being confined to the educated, articulate middle class of a country, even though the difficulties encountered due to mental disorders are predominant in poorer communities.

3.4 Process and procedure for consultation

There are various processes for consultation and a number of objectives can be achieved through them. For example, written submissions from interested individuals and groups could be invited, oral consultations with each of the above-mentioned constituencies could be held, and different constituent groups could be brought together. Or there could be a combination of these processes, such as a written submission followed by oral hearings, and focus groups could be utilized or other creative mechanisms employed. Although usually the primary objective of consultations is to hear what people or groups think and feel about the draft legislation, it can be an opportunity for drafters to engage with stakeholders, and for different stakeholders to engage with each other. Consultation can be used to develop consensus positions between groups with different perspectives.

Written submissions have the advantages of time and cost, and provide an accurate public record of stakeholder views. Obtaining and processing written consultation is relatively less time-consuming and less expensive than holding oral hearings. If people could be persuaded to respond, a larger number of individuals and groups could be involved. The main disadvantages of this process are the lack of opportunity for dialogue, and the fact that in many countries a large percentage of the population is illiterate. In written representations, respondents present their point of view, but other views are not necessarily presented. Thus the possibilities of building a consensus and initiating a change of attitude are substantially reduced. It can also exclude a large part of the constituency whose opinions are particularly important, such as poor people and those from disadvantaged or minority backgrounds, as they may not be able to read the proposed legislation or write a response.

Moreover, when written responses are received, special care has to be taken to ensure that the more articulate or more "elegantly" written and presented responses are not taken more seriously than the poorly crafted and poorly presented ones. Unless those receiving the submissions are particularly aware of potential prejudices, they may consider a response generated by a computer and printed to be more important than a handwritten one that is difficult to decipher and written in inarticulate grammar. This could undermine certain goals of the legislation, such as greater equity in services for the poor and the empowerment of people with disability. In addition, written submissions can become an articulation of a particular problem being faced by a respondent, while the larger policy issues that the consultation attempts to raise get sidelined. While recognizing that it is time-consuming and expensive, the optimum process with regard to written submissions would be to document and circulate the opinions of all respondents and encourage them to engage with opinions opposed to their own.

Written consultation and a written response are most important in interactions of the various constituencies discussed above with governmental authorities. A written opinion helps government departments in taking positions and making commitments. This can significantly aid the process of implementation of legislation. For example, consultation with the ministry of finance will help that ministry identify the need for additional resources for implementing mental health legislation, and formalize the commitment to provide these resources once the law is adopted. Oral consultation has the advantage of initiating a dialogue between participants. This makes it a more useful method for forming and changing opinions. This form of consultation also involves discussion and debate, that enables a more in-depth exploration of the issues and enhances the chances of achieving consensus. Sometimes stakeholders do not have all the information that helped in the formulation of certain decisions taken in the drafting process, and oral discussions can allow all relevant information to be shared. Oral consultations also provide an opportunity for the draft legislation to be explained to illiterate people or to people who find the language in which the law has been drafted difficult to understand, and to receive feedback from them on it.

The written and oral consultation methods have their advantages and disadvantages and hence a mixture of both is ideal. The consultation process could commence by seeking opinions in writing from interested individuals and groups. These opinions could be processed and those individuals and groups whose responses necessitate further discussion and deliberation could be invited for oral consultations. At the same time, to keep all the stakeholders involved in the consultation process, a summary of the written submission on key issues, as well as the broad thrust of the oral deliberations, could be shared in the media and made available on request. Interested parties could again be given an opportunity to make submissions at this stage.

In most countries, mental health legislation is part of a process of overturning some of the most deeply held prejudices of society. This can be done not only through the "product" (i.e. the legislation produced), but also through the "process". The consultation process on draft mental health legislation provides an opportunity for prejudices to be recognized and confronted.

Example: Consultation process in the Republic of Korea

The Department of Mental Health in the Ministry of Health and Welfare proposed amendments to the Mental Health Act that would establish community mental health centres to promote more community-based rehabilitation. The centres would undertake health prevention, identification of new patients, counselling and treatment, as well as coordinate community resources for improved mental health. Public hearings were held and opposition to the proposed new law was voiced by some professionals who were operating rehabilitation facilities. They felt that their roles would be undermined by the new community mental health centres. However, users and family members supported the new role of the community mental health centres. Following a full hearing and consideration of the conflicting viewpoints, it was decided to proceed with legislation to establish community mental health centres.

(Personal communication, Dr Tae-Yeon Hwang, Director, Department of Psychiatric Rehabilitation and Community Mental Health, WHO Collaborating Centre for Psychosocial Rehabilitation and Community Mental health, Yongin Mental Hospital)

The consultation process will vary from country to country. There are, however, principles that can guide countries in this endeavour. It should also be remembered that many countries have a statutory stage for “public comment”, when additional comment can be made before the draft is considered by the legislature (see subsection 4.1 below). Moreover, the legislature itself may invite submissions in writing or orally.

Example: Drafting the law in Chile

Building consensus and political will

The Declaration of Caracas (1990) had a strong influence in Chile, setting up a process of analysis and reflection about the mental health policies and services operating in the public health system (a system that covered between 60% and 70% of the population and owned the four psychiatric hospitals functioning in Chile). The country was in the process of returning to democracy after 17 years of dictatorship. The population was sensitive about social issues and human rights violations (e.g. murder, disappearances, prison, concentration camps, torture, exile), although not specifically aware of the human rights of people with mental disorders. The first national mental health policies and plan, which were formulated with the participation of more that 100 mental health professionals and approved by the Minister of Health in 1993, included considerations about the human rights of people utilizing psychiatric services and established the need for improving laws to protect the rights of patients.

Drafting and consultation

In 1995, a task force was created by the Mental Health Unit of the Ministry of Health comprising psychiatrists, nurses, psychologists, lawyers and other professionals, with the objective of drafting a mental health law. Taking the social and economic realities into account, the task force decided that protecting the rights of people in inpatient facilities would be accorded priority. This was to be accomplished by changing regulations issued in 1927. Changing these regulations required a decree signed by the President of Chile and the Minister of Health, thus avoiding a longer process in Parliament (similar to the “Power to Remove Difficulties” clause in India's Mental Health Act - see subsection 3.1). In 1996, a first draft was sent for consultation to mental health professionals in all regions of the country, and to the national organization of families and friends of people with mental disability (at that time there were no user groups in Chile). A major step in the process was to convince many mental health professionals that people with mental disorders could give informed consent for treatment most of the time, and that the common practice in the country at that time, of family members giving consent on behalf of their relative with a mental disorder, needed change.

(Personal communication, Dr Alberto Minoletti, Ministry of Health, Chile)

The group, body or individual(s) mandated to draft legislation must ensure that the consultation process is comprehensive, fair and open. To achieve this, they will require human and financial resources. Some countries may make use of government departments (likely to be the department of health) or those responsible for mental health policy development (if not in the same department) to coordinate or assist with the process. In countries with a law commission or similar structure, resources for consultation may already be allocated in the budgets of these bodies for consultation purposes.

At the end of the consultation phase, it is useful for the drafting body to publish a report on suggestions, objections and queries received during the consultation process, and the drafting body's response to them. Sections of the proposed legislation that have received substantive objections need particular attention. As a good practice measure, it is advisable that the drafting body give a detailed response to any substantive objections which are not acceptable to the drafting body and the reasons why, in their opinion, modifications, alterations or changes to the proposed legislation are not needed.

3.5 Language of legislation

Once the full consultation period is completed, the drafters will need to prepare the legislation for submission to the structure that passes drafts into law. This process will usually require an expert in legal drafting who is familiar with the style and norms of legislation in the country.

In addition, mental health laws should be written, as far as possible, in a manner that is easily accessible to the many people who may need to read and understand it. In many legal traditions of the past there was a belief that law was written for legal experts and that legal jargon and Latin terms (no matter in which language the law was being drafted) should be utilized. This made it very difficult for mental health professionals and the affected public to understand it. Mental health law should thus be written as simply as possible (without oversimplifying important provisions), and in language aimed at the general public rather than at legal experts.

Countries will generally have policies concerning which language(s) and the number of languages in which legislation must be produced. Mental health laws will follow this national norm.

Drafting mental health legislation: Key issues

- **Most countries will have well-established structures and processes that should be followed for developing legislation. Nonetheless, the mental health section in the ministry of health can play a major facilitating role in the drafting process.**
- **There must be significant and sufficient expertise brought into the drafting process to ensure that useful and meaningful legislation is produced.**
- **The scope intended to be covered by the legislation will influence the participants, but generally professional and non-professional expertise should be included.**
- **Once a draft has been completed it should undergo widespread review through consultation with all the key stakeholders.**
- **Forms of consultation can vary, and countries can employ different means for achieving maximum input and discussion. Nonetheless, a time-bound process that includes the following three stages is useful to follow:**
    1. **Publication of the draft document in the print and electronic media of the country, and inviting responses from the general public**
    2. **Inviting written responses from all key stakeholders**
    3. **Regional and national public meetings to analyse, discuss and negotiate the most frequent and important objections or suggestions regarding the drafted legislation**

- **Adequate human and financial resources will be required if the consultation process is to be comprehensive, fair and open.**

- **At the end of the consultation process, it is useful for the drafting body to publish a report on suggestions, objections and queries received during that process, and the drafting body's response to them.**

- **Mental health laws should be written, as far as possible, in a manner that is accessible to the general public.**

4. Adoption of legislation

Following revision of the new law on the basis of comments received during the consultation process, the legislation is submitted to the body empowered to pass laws. This is potentially, though not necessarily, a very time-consuming step, and a stage when proposed legislation can get bogged down in technicalities. It requires persuading politicians and key members of the executive branch of government and the legislature of the urgent need for new mental health legislation, and therefore of the need to devote adequate legislative time to this process. Although government support for a new law must (usually) have been obtained prior to the formation of the drafting body, once a final document is ready to be sent to the legislature, other political priorities may emerge that receive precedence, hence causing delays in the process, since mental health is given low political priority in many countries.

4.1 Legislative process

The legislative process for adopting new laws varies in different countries, depending on their legal traditions and political systems. What follows is a description of a general process and the difficulties that may arise at different stages.

4.1.1 Responsibility for adopting legislation

Parliament or a sovereign, law-making body is ultimately responsible for adopting legislation in most countries. In some countries the national parliament may be the sole legislative body, while in other countries with a “federal” constitution, “states” or “provinces” within the country may be authorized to make laws in addition to the national legislature. In federal States, legislative powers in different fields are divided between the federation and its constituent states. Depending on the locally determined jurisdiction, health laws, or laws that affect mental health, this may be a national or regional responsibility. In some countries there may be national laws that cover overarching principles and objectives, with state/district/provincial laws providing more detail concerning different provisions and their application. In such cases, the latter laws would have to follow key principles that are outlined in the national mental health law.

While for most countries a law must be passed in the legislature and promulgated before it can be implemented, some countries’ constitutions make it possible to immediately implement changes in laws through an administrative ordinance issued by the government. However, such an order would subsequently need to be ratified by the parliament within a specified time period. If not ratified, the order would lapse and the previous legislation would apply. Such a provision may occasionally be useful in bringing about speedy implementation of mental health legislation while the proposed legislation makes its way through the formal legislative process. This method also has possible advantages in identifying difficulties with implementation of proposed legislation, as it allows amendments to be made during the legislative process, based on practical experience.

4.1.2 Debate of draft legislation and its adoption

Many legislatures have subcommittees that carefully examine the legislation before it is introduced into the main legislative body. These committees often wish to receive inputs from various perspectives to assist them in making their decisions. They may hold public hearings, request specific inputs or require clarification on different aspects of the law.

The debate and adoption stage of the legislative process can be long and labour-intensive. During this stage, legislators may propose amendments to the proposed draft legislation. Those in charge of piloting the legislation through the sovereign law-making body will have to actively pursue and respond to proposed amendments. Ultimately, the decision to include or reject proposed amendments is the prerogative of the sovereign body, but those responsible for submitting the legislation will have to provide substantial guidance to lawmakers about the effects of the proposed amendments, with recommendations for accepting or rejecting them.

After having considered the legislation and made amendments, the legislative body (which may consist of more than one level or house) will then pass or reject the legislation.

4.1.3 Sanction, promulgation and publication of new legislation

The purpose of this stage of the legislative process is to make the adopted law publicly known, and to announce it officially. As a rule, legislation cannot come into force without its official publication, and before citizens and others have had time to become familiar with it. The terms used here, such as “sanction”, “publication” and “promulgation”, may be different in different countries, but the functions are fairly general and countries will need to identify their country equivalence if different terminology is used.

Sanction of the adopted law is the prerogative of the head of State. Usually the head of State signs the official text of the law and this act signifies sanction of the law (e.g. Germany, Lithuania, Poland, Spain and the USA).

Promulgation means the official announcement of the adopted law by the issuing of a special Act, for example, an order on official publication of the law. Usually, the government promulgates acts of legislation.

Publication means printing of the text of the law in the official government publication. This is a necessary stage before the adopted law can come into force. In many countries there are official sources for full and authentic texts of the laws (e.g. Collection of Legislation of the Russian Federation, Magazine of Laws of the Polish Republic, Gazette of the Estonian Republic, Bundesgesetzblatt in Germany).

Usually, the constitution or other legal requirement stipulates a period of time after publication before the new law can come into force (15 days in Italy, 20 days in Japan, and 10 days in the Russian Federation). Sometimes, this date may be established in the text of the law itself. Such preparation is vital for citizens and others to become familiar with the text as well as for making organizational arrangements, if necessary, for the operationalization of the law. In some countries the law only comes into operation on a date fixed by the head of State by proclamation in the appropriate government publication. This has advantages, as it allows for a comprehensive preparation process confident in the knowledge that no further changes or amendments will take place.

Delays can occur at all stages, from sanction to promulgation and publication, and those responsible for carrying the law forward will need to follow up with the relevant authorities to ensure that legislation which is passed by the sovereign body actually enters the statute books and thus becomes legally enforceable.

4.2 Key actions during adoption of legislation

4.2.1 Mobilizing public opinion

Example: Adopting legislation in China

Difficulties in the process of adoption of legislation
The drafting process for the mental health law in China has lasted more than 16 years. The current draft (13th version) has sections that protect civil rights, including employment and education of persons with mental disorders, informed consent, confidentiality, voluntary and involuntary hospitalization and treatment; rehabilitation and community-based mental health services; and promotion of mental health and prevention of mental disorders.

However there are some difficulties with adopting the legislation. First, many stakeholders consider mental health legislation as just "care and treatment" legislation, limited to provision of institution-based services. Secondly, the professionals and the health system in general are tending to resist change from a familiar system. Thirdly, many professionals fear that enacting new legislation might increase the likelihood of their being blamed by patients and relatives for the failures of the system. Hence professionals such as psychiatrists and nurses, who could potentially be the most enthusiastic proponents of new legislation, remain indifferent to the issue.

Efforts have been made to speed up the process of adoption of mental health legislation. Activities have included more survey and research, identifying the country's principal mental disorders and barriers, studying components of legislation in countries socially and culturally similar to China, and building a consensus for change.

(Personal communication, Dr Bin Xie, consultant, Ministry of Health, Beijing)

Mobilizing public opinion is crucially important for encouraging legislators to debate and pass proposed mental health legislation. Obtaining the support of public opinion should be initiated as early as possible – ideally during the consultation process in the previous step. Consultation provides an opportunity to raise public awareness about the topics included in the proposed legislation, and should therefore be continued during this stage. Media strategies can be useful for this purpose, and the professionals in charge of mental health at the ministry of health can provide journalists with material for news, reports and interviews. Workshops and seminars for key groups and organizations should be organized, where main components of the new legislation can be explained and discussed.

Mental health advocacy groups can play an active role in these activities. The development of a new law is a valuable opportunity to empower organizations in their fight against marginalization and stigmatization of people with mental disorders. Thus a mental health law, which aims to provide people with mental disorders with a normal life within the community, could well become a vehicle to educate, influence social attitudes and facilitate social change.

4.2.2 Lobbying members of the executive branch of government and the legislature

Another important activity to stimulate the process of adopting mental health legislation is to lobby members of the executive branch of government and the legislature. Members of the legislature need to be informed of the deficiencies in the existing legislation for mental health or of the negative implications and consequences of not having mental health legislation. They need to understand the social needs that prompted the development of the proposed law, the principal ideas on which the draft is based, the probability that the future law will solve existing problems within the mental health field, and other issues pertinent to the legislation.

Those in charge of mental health at the ministry of health should conduct frequent meetings with key members of these institutions as well as with politicians from the full spectrum of political parties. It is helpful to periodically send them written documents containing information about

mental health facts and best practices, and to ask their opinion about policy and legislative initiatives. Lobbying is essential during the entire process of legislation – and particularly in the adoption phase – to ensure that the proposed law is sent to the legislature and that it moves forward through the different stages of analysis, discussion and promulgation.

Adopting mental health legislation: Key issues

- **Parliament or a sovereign law-making body has final responsibility for passing legislation.**
- **In some countries, mental health laws are a "state" or "provincial" responsibility, while in others there is a national mental health law. State laws must always follow the principles of the national legislation where both apply.**
- **In some countries, laws may be promulgated by an administrative ordinance, and this would need to be ratified later by the parliament or law-making body.**
- **Many legislatures have subcommittees that debate legislation and receive public input before a bill is submitted to a full sitting of the legislature.**
- **During debate on a law, amendments can be proposed and adopted. To do this effectively, lawmakers must be fully briefed and informed of all implications of any changes.**
- **Once a law is passed by the legislature other steps are required such as: *sanction* (head of State signs the text); *promulgation* (official announcement of the adopted law); and *publication* (printed in the text of the government's official legal statutes).**
- **During the adoption of legislation it is important to mobilize public opinion and the media for the purposes of both advocacy for the passing of the bill and to inform the public on the issues, changes and opportunities afforded by the legislation.**
- **Members of the executive and the legislature should be lobbied at all stages of the legislative process, and particularly at the adoption stage, to ensure that the legislation, with its full potential to improve people's lives, is actually passed.**

5. Implementing mental health legislation

The process leading up to implementation ideally starts from the point of conception of mental health legislation. Many implementation difficulties can be identified, and corrective action taken, during the drafting and consultation phase of the proposed legislation. The complexity of modern mental health legislation adds to difficulties in its practical application. Often much attention can be paid to the drafting and legislative process, while little preparatory work is done with regard to implementation until after the legislation has been enacted.

The experience of many countries shows that "law in books" and "law in practice" sometimes are rather different. Implementation problems tend to occur not only in countries without a tradition of mental health law, but also in countries with a history of such law.

Once legislation has been passed through the legislative process, there is usually a short period before enactment of the legislation. This is a critical time, as it allows for procedures to be put in place, review bodies to be set up, training to take place, and to make sure that all those involved are ready to implement the legislation once it is enacted. In countries which have regulations attached to legislation, these regulations must also be finalized and signed before the legislation is enacted.

In some countries a decision may be made after the adoption of the law, to allow a period before enforcement, which gives the authorities time to put in place the necessary infrastructure to implement the law.

5.1 Importance and role of bodies responsible for implementation

As with the drafting of legislation, responsibility for overseeing implementation can take numerous forms. Moreover, different functions of the legislation may be undertaken and monitored by different groups. For example, if (as recommended in Chapter 2) a regulation and oversight body has been established, it is likely to be compelled, through its given functions, to

oversee certain legislative requirements. For example, regulatory or overseeing bodies could be given the task of performing regular inspections of facilities to ensure patients' rights are being protected. They may also have to hear complaints and monitor intrusive and irreversible treatments (see Chapter 2, section 13)

Through these responsibilities they will be able to assess whether the various legislative provisions are being met. If these review bodies report directly to the responsible minister, the latter can be kept informed of the extent and effectiveness of implementation. This should not, however, preclude the government itself from setting norms, standards and indicators to establish whether the provisions of the legislation are being met. These need to be monitored and evaluated, and necessary steps taken if the legislation is not being implemented.

Example: Commission to oversee the law established in Portugal

In Portugal, the mental health legislation requires the setting up of a commission whose task is to "gather and analyse the information regarding the application of the … law" and "propose to the Government the measures deemed necessary for the implementation of the current Act". This approach formalizes the monitoring of the legislation in the Act itself, and ensures that an ongoing assessment and feedback process takes place. The composition of the commission ensures that the legislative rights of users and families are considered through the legal appointment to the commission of representatives of these groups.

(Personal communication, Dr J.M. Caldas de Almeida, Regional Adviser for WHO Region of the Americas, 2003)

Whatever oversight agency is established, or whichever body is given this function, it should have a set timetable, measurable targets and the necessary administrative and financial powers to ensure effective and speedy implementation. The agency may require the mandate, authority and adequate financial resources to, for example:

- develop rules and procedures for implementation;
- prepare standardized documentation instruments for recording and monitoring implementation;
- ensure a proper process of training of mental health professionals, introducing certification procedures if necessary;
- address human resource issues, for example by empowering non-medical mental health professionals (nurses, nursing aides, psychologists, psychiatric social workers) to act as specialists in certain situations, after adequate training and supervision; and
- monitor implementation.

Visiting mental health facilities to monitor the implementation of the law constitutes a valuable safeguard against unjustified involuntary detention and limitation of patients' rights. Such visiting boards can monitor conditions in mental health facilities, ensure that treatment and care practices do not violate the rights of persons with mental disorders, and ensure that safeguards contained in legislation are being implemented by the mental health facilities.

In addition, there must be speedy and effective implementation of complaints procedures as provided in legislation. In particular, mental health facilities should make users and their families aware of their rights as incorporated in mental health legislation, and of the means for using the complaints procedures to obtain redress for their grievances, if any.

Despite these important provisions for oversight bodies, this does not guarantee protections for people with mental disorders. Many countries have such bodies, but human rights abuses persist. It should always be remembered that the law provides recourse to the courts, and that it should be utilized if necessary. Legislation generally includes a section on penalties for offences, and any citizen or organization has the right to bring cases of violation of the law to the attention of prosecutors or other responsible officials within the criminal justice system (see Chapter 2, section 18).

Example: The National Commission takes active steps to protect the rights of people with mental disorders in Chile

As part of the overall health sector reform in Chile, a new charter on the rights of patients has been introduced which has served to facilitate the implementation of measures to protect and promote the rights of people with mental disorders. A National Commission for the Protection of People with Mental Illness, with the participation of users and families, started work in March 2001. A process of education of mental health workers about the rights of people with mental disorders who are admitted to psychiatric facilities has been started in the country with positive results. The common practice of psychosurgery for mental disorder associated with violent behaviour has effectively been stopped in the country, violations of human rights in some psychiatric facilities are being investigated, and people with mental disorder and their families have been able to present their difficulties regarding access to treatment and rehabilitation. As an example of the work of the Commission, prior to its establishment, every year psychosurgery was performed, on average, on 40 patients for severe mental disorder associated with aggressive behaviour. In the first two-and-a-half years after its establishment, the Commission was requested to assess only 11 candidates for psychosurgery and all were turned down, as other more appropriate interventions, with less risk to the patient, were available.

(Personal communication, Dr A. Minoletti, Ministry of Health, Chile, 2002)

5.2 Dissemination and training

The general public as well as professionals, people with mental disorders, families of people with mental disorders, and advocacy organizations working on their behalf are frequently ill informed about the changes brought about by new legislation. In some instances, they may be well informed of the changes, but remain unconvinced about the reasons for these changes and hence do not act in accordance with the law. This is especially true when mental health legislation requires significant changes to their customary practices related to mental health.

5.2.1 Public education and awareness

Cultural and social values, beliefs, attitudes and traditions of a particular society influence attitudes about mental health, mental disorders and people who experience them. Stigma, myths and misconceptions associated with mental disorders lead to discrimination and limitations on human rights, and can represent obstacles to effective implementation of human-rights-oriented legislation. Hence, changing public attitude constitutes an important component in implementing mental health legislation.

Disseminating information about mental health, including information about the rights provided in new legislation, can help to change public attitudes towards people with mental disorders. Public awareness programmes need to highlight special provisions in legislation and provide explanations for their inclusion, such as why sections regarding access to mental health care and for protecting the human rights of persons with mental disorders have been included. The media can play a useful role in this process. They can highlight the importance of respecting human rights of persons with mental disorders and assist in educating the public about advances in the treatment of mental disorders, especially the effectiveness of community-based rehabilitation programmes.

5.2.2 Users, families and advocacy organizations

It is necessary to educate, inform and train users of mental health services, their family members and advocacy organizations. It is critical for these individuals and/or groups to know what the legislation says, and, specifically, to know their rights as provided for in the legislation. The importance of involving NGOs of users and their families in activities through the whole process of drafting, consultation and adoption of mental health legislation has been emphasized in this

chapter. Nonetheless, not all users or family members will have been part of these processes and all will need to be informed even after the law has been passed. Organizations representing users and family members as well as advocacy organizations can also be involved in awareness-raising programmes. In countries where user and family organizations are not well established, or have poor financial resources to disseminate information, mechanisms will need to be found to disseminate the information as widely as possible (for further details, see Module on *Advocacy for Mental Health* (WHO 2003b): http://www.who.int/mental_health/resources/policy_services/en/).

Example: Using advocacy services for effective implementation in Austria

A patients' advocacy service with broad functions has been implemented in Austria. This service assumes the legal representation in court proceedings of patients committed to psychiatric hospitals. The service also provides counselling and information on patients' rights for all patients as well as for their families and friends, and for interested people in general. Two non-profit organizations run the service and are supervised by the Austrian Federal Ministry of Justice. The organizations are responsible for training, guiding and supervising patients' advocates. The services of patients' advocates are confidential and free of charge for all patients. All involuntary patients are automatically assigned a patients' advocate.

(Beermann, 2000)

5.2.3 Mental health, health and other professionals

Thorough knowledge of mental health legislation by mental health, health and other professionals is extremely important for effective implementation. It is therefore necessary to promote special training for health and mental health professionals and staff, law-enforcement agencies (the police and judicial system), lawyers, social workers, teachers and human resource administrators, among others. Joint forums for training, where professionals from health and non-health disciplines are able to interact with each other, can create a better understanding of mental health and mental disorders, the human rights of persons with mental disorders and the common language used by all who interact with persons with mental disorders. Particularly important for the training of health and mental health professionals and staff are issues regarding rights to treatment and care, including the correct procedures for involuntary admission and treatment.

As carefully as legislation may be drafted, there are invariably clauses which may be ambiguous, or where the full intent and implications are not understood. Training may enable a full exploration of each clause of the legislation and a thorough discussion of its meaning and implications.

Example: Training for implementation of mental health legislation in South Africa

In training for the implementation of the Mental Health Care Act 2002 in South Africa, short clauses such as "the least restrictive environment" and "in the best interests of the user" sparked many hours of debate regarding their implication in various settings and in different scenarios. Participants expressed the view that without the training and without the trainer specifically concentrating on the implications of these clauses, their importance would in all likelihood have gone unnoticed, and the reasons why they were included would thus have been lost in implementation.

(Personal correspondence with M. Freeman, Department of Health, South Africa, 2003)

5.2.4 Developing information and guidance materials

A guidebook (or books) can be developed to provide information that would be important to different role players such as health practitioners, patients and family members. This guide could give particular information about aspects of the legislation that may be difficult to understand. It could provide detail or guidance about interpretation. Algorithms could also be developed that clearly illustrate processes, such as involuntary admission and treatment, and indicate which forms are needed at which stages of the process.

Example: British Columbia develops a "Guide to the Mental Health Act"

In British Columbia, a *Guide to the Mental Health Act* was developed to assist in implementing new legislation. It provides an overview of the entire Act and has appendices for different actors, such as how the community physician may certify an involuntary patient, how families can get help accessing physicians and the courts, and criteria and procedures for the police.

(Personal correspondence with Dr John Gray, International Association of Gerontology, Canada)

Formal guidance to professionals, such as a code of practice, is another important way of ensuring that legislation is properly implemented. Such guidance can re-emphasize the values and principles underpinning the legislation, explain what the various aspects of the legislation were meant to achieve, and include relevant case law.

Example: Code of Practice for England and Wales

In England and Wales, the mental health legislation required the Secretary of State for Health to produce a code of practice. This guidance expands considerably on the basic text, and affords professionals and the public the opportunity to see how the legislation should be implemented (see www.doh.gov.uk/mhac1983.htm).

(Mental Health Act 1983, Code of Practice (1999), London, Stationary Office)

5.3 Financial and human resources

The speed and effectiveness of implementation is likely to depend on the availability of adequate financial resources. Difficulties associated with drafting laws that cannot be implemented owing to financial constraints have already been discussed (see Chapter 2, section 4). An added resource problem is that new mental health legislation usually requires a shift from institutional to community-based care, and this can require additional funding. While in the long run, reallocation of funds from institutions to community-based facilities is feasible, in the short-term, there may need to be both institutional and community-based facilities – until community-based facilities are fully developed enough to provide adequate services.

The proportion of a country's budget or health budget that should be spent on mental health is debatable and falls outside the scope of this Resource Book. It is important to emphasize, however, that mental health is often given low priority vis-à-vis other health care issues, and that for effective implementation of good mental health legislation a fairer allocation of resources for mental health may be needed. Secondly, there is debate concerning potential conflict in the distribution of resources in support of the different provisions contained within the mental health law; for example, should resources be deployed for employing additional personnel in community care, or for the establishment and running of a mental health review body?

Many aspects of progressive legislation will need adequate budgetary provision for implementation activities. Funds are required for setting up and operationalizing the review body, for training mental health professionals in the use of the legislation, and for making the necessary changes to the mental health services as required by the legislation. Negotiation for this should be done simultaneously with the process of drafting and adopting mental health legislation (Issues regarding mental health financing can be found in the *Mental Health Policy and Service Guidance Package: Mental Health Financing* (WHO, 2003d): http://www.who.int/mental_health/resources/policy_services/en/).

Example: Obstacles to and facilitating factors for effective implementation of mental health legislation

Obstacles	**Facilitating factors**
Lack of coordinated action in the implementation of mental health law (absence of a centralized agency or authority overseeing the process of implementation)	Appoint a coordinating agency, or ensure that an agency is appointed (e.g. a mental health review body) to oversee the implementation process, by having this included in the text of the law
Lack of knowledge, misunderstanding and resistance by the general public, users and carers to the changes brought about by the new mental health legislation	Public education and awareness-raising campaigns could highlight the provisions and rationale of the new mental health law
Mental health, health and other professionals are unaware, or resist the provisions, of mental health legislation	Training programmes for mental health, health and other professionals could include explanations on the provisions of mental health legislation Guidance documents could inform people of the details of the legislation
Shortage of mental health human resources to implement some of the mandates of the law	Mental health training should be provided to general health professionals and staff (for further details, see modules on *Organization of Services for Mental Health* (WHO, 2003c); and *Human Resources and Training in Mental Health* (WHO, 2005): (http://www.who.int/mental_health/resources /policy_services/en/)
Insufficient funding to develop the mechanisms needed to implement the law (e.g. advocacy, awareness-raising, training, visiting boards, complaints procedures)	Additional funding for mental health as well as protecting budgets should be allocated to mental health and for implementation of mental health legislation

Human resource issues are of particular importance for the implementation of legislation in all countries. Mental health professionals are key to the delivery of effective mental health care within specialized mental health services, both in general health care and in the community. Without sufficient numbers of professionals or adequate training, the primary objective of a mental health law, to improve mental health care, will fail. In addition, investment needs to be made in training all people who have a role to play in the implementation of the law (for example the judiciary, the police force, people serving on a mental health review body) in order to ensure that they are familiar with all aspects of the legislation, and with their own roles and responsibilities in putting its provisions into practice.

Implementing mental health legislation: Key issues

- **Significant preparation is required to ensure the smooth introduction of new mental health legislation. The period between the passing and the enactment of legislation can be a particularly important time for organizing implementation procedures such as establishing review boards, training people on the new legislation and preparing those who will implement it.**
- **Having standardized forms and other administrative processes in place facilitates the transition.**
- **Procedures must be set up to monitor the implementation of legislation. This may be done by an independent body and/or by the implementing agency itself (e.g. the government).**
- **Both the implementing and monitoring bodies should have timetables with measurable targets, and the powers to carry out their functions.**
- **Changing public attitudes and reducing stigma and discrimination is an important component in ensuring the success of the legislation.**
- **Users, families and advocacy groups need to have complete knowledge of the legislation in order to maximize the benefits. Training these groups is an essential aspect of implementation.**
- **Mental health and other professionals also need to be trained to carry out the letter and the intention of the legislation.**
- **Financial and human resources to implement the legislation must be provided by the relevant authorities to give substance and credibility to the legislation. Negotiation for the provision of these resources should be conducted simultaneously with the processes of drafting and adopting the legislation.**

As we have seen, progressive legislation on mental health can represent an important means of protecting the rights of people with mental disorders. In this Resource Book we have highlighted key international and regional human rights standards that governments have the obligation to respect, protect and fulfil. The Book also identifies what issues and provisions need to be included in a progressive mental health law. Finally, it also examines best practice strategies for the effective drafting, adoption and implementation of mental health law, highlighting difficulties and barriers and ways in which these can be overcome.

It is every country's responsibility to act on this information and to generate the necessary political commitment for successful initiation/development or reform of mental health law and its implementation.

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Annex 1. WHO Checklist on Mental Health Legislation

WORLD HEALTH ORGANIZATION

WHO Checklist on Mental Health Legislation

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Introduction and how to use this checklist

This checklist is a companion to the WHO *Resource Book on Mental Health, Human Rights and Legislation.* Its objectives are to: a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation; and b) help them in the process of drafting new law. This checklist can help countries assess whether key components are included in legislation, and ensure that the broad recommendations contained in the Resource Book are carefully examined and considered.

A committee to work through the checklist is recommended. While an individual in, for example, the ministry of health, may be able to complete the checklist, this has certain limitations. First, no single person is likely to have all the relevant information that a well selected team would have. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee that allows critical debate and the development of a consensus is invaluable. Although countries should decide for themselves on the composition of the committee, it is advisable to include a legal practitioner familiar with the various national laws, the governmental mental health focal point, representatives of service user and family groups, and representatives of mental health professionals, NGOs and different government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This checklist should generally *not be utilized without thoroughly studying the Resource Book itself*. A number of important items included in the checklist are explained in the Resource Book, and the rationale and different options for legislation are discussed. The Resource Book emphasizes that countries should make their own decisions about various alternatives and ways of drafting legislation as well as about a number of content issues. The format of this checklist allows for such flexibility, and aims to encourage internal debate; it thus permits countries to make decisions based on their own unique situations.

The checklist covers issues from a broad perspective, and many of the provisions will need to be fleshed out or elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example, not all countries will choose to have community treatment orders; not all countries have provision for "non-protesting patients"; and in most countries, sterilization of people with mental disorders will not be relevant. However, while each country in its evaluative process may determine that a particular provision is not relevant, this determination should be made part of the checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one (or more) of the provisions is not relevant to a country's particular context.

The Resource Book points out that countries may have laws that affect mental health in a single statute or in numerous different statutory laws relating to areas such as general health, employment, housing, discrimination and criminal justice. Moreover, some countries utilize regulations, orders and other mechanisms to complement a statutory act. It is therefore essential, when conducting this audit, to collect and collate all legal provisions pertaining to mental health, and to make decisions based on comprehensive information.

The Resource Book makes it clear that drawing up or changing mental health legislation is a "process". Establishing what needs to be included in the legislation is an important element of that process, and this checklist can be a useful aid to achieving this goal. Nonetheless, the objective of drafting a law that can be implemented in a country must never be separated from the "content", and must always be a central consideration.

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For each component included in the checklist, three questions need to be addressed: a) Has the issue been adequately covered in the legislation? b) Has it been covered, but not fully and comprehensively? c) Has it not been covered at all? If the response is either (b) or (c), the committee conducting the assessment must decide on the feasibility and local relevance of including the issue, leading to the drafting of locally appropriate legislation.

This checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them; however, for the sake of simplicity and ease of use, the scope of this checklist has been limited.

Legislative issue	**Extent to which covered in legislation (tick one)** **a) Adequately covered** **b) Covered to some extent** **c) Not covered at all**	**If (b), explain:** **• Why it is not adequately covered** **• What is missing or problematic about the existing provision** **If (c), explain why it is not covered in current legislation** **(Additional information may be added to new pages if required)**	**If (b) or (c), explain how/whether it is to be included in new legislation** **(Additional information may be added to new pages if required)**
A. Preamble and objectives 1) Does the legislation have a preamble which emphasizes: a) the human rights of people with mental disorders? b) the importance of accessible mental health services for all?	 a) b) c) a) b) c)		

2) Does the legislation specify that the purpose and objectives to be achieved include: a) non-discrimination against people with mental disorders? b) promotion and protection of the rights of people with mental disorders? c) improved access to mental health services? d) a community-based approach?	a) b) c) a) b) c) a) b) c) a) b) c)		
B. Definitions 1) Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?	a) b) c)		

2) Is it evident from the legislation why the particular term (above) has been chosen? 3) Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation? 4) Are all key terms in the legislation clearly defined? 5) Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)? 6) Are all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	a) b) c) a) b) c) a) b) c) a) b) c) a) b) c)		

C. Access to mental health care			
1) Does the legislation make provision for the financing of mental health services?	a) b) c)		
2) Does the legislation state that mental health services should be provided on an equal basis with physical health care?	a) b) c)		
3) Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	a) b) c)		
4) Does the legislation promote mental health within primary health care?	a) b) c)		
5) Does the legislation promote access to psychotropic drugs?	a) b) c)		
6) Does the legislation promote a psychosocial, rehabilitative approach?	a) b) c)		
7) Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	a) b) c)		

8) Does the legislation promote community care and deinstitutionalization?	a) b) c)		
D. Rights of users of mental health services			
1) Does the legislation include the rights to respect, dignity and to be treated in a humane way?	a) b) c)		
2) Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	a) b) c)		
a) Are there sanctions and penalties for people who contravene patients' confidentiality?	a) b) c)		
b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	a) b) c)		
c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	a) b) c)		

3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	a) b) c)		
a) Are circumstances in which such access can be denied outlined?	a) b) c)		
b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	a) b) c)		
4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	a) b) c)		
5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	a) b) c)		
6) Does the law insist on the privacy of people with mental disorders?	a) b) c)		
a) Is the law clear on minimal levels of privacy to be respected?	a) b) c)		

7) Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	a) b) c)		
8) Does the law make provision for: • educational activities, • vocational training, • leisure and recreational activities, and • religious or cultural needs of people with mental disorders?	a) b) c)		
9) Are the health authorities compelled by the law to inform patients of their rights?	a) b) c)		
10) Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	a) b) c)		

E. Rights of families or other carers			
1) Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	a) b) c)		
2) Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualized treatment plan?	a) b) c)		
3) Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	a) b) c)		
4) Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?	a) b) c)		
5) Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	a) b) c)		
F. Competence, capacity and guardianship			
1) Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	a) b) c)		

2) Does the law define “competence” and “capacity”?	a) b) c)		
3) Does the law lay down a procedure and criteria for determining a person’s incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	a) b) c)		
4) Are procedures laid down for appeals against decisions of incapacity/ incompetence, and for periodic reviews of decisions?	a) b) c)		
5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	a) b) c)		
6) Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	a) b) c)		
7) Does the law make provision for a systematic review of the need for a guardian?	a) b) c)		
8) Does the law make provision for a patient to appeal against the appointment of a guardian?	a) b) c)		

G. Voluntary admission and treatment			
1) Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	a) b) c)		
2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?	a) b) c)		
3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	a) b) c)		
4) Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	a) b) c)		
5) Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	a) b) c)		

H. Non-protesting patients 1) Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment? 2) Are the conditions under which a non-protesting patient may be admitted and treated specified? 3) Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	 a) b) c) a) b) c) a) b) c)		
I. Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined) 1) Does the law state that involuntary admission may only be allowed if: a) there is evidence of mental disorder of specified severity? and;	 a) b) c)		

b) there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given? and;	a) b) c)		
c) admission is for a therapeutic purpose?	a) b) c)		
2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	a) b) c)		
3) Does the law insist on accreditation of a facility before it can admit involuntary patients?	a) b) c)		
4) Is the principle of the least restrictive environment applied to involuntary admissions?	a) b) c)		
5) Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?	a) b) c)		
6) Are speedy time frames laid down within which the independent authority must make a decision?	a) b) c)		

7) Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	a) b) c)		
8) Does the law provide for a right to appeal an involuntary admission?	a) b) c)		
9) Does the law include a provision for time-bound periodic reviews of involuntary (and long-term “voluntary”) admission by an independent authority?	a) b) c)		
10) Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	a) b) c)		
J. Involuntary treatment (when separate from involuntary admission) 1) Does the law set out the criteria that must be met for involuntary treatment, including: • Patient suffers from a mental disorder?	a) b) c)		

• Patient lacks the capacity to make informed treatment decisions?	a) b) c)		
• Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	a) b) c)		
2) Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	a) b) c)		
3) Does the law make provision for a second practitioner to agree on the treatment plan?	a) b) c)		
4) Has an independent body been set up to authorize involuntary treatment?	a) b) c)		
5) Does the law ensure that treatment is for a limited time period only?	a) b) c)		

6) Does the law provide for a right to appeal involuntary treatment? 7) Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	a) b) c) a) b) c)		
K. Proxy consent for treatment 1) Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting? 2) Is the patient given the right to appeal a treatment decision to which a proxy consent has been given ? 3) Does the law provide for use of "advance directives" and, if so, is the term clearly defined?	 a) b) c) a) b) c) a) b) c)		
L. Involuntary treatment in community settings 1) Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	 a) b) c)		

2) Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	a) b) c)		
M. Emergency situations 1) Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others? 2) Is there a clear procedure in the law for admission and treatment in emergency situations? 3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases? 4) Does the law specify a time limit for emergency admission (usually no longer than 72 hours)? 5) Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	 a) b) c) a) b) c) a) b) c) a) b) c) a) b) c)		

6) Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	a) b) c)		
7) Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	a) b) c)		
N. Determinations of mental disorder			
1) Does the legislation:			
a) Define the level of skills required to determine mental disorder?	a) b) c)		
b) Specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	a) b) c)		
2) Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	a) b) c)		

O. Special treatments			
1) Does the law prohibit sterilization as a treatment for mental disorder?	a) b) c)		
a) Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	a) b) c)		
2) Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?	a) b) c)		
a) Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	a) b) c)		
b) In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	a) b) c)		

3) Are psychosurgery and other irreversible treatments outlawed on involuntary patients? a) Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients? 4) Does the law specify the need for informed consent when using ECT? 5) Does the law prohibit the use of unmodified ECT? 6) Does the law prohibit the use of ECT in minors?	a) b) c) a) b) c) a) b) c) a) b) c) a) b) c)		
P. Seclusion and restraint 1) Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others? 2) Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	 a) b) c) a) b) c)		

3) Does the law specify a restricted maximum time period for which seclusion and restraints can be used? 4) Does the law ensure that one period of seclusion and restraint is not followed immediately by another? 5) Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities? 6) Does the law lay down adequate procedures for the use of seclusion and restraints, including: • who should authorize it, • that the facility should be accredited, • that the reasons and duration of each incident be recorded in a database and made available to a review board, and • that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	a) b) c) a) b) c) a) b) c) a) b) c)		

Q. Clinical and experimental research			
1) Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?	a) b) c)		
2) Where a person is unable to give informed consent (and where a decision has been made that research can be conducted):	a) b) c)		
a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	a) b) c)		
b) Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	a) b) c)		

R. Oversight and review mechanisms			
1) Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	a) b) c)		
a) Does the above body:			
(i) Assess each involuntary admission/ treatment?	a) b) c)		
(ii) Entertain appeals against involuntary admission and/or involuntary treatment?	a) b) c)		
(iii) Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	a) b) c)		
(iv) Regularly monitor patients receiving treatment against their will?	a) b) c)		
(v) Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	a) b) c)		

b) Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a “wise person” reflecting the “community” perspective?	a) b) c)		
c) Does the law allow for appeal of this body’s decisions to a higher court?	a) b) c)		
2) Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	a) b) c)		
a) Does the above body:			
(i) Conduct regular inspections of mental health facilities?	a) b) c)		
(ii) Provide guidance on minimizing intrusive treatments?	a) b) c)		
(iii) Maintain statistics; on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	a) b) c)		

(iv) Maintain registers of accredited facilities and professionals?	a) b) c)		
(v) Report and make recommendations directly to the appropriate government minister?	a) b) c)		
(vi) Publish findings on a regular basis?	a) b) c)		
b) Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	a) b) c)		
c) Is this body's authority clearly stated in the legislation?	a) b) c)		
3) a) Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	a) b) c)		

b) Does the law stipulate:			
• the time period from the occurrence of the incident within which the complaint should be made?	a) b) c)		
• a maximum time period within which the complaint should be responded to, by whom and how?	a) b) c)		
• the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	a) b) c)		
• the right of patients to an interpreter during the proceedings, if necessary?	a) b) c)		
• The right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	a) b) c)		

• the right of patients and their counsel to attend and participate in complaints and appeals procedures?	a) b) c)		
S. Police responsibilities 1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services? 2) Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour? 3) Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder? 4) Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	 a) b) c) a) b) c) a) b) c) a) b) c)		

5) Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	a) b) c)		
T. Mentally ill offenders 1) Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution? 2) Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment? a) Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	 a) b) c) a) b) c) a) b) c)		

3) Does the law allow for people who are found by the courts to be "not responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	a) b) c)		
4) Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	a) b) c)		
5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?	a) b) c)		
a) Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	a) b) c)		
6) Does the legislation provide for secure mental health facilities for mentally ill offenders?	a) b) c)		

U. Discrimination 1) Does the law include provisions aimed at stopping discrimination against people with mental disorders?	a) b) c)		
V. Housing 1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing? 2) Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing? 3) Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	a) b) c) a) b) c) a) b) c)		
W. Employment 1) Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	a) b) c)		

2) Does the law provide for “reasonable accommodation” for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	a) b) c)		
3) Does the law provide for equal employment opportunities for people with mental disorders?	a) b) c)		
4) Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental discorders?	a) b) c)		
X. Social security			
1) Does legislation provide for disability grants and pensions for people with mental disabilities?	a) b) c)		
2) Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	a) b) c)		

Y. Civil issues			
1) Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	a) b) c)		
Z. Protection of vulnerable groups ***Protection of minors***			
1) Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	a) b) c)		
2) If minors are placed in mental health facilities, does the legislation stipulate that	a) b) c)		
a) they should have a separate living area from adults?	a) b) c)		
b) that the environment is age-appropriate and takes into consideration the developmental needs of minors?	a) b) c)		

3) Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	a) b) c)		
4) Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?	a) b) c)		
5) Does legislation ban all irreversible treatments for children?	a) b) c)		
Protection of women			
1) Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	a) b) c)		
2) Does the law ensure that women in mental health facilities:			
a) have adequate privacy?	a) b) c)		
b) are provided with separate sleeping facilities from men?	a) b) c)		

3) Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	a) b) c)		
Protection of minorities 1) Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status? 2) Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters? 3) Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	 a) b) c) a) b) c) a) b) c)		

AZ. Offences and penalties			
1) Does the law have a section dealing with offences and appropriate penalties?	a) b) c)		
2) Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	a) b) c)		

Annex 2. Summary of the major provisions and international instruments related to the rights of people with mental disorders

Key human rights related to mental health	Instruments safeguarding the human right
People with mental disorders are entitled to the enjoyment and protection of their fundamental human rights.	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • International Covenant on Civil and Political Rights (ICCPR) • UN Declaration of Human Rights • African (Banjul) Charter on Human and Peoples' Rights • Convention for the Protection of Human Rights and Fundamental Freedoms • American Declaration of the Rights and Duties of Man • American Convention on Human Rights • UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • Declaration of Caracas • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill
Right to the highest attainable standard of health care – including mental health	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • African (Banjul) Charter on Human and Peoples' Rights • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • European Social Charter • Declaration of Caracas • International Convention on the Elimination of All Forms of Racial Discrimination • Convention on the Elimination of All Forms of Discrimination Against Women • Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights
Protection against discrimination	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • International Covenant on Civil and Political Rights (ICCPR)

	• Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill • Convention on the Elimination of All Forms of Discrimination Against Women
Children with mental disabilities have the right to enjoy a full and decent life	• UN Convention on the Rights of the Child • The Salamanca Statement and Framework for Action on Special Needs Education • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)
People with mental disorders should be protected against torture, cruel, inhuman or degrading treatment or punishment	• UN Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment • African (Banjul) Charter on Human and Peoples' Rights • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Declaration of Caracas • International Covenant on Civil and Political Rights (ICCPR) • European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Mentally Ill
Standards for involuntary care and treatment	• UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles • Council of Europe Recommendation 1235 on Psychiatry and Human Rights • Declaration of Caracas • World Psychiatric Association's Declaration of Madrid

Annex 3. United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

Adopted by General Assembly resolution 46/119 of 17 December 1991

Application
These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions
In these Principles:
"Counsel" means a legal or other qualified representative;
"Independent authority" means a competent and independent authority prescribed by domestic law;
"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;
"Mental health facility'' means any establishment, or any unit of an establishment, which as its primary function provides mental health care;
"Mental health practitioner'' means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;
"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;
"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;
"The review body" means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

General limitation clause
The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Principle 1
Fundamental freedoms and basic rights
1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on

Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.
6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.
7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.

Principle 2
Protection of minors
Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3
Life in the community
Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Principle 4
Determination of mental illness
1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.
3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.
4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

Principle 5
Medical examination
No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

Principle 6
Confidentiality
The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

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

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

Principle 9
Treatment
1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.
4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 10
Medication
1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.
2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

Principle 11
Consent to treatment
1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.
2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:
(a) The diagnostic assessment;
(b) The purpose, method, likely duration and expected benefit of the proposed treatment;
(c) Alternative modes of treatment, including those less intrusive; and
(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.
3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.
4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.
6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:
(a) The patient is, at the relevant time, held as an involuntary patient;
(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and
(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.
7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.
8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.
9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.
10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.
11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.
12. Sterilization shall never be carried out as a treatment for mental illness.
13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.
14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.
15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.
16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

Principle 12
Notice of rights
1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.
2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.
3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

Principle 13
Rights and conditions in mental health facilities
1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
(a) Recognition everywhere as a person before the law;
(b) Privacy;
(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
(d) Freedom of religion or belief.
2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:
(a) Facilities for recreational and leisure activities;
(b) Facilities for education;
(c) Facilities to purchase or receive items for daily living, recreation and communication;
(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.
3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.
4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

Principle 14
Resources for mental health facilities
1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
(a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
(b) Diagnostic and therapeutic equipment for the patient;
(c) Appropriate professional care; and
(d) Adequate, regular and comprehensive treatment, including supplies of medication.
2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

Principle 15
Admission principles
1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.
2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

Principle 16
Involuntary admission
1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:
(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.
In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.
2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.
3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

Principle 17
Review body
1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.
2. The review body's initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.
3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.
4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.
5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.
6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

Principle 18
Procedural safeguards
1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.
4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and shall be subject to judicial review.
5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.
6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.
7. Any decision whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.
8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

Principle 19
Access to information
1. A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.
2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

Principle 20
Criminal offenders
1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.
2. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.
3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.
4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.

Principle 21
Complaints
Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

Principle 22
Monitoring and remedies
States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

Principle 23
Implementation
1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.
2. States shall make these Principles widely known by appropriate and active means.

Principle 24
Scope of principles relating to mental health facilities
These Principles apply to all persons who are admitted to a mental health facility.

Principle 25
Saving of existing rights
There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent.

For further information and guidance on the MI Principles, see also Guidelines for the Promotion of Human Rights of Persons with Mental Disorder. Geneva, World Health Organization, 1996; available at: http://whqlibdoc.who.int/hq/1995/WHO_MNH_MND_95.4.pdf

Annex 4. Extract from the PAHO/WHO Declaration of Caracas

The legislators, associations, health authorities, mental health professionals and jurists assembled at the Regional Conference on the Restructuring of Psychiatric Care in Latin America within the Local Health Systems Model,

DECLARE

1. That the restructuring of psychiatric care on the basis of Primary Health Care and within the framework of the Local Health Systems Model will promote alternative service models that are community-based and integrated into social and health care networks.

2. That the restructuring of psychiatric care in the Region implies a critical review of the dominant and centralizing role played by the mental hospital in mental health service delivery.

3. That the resources, care and treatment that are made available must:

   a) safeguard personal dignity and human and civil rights;
   b) be based on criteria that are rational and technically appropriate; and
   c) strive to maintain patients in their communities.

4. That national legislation must be redrafted if necessary so that:

   a) the human and civil rights of mental patients are safeguarded; and
   b) that the organization of community mental health services guarantees the protection of these rights.

5. That training in mental health and psychiatry should use a service model that is based on the community health center and encourages psychiatric admission in general hospitals, in accordance with the principles that underlie the restructuring movement.

6. That the organizations, associations, and other participants in this Conference hereby undertake to advocate and develop programs at the country level that will promote the desired restructuring, and at the same time commit themselves to monitoring and defending the human rights of mental patients in accordance with the national legislation and international agreements.

   To this end, they call upon the Ministries of Health and Justice, the Parliaments, Social Security and other care-providing institutions, professional organizations, consumer associations, universities and other training facilities and the media to support the restructuring of psychiatric care, thus assuring this successful development for the benefit of the population in the Region.

Extract from the text of the Declaration of Caracas adopted on 14 November 1990 by the Regional Conference on the Restructuring of Psychiatric Care in Latin America, convened in Caracas, Venezuela, by the Pan American Health Organization/WHO Regional Office for the Americas. International Digest of Health Legislation, 1991, 42(2):336–338.

Annex 5. Extract from the Declaration of Madrid of the World Psychiatric Association

Madrid Declaration on Ethical Standards for Psychiatric Practice

Approved by the General Assembly on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, in August 2002

In 1977, the World Psychiatric Association approved the Declaration of Hawaii, setting out ethical guidelines for the practice of psychiatry. The Declaration was updated in Vienna in 1983. To reflect the impact of changing social attitudes and new medical developments on the psychiatric profession, the Word Psychiatric Association has once again examined and revised some of these ethical standards.

Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill and infirm because of a mental disorder or impairment. Although there may be cultural, social, and national differences, the need for ethical conduct and continual review of ethical standards is universal.

As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician and of the specific ethical demands of the speciality of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.

Ethical behavior is based on the psychiatrist's individual sense of responsibility towards the patient and their judgement in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

Psychiatrists should at all times, keep in mind the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity.

It is in this spirit that the World Psychiatric Association approved at the General Assembly on August 25th, 1996, the following ethical standards that should govern the conduct of psychiatrists worldwide.

1. Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

2. It is the duty of psychiatrists to keep abreast [of] scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

3. The patient should be accepted as a partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient make free and informed decisions. It is the duty of psychiatrists to provide the patient with

relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.

4. When the patient is incapacitated and/or unable to exercise proper judgement because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. Not treatment should be provided against the patient´s will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations.

6. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to the third person would ensue if confidentiality were maintained; as in the case of child abuse, in these circumstances, psychiatrist should whenever possible, first advise the patient about the action to be taken.

7. Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted ethics committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centers.

GUIDELINES CONCERNING SPECIFIC SITUATIONS

The World Psychiatric Association Ethics Committee recognizes the need to develop a number of specific guidelines on a number of specific situations. The first five were approved by the General Assembly in Madrid, Spain, on August 25, 1996 and the last three by the General Assembly in Hamburg, Germany, on August 8, 1999.

1. Euthanasia: A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informal decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.

2. Torture: Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.

3. Death Penalty: Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.

4. Selection of Sex: Under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection.

5. Organ Transplantation: The role of the psychiatrist is to clarify the issues surrounding organ donations and to advise on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned. The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters. Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situation of organ transplantation.

6. Psychiatrists Addressing the Media:
The media has a key role in shaping the perceptions and attitudes of the community. In all contacts with the media psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and pride, and which reduces stigma and discrimination against them. An important role of psychiatrists is to advocate for those people who suffer from mental disorders. As the public perception of psychiatrists and psychiatry reflects on patients, psychiatrists shall ensure that in their contacts with the media they represent the profession of psychiatry with dignity. Psychiatrists shall not make announcements to the media about presumed psychopathology on any individuals. In presenting research findings to the media, psychiatrists shall ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

7. Psychiatrists and Discrimination on Ethnic or Cultural Grounds
Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.

8. Psychiatrists and Genetic Research and Counselling
Research on the genetic basis of mental disorders is rapidly increasing and more people suffering from mental illness are participating in such research. Psychiatrists involved in genetic research or counselling shall be mindful of the fact that the implication of genetic information [is] not limited to the individual from whom it was obtained, and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned. Psychiatrists shall therefore ensure that:

- People and families who participate in genetic research do so with a fully informed consent;
- Any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse,
- Care is taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings.

Psychiatrists shall only refer people to facilities for diagnostic genetic testing if that facility has:

- Demonstrated satisfactory quality assurance procedures for such testing;
- Adequate and easily accessible resources for genetic counselling. Genetic counselling with regard to family planning or abortion shall be respectful of the patients' value system, while providing sufficient medical and psychiatric information to aid patients make decisions they consider best for them.

Annex 6. Example: Rights of a Patient, as specified in Connecticut, USA

Your Rights as a Client or Patient of the Connecticut Department of Mental Health & Addiction Services (USA)

You are entitled to be treated in a humane and dignified way at all times, and with full respect to:

- Personal Dignity
- Right to Privacy
- Right to Personal Property
- Civil Rights

You have the right to freedom from physical or mental abuse or harm;
You have the right to a written treatment plan that is developed with your input and suited to your own personal needs, goals and aspirations;
You should be informed of your rights by the institution, agency or program.
In addition, a list of your rights must be posted on each ward of a hospital.

Other rights you have include:
Humane and dignified treatment: You have the right to receive humane and dignified treatment at all times and with full respect to your personal dignity and privacy. A specialized treatment plan shall be developed in accordance with your needs. Any treatment plan shall include, but not be limited to, reasonable notice of discharge, your active participation in and planning for appropriate aftercare. (See CGS 17a-542)

Personal Dignity: While in an inpatient facility, you have the right to wear your own clothing, to maintain your own personal belongings (given reasonable space limitations) and to be able to have access to and spend your own money for personal purchases.* Except for patients in Whiting Forensic Division, you have the right to be present during any search of your personal belongings. Any exception to these rights must be explained in writing and made a part of your clinical record. (See CGS 17a-548)

Privacy & Confidentiality: You have the right to privacy & confidentiality. Records that would identify your person, manner of treatment or your diagnosis cannot be given to any other person or agency without your written consent. All records maintained by the courts [as they relate to a recipient's treatment] shall be sealed and available only to respondent or counsel.* No person, hospital, treatment facility nor DMHAS may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any service recipient that would constitute a violation of state or federal statutes concerning confidentiality.*
(See CGS 17a-500, 17a-688, 52-146f and 42 CFR part 2)

Physician's Emergency Certificate & Commitment: You, your advocate or counsel, can find out more about what Commitment procedures apply by reviewing the appropriate statutes. All persons admitted through a Physician's Emergency Certificate have the right, upon request, to a Probable Cause hearing within 3 business days from admission. All voluntarily admitted patients shall be informed, upon admission, of their ability to leave after three days notice. Any voluntarily confined patient shall not be denied his or her request to leave within three days notice in writing unless an application for commitment has been filed in a court of competent jurisdiction. Different statutes apply depending on your placement in addictions treatment or for a psychiatric disorder. (See CGS 17a-495 et seq.; 17a-502; 17a-506; 17a-682 to 17a-685, 54-56d)

Visiting and Communication Rights: You may receive visitors during scheduled visiting hours. You have the right to visit with and may have private conversations with clergy, attorneys or paralegals of your choice at any reasonable hour. Facilities may reasonably maintain rules regulating visitors. Mail or other communications to or from a service recipient in any treatment facility may not be intercepted, read or censored.* Any exceptions to rights regarding communications must be explained in writing, signed by the head of the facility (or designee) and made a part of your clinical record. (See CGS 17a-546, 17a-547)

Access to Your Medical Record: You or your attorney may have the right, upon written request, to inspect your hospital records. Unless your request is made in connection with litigation, a facility may refuse to disclose any portion of the record which the mental health facility has determined would create a substantial risk that you would inflict a life threatening injury to self or others, experience a severe deterioration in mental state,* or would constitute an invasion of privacy of another. (See CGS 17a-548, 52-146f)

Restraint & Seclusion: If conditions are such that you are restrained or placed in seclusion, you must be treated in a humane and dignified manner. The use of involuntary seclusion or mechanical restraints is allowed only when there is an imminent danger to yourself or others. Documentation of reasons for these interventions must be placed in your clinical records within 24 hours. Medications cannot be used as a substitute for a more appropriate treatment. (See CGS 17a-544)

Remedies of Aggrieved Persons: If you have been aggrieved by a violation of sections 17a-540 to 17a-549 you may petition the Superior Court within whose jurisdiction you reside for appropriate relief. (See CGS 17a-550)

Disclosure of Your Rights: A copy of your rights shall be prominently posted in each ward where mental health services are provided. (See CGS 17a-548)

Medication, Treatment, Informed Consent & Surgical Procedures:
You, your advocate or counsel, can find out more about what procedures apply by reviewing the appropriate statutes (see CGS 17a-543a-j). If you have been hospitalized under any sections of 17a-540 to 550, you shall receive a physical examination within 5 days of admission and at least once every year thereafter. Reports of such exams must be entered into your clinical record. (See CGS 17a-545). No medical or surgical procedures, no psychosurgery or shock therapy shall be administered to any patient without such patient's written informed consent, except as provided by statute.* A facility may establish a procedure that governs involuntary medication treatments but any such decision shall be made by someone not employed by the treating facility and not until the patient's advocate has had reasonable opportunity to discuss such with the facility.* If a facility had determined to administer involuntary medication pursuant to statute, the patient may petition the Probate Court to hold a hearing to decide whether to allow this intervention. Notwithstanding the provisions of this section (17a-540 to 550) if obtaining consent would cause a medically harmful delay, emergency treatment may be provided without consent. (See CGS 17a-543a-f)

Denial of Employment, Housing, Etceteras: You cannot be denied employment, housing, civil service rank any license or permit (including a professional license) or any other civil or legal right, solely because of a present or past history of a mental disorder, unless otherwise provided.* (See CGS 17a-549)

Filing of Grievances: Recipients of DMHAS facilities or programs have the right to file a grievance if any staff or facility has: 1) violated a right provided by statute, regulation or policy; 2) if you have been treated in an arbitrary or unreasonable manner; 3) denied services authorized by a treatment plan due to negligence, discrimination ...or other improper reasons; 4) engaged in coercion to improperly limit your treatment choices; 5) unreasonably failed to intervene when your rights have been jeopardized in a setting controlled by the facility or DMHAS; or 6) failed to treat you in a humane or dignified manner. (See CGS 17a-451-t[1-6])

Other Rights may be guaranteed by state or federal statute, regulation or policies which have not been identified in this list. You are encouraged to seek counsel to learn of or to better understand these laws and policies.

Many of the rights of service recipients in facilities in Connecticut are specified in sections 17a-540 through 17a-550 of the Connecticut General Statutes. There may also be other rights provided by other state and federal statutes as well as by case law, but the ones identified in 17a-540 through 17a-550 are specifically protected and must be adhered to by inpatient or outpatient facilities in Connecticut. These statutes apply to both voluntary and involuntary service recipients, unless otherwise provided.

In general, both public and private facilities are prohibited from depriving you of any of your personal, property or civil rights. These include the right to vote, to hold or convey property and contract, except in accordance with due process of law and unless you have been declared incapable pursuant to sections 45a-644 to 45a-662. Any finding of incapability should specifically state which civil or personal rights you are incapable of exercising.

For more information about your rights as a recipient of substance abuse or mental health services in Connecticut, contact 1-800-446-7348.

*There may be exceptions and limitations to some rights. Your rights are detailed in the Connecticut General Statutes, sections 17a-450 et seq.; 17a-540 et seq.; 17a-680 et seq.; 52-146d-j; 54-56d; in Federal regulation 42 CFR part 2, the Rehabilitation Act, the Americans with Disabilities Act; in the Patients' Self-Determination Act, in Section 1983 and in other parts of state and federal law.

(http://www.dmhas.state.ct.us/documents/ptrights.pdf)

Annex 7. Example: Rights of Recipients of Mental Health Services, State of Maine Department of Behavioral and Developmental Services, USA

Extract of Table of contents and Rights of Recipients Summary

Table of Contents

Non-Discrimination Notice
Basis Statement
Introduction

A. RULES OF GENERAL APPLICABILITY

I. Statement of Intent
II. Definitions
III. Basic Rights
IV. Least Restrictive Appropriate Treatment
V. Notification of Rights
VI. Assistance in the Protection of Rights
VII. Right to Due Process with regard to Grievances
VIII. Complaints
IX. Confidentiality and Access to Records
X. Fair Compensation for Work
XI. Protection During Experimentation and Research

B. RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS

I. Statement of Intent
II. Privacy and Humane Treatment Environment
III. Individualized Treatment and Discharge Plan
IV. Individualized Treatment or Service Plan in Residential Settings in Residential Settings
V. Informed Consent to Treatment
VI. Basic Rights
VII. Freedom From Unnecessary Seclusion and Restraint in Residential Settings

C. RIGHTS IN OUTPATIENT SETTINGS

I. Statement of Intent
II. Individualized Support Planning Process
III. Individualized Treatment or Service Plan
IV. Informed Consent to Treatment

Summary in English, French, Russian, Serbo-Croatian, Somali, Spanish, Vietnamese

Rights of Recipients Summary in English

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES
RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

This is a summary of your rights as a recipient of services under the Rights of Recipients of Mental Health Services. You have a right to obtain a full copy of the Rights from this agency or from the Department of Behavioral and Developmental Services, 40 State House Station, Augusta, Maine 04333, Tel: 287-4200 (V), 287-2000 (TTY). If you are deaf or do not understand English, a qualified interpreter will be made available at no charge so that you can understand your rights and understand your treatment.

1. Basic rights. You have the same civil, human, and legal rights which all Maine residents have. You have a right to be treated with courtesy and full respect for your individuality and dignity.

2. Confidentiality and Access to Records. No one else can see your record unless you specifically authorize them to see it, except in instances described in the complete Rights book. You may add written comments to your record to clarify information you believe is inaccurate or incomplete. You have the right to review your record at any reasonable time.

3. Individualized Treatment or Service Plan. You have the right to an individualized plan, developed by you and your worker, based upon your needs and goals. The plan must be in writing and you have the right to a copy of it. The plan needs to specifically detail what everyone will do, the time frames in which the tasks and goals will be accomplished and how success will be determined. The plan must be based upon your actual needs and, if a needed service is not available, detail how your need will be met.

4. Informed Consent. No services or treatment can be provided to you against your will, unless you have a guardian who has consented, there is an emergency, or a special hearing about your treatment has occurred. You have the right to be informed (or if under guardianship, the guardian has the right to be informed) of the possible risks and anticipated benefits of all services and treatment, including medications, in a manner which you understand. If you have any questions, you may ask your worker or anyone else you choose before making decisions about treatment or services.

5. Assistance in the Protection of Rights. You have the right to appoint a representative of your choice to help you understand your rights, protect your rights or help you work out a treatment or service plan. If you wish a representative, you must designate this person in writing. You can have access to the representative at any time you wish and you can change or cancel the designation at any time.

6. Freedom From Seclusion and Restraint. You cannot be secluded or restrained in an outpatient setting.

7. Right to File a Grievance. You have the right to bring a grievance to challenge any possible violation of your rights or any questionable practices. You have the right to have your grievance answered in writing, with reasons for the decisions. You may appeal any decision to the Division of Mental Health. You may not be punished in any way for filing a grievance. For help with grievances, you may contact the Office of Advocacy, 60 State House Station, Augusta, Maine 04333, Tel: 287-4228 (V), 287-1798 (TTY) or Disability Rights Center, P.O. Box 2007, Augusta, Maine 04338-2007, Tel: 1-800-452-1948 (V/TTY).

I have received a copy of the summary of the Rights of Recipients of Mental Health Services

Date Client Signature Date Witness Signature

(To view full notice of rights for recipients of mental health services of the State of Maine, please see the following website: http://www.state.me.us/bds/Licensing/RightsRecipients/Index.html)

Annex 8. Example: Forms for involuntary admission and treatment (combined approach) and appeal form, Victoria, Australia

SCHEDULE 1

Regulation 5(1)

FORM OF INVOLUNTARY ADMISSION REQUEST

Mental Health Act 1986
(Section 9)
Mental Health Regulations 1998

PART A

REQUEST FOR ADMISSION OF A PERSON AS AN INVOLUNTARY PATIENT TO AN APPROVED MENTAL HEALTH SERVICE

TO THE ADMITTING REGISTERED MEDICAL PRACTITIONER

Please admit

....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of person to be admitted

of ....

(ADDRESS OF PERSON TO BE ADMITTED)

as an involuntary patient to an appropriate approved mental health service.

PART B

DETAILS OF PERSON MAKING THE REQUEST

....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of person making the request

of ....

address of person making the request

signed .... date ....

PART C

TAKING PERSON TO APPROVED MENTAL HEALTH SERVICE
(TO BE COMPLETED IF NECESSARY) *

I hereby authorise ....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of a **member of the police force, an ambulance officer or a person authorised by the person making the request

employed by .... designation ....

to take the above named person to an appropriate approved mental health service.

....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of person making the request

signed .... date ....

* This authorisation to take a person to an approved mental health service is only to be used when a Request and Recommendation have been completed. In the case of an Authority to Transport without Recommendation, schedule 4 must be used.

** Circle as necessary

SCHEDULE 2

Regulation 5(2)

FORM OF INVOLUNTARY ADMISSION RECOMMENDATION

Mental Health Act 1986
(Section 9)
Mental Health Regulations 1998

RECOMMENDATION FOR ADMISSION OF A PERSON AS AN INVOLUNTARY PATIENT TO AN APPROVED MENTAL HEALTH SERVICE

TO THE ADMITTING REGISTERED MEDICAL PRACTITIONER

Please admit

....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of person to be admitted

of...

address of person to be admitted

I am a registered medical practitioner and state as follows
I have personally examined the abovenamed person on (date)..............................
at..........*am/pm.

It is my opinion that:

(a) the person appears to be mentally ill *(a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory)*; and

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service; and

(c) because of the person's mental illness, the person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

I do not consider the person to be mentally ill by reason only of any one or more of the exclusion criteria listed in section 8(2) of the **Mental Health Act 1986.**

I base my opinion on the following facts

FACT/S PERSONALLY OBSERVED BY ME ON EXAMINATION

....

....

FACTS COMMUNICATED TO ME BY ANOTHER PERSON

....

....

TO BE COMPLETED WHERE NO FACTS ARE PERSONALLY OBSERVED
As no facts were personally observed by me, the following facts were communicated directly to me *in person/in writing/by telephone/by electronic communication by

Dr ....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS) of other registered medical practitioner

of ....

doctor's address

doctors telephone number ....

who examined the above named person on (date) ....
(being a period not more than 28 days prior to today's date)

FACTS COMMUNICATED BY OTHER EXAMINING REGISTERED MEDICAL PRACTITIONER:

....

....

I consider that the above named person should be admitted to an approved mental health service.

....

GIVEN NAME(S)/FAMILY NAME (BLOCK LETTERS)
of recommending registered medical practitioner

signed ....
SIGNATURE of recommending registered medical practitioner

Qualifications: ....

Address ....

Telephone number .... date ....
*circle as necessary

(See: http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf?OpenDatabase)

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Mental Health Act 1986

Sections 29

Mental Health Statewide Patient Number | | | | | | | | |

Local Hospital Patient Number: | | | | | | | | | | |

Family Name: ______________________________

Given Names: ______________________________

Date of Birth: ____________________ **Sex:** ________

Alias: ______________________________

APPEAL TO THE MENTAL HEALTH REVIEW BOARD

Notes to completing this form

Appeals

A patient may appeal to the Board at any time.

A community visitor or any other person who satisfies the Board of a genuine concern for the patient may make an appeal on behalf of an involuntary or security patient.

Further information

To find out more about the Board:

- Ask your case manager or another member of the treating team for the relevant patients' rights booklet.
- Call the Board on the number below.
- Visit the Board's website at **www.mhrb.vic.gov.au**

Privacy Statement

The information being collected on this form will be used by the Mental Health Review Board to schedule your appeal. The Board will notify you and the approved mental health service that a hearing has been scheduled. It will request the service to provide information about you and your treatment. The Board will use this information to help it decide your appeal. The exchange of information between the Board and your treating mental health service is authorised under the **Mental Health Act 1986.**

The Board will keep your information secure and not disclose it for any other purpose unless there is a legal requirement for it to do so.You can access information held about you by the Board by contacting the Executive Officer at the address shown.

TO THE EXECUTIVE OFFICER MENTAL HEALTH REVIEW BOARD

____

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of patient

____

address of patient if living in the community

I am a patient of: ______________________________

approved mental health service

I wish to appeal against:

(please cross ☒)

- ☐ being an involuntary inpatient.
- ☐ my community treatment order. I want to be discharged off the order.
- ☐ the conditions of my community treatment order. I want the conditions changed.
- ☐ my transfer to: ______________________________
  another approved mental health service
- ☐ my restricted community treatment order. I want to be discharged off the order (hospital order patients only).
- ☐ being a security patient.
- ☐ the refusal of the Chief Psychiatrist to grant me special leave (security patients only).

I wish to appeal because: ______________________________

____

____

____

____

____

____

____

____

Signed: ______________________________ Date: | | | | | | |

TO BE COMPLETED IF A PERSON MAKES AN APPEAL ON BEHALF OF A PATIENT

I wish to appeal on behalf of the abovenamed patient.

____

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of person making appeal

of: ______________________________

address of person making appeal

Signed: ________________ Relationship to patient: ________________ Date: | | | | | | |

eg. community visitor, spouse, friend etc.

Fax, mail or email your appeal to:

The Executive Officer	**Telephone:**	**8601 5270**
Mental Health Review Board	**Facsimile:**	**8601 5299**
Level 30, 570 Bourke Street	**Toll Free:**	**1800 242 703**
Melbourne 3000	**Email**	**mhrb@mhrb.vic.gov.au**

You may ask a member of staff to send your appeal to the Board.

White - ADMIN (send/fax copy to MHRB) Yellow - PATIENT FILE Green - PATIENT/APPLICANT

MHA 5 APPEAL TO MHRB

ROLLS FILING SYSTEMS (03) 8770 1111

DEC 2004

Annex 9. Example: New Zealand Advance Directives for Mental Health Patients

ADVANCE DIRECTIVES IN MENTAL HEALTH CARE AND TREATMENT

Information for mental health service users
HDI
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Example:

An advance directive refusing ECT
Manu has been sectioned under the Mental Health Act on several occasions. He was once given a series of electroconvulsive shock treatments without his consent. He does not remember much about the procedure, but did not like the fact that afterwards he experienced memory blanks.

He has read a lot of material about ECT and strongly believes he does not want to take the risk of experiencing further memory blanks. He also knows from experience that other treatment, as well as family support, will help prevent disabling depression.

It is now three months since Manu's last hospitalisation and, at his next outpatient appointment, he sits down with his psychiatrist to discuss a personal crisis plan.
It is agreed that Manu will prepare an advance directive stating that he does not wish to receive ECT under any circumstances.

His crisis plan covers issues such as noticing early symptoms of depression and seeking help from the psychiatric team, as well as advice to his family about how best to support him. Manu is hopeful that even if he is sectioned again under the Act, the wishes he has expressed in his directive will be considered by his clinicians.

What options do I have if my advance directive is not followed?

If your advance directive about your future health care is not followed and you are not satisfied with the clinician's explanation, you can complain to the Health and Disability Commissioner.

What happens if I do not have an advance directive?

If you have a crisis and are considered incompetent to consent to treatment (and you're not being sectioned under the Mental Health Act), your clinician can still decide on your treatment, taking into account:

- your best interests; and
- your probable choice if you were competent to make it; or
- the views of other people who are interested in your welfare.

What about nominating someone to make decisions on my behalf?

In some countries your advance directive can include a nominated person to make decisions on your behalf. However, in New Zealand you need to appoint a person to be your Enduring Power of Attorney in relation to your personal care and welfare, through the Protection of Personal Property Rights Act 1988. If you wish, you can give this person the power to make health care decisions on your behalf when you are not competent to do so yourself. You should seek advice from a lawyer if you wish to appoint someone as your Enduring Power of Attorney.

What about decisions that don't relate to my health care?

There may be decisions not related to your health care that you wish to communicate in advance. One way to do this is through crisis planning. The people working in your mental health service should discuss your preferences with you in case you experience another crisis. Your crisis plan can record decisions such as who you would like to look after your children, or the names of family members you would like to be contacted while you are in hospital.

You can also incorporate your advance directive into the crisis planning process. If your clinician does not involve you in any crisis planning you can simply write down your own wishes and ask for them to be put in your file.

Example:

An advance directive refusing a specific drug
When Bill was hospitalised he was given a high dose of the drug X and had a very severe reaction to it. Bill discussed his medication with his psychiatrist and they decided that it would be better to avoid drug X altogether, especially as a suitable alternative had been found. Bill has family in different parts of New Zealand, and often travels around. He decided it would be a good idea to carry with him an advance directive to safeguard against being given the drug if he required admission to a different mental health service that did not have his records. He also felt it would be helpful to record the names of both drug X and his current medication, as when he is unwell he sometimes gets confused and can't remember the names.

An Enduring Power of Attorney for informing family and friends
John is a young gay man who currently has a partner and a wide circle of friends who were really supportive when he had a mental health crisis last year. However, when his parents came to see him during the crisis they made things worse. They disapprove of John's lifestyle and tried to prevent his friends from seeing him. They didn't want him to go home to his flat, which he shares with his partner and a couple of other gay men. Although John wishes his parents to be informed if he is hospitalised, he wants decisions about his care to be made by his partner. For this reason, John, with help from his lawyer, has appointed his partner as an Enduring Power of Attorney for his personal care and welfare.

What is the best way to protect my wishes and interests?

An advance directive will help ensure your wishes and interests are respected in a crisis, but an Enduring Power of Attorney and a crisis plan will protect your wishes and interests even more.

Do you want more control over what happens in a crisis?

If you do, an advance directive could be a good way for you to gain more control over the treatment and care you are given in a future episode. Past episodes will have helped you understand what treatments and care work for you and what don't. You have the right, under the Code of Health and Disability Services Consumers' Rights, to use an advance directive to make your wishes known about the treatments and care you receive during a future episode.

What is an advance directive?

In simple terms, an advance directive is the giving or refusing of consent to treatment in the future. It is a statement to others, usually in writing, setting out your treatment preferences if you experience another episode of mental illness that leaves you unable to decide or communicate your preferences at the time.

Under the New Zealand Code, advance directives relate only to the type of health care and treatment you want. In some countries advance directives can include decisions not directly related to your health care, but in New Zealand different processes are needed to make these wishes known.

Who can make an advance directive?

The Code of Health and Disability Services Consumers' Rights gives any person who is legally competent to make a health care choice the right to make an advance directive.

What can I make an advance directive about?

Advance directives should focus on treatment and care. For example, you could state:

- the treatments you do or don't want to be given when you are in a crisis, including drugs or ECT
- the places you would prefer to receive services when in crisis, such as hospital, home or a crisis house.

Example:

An advance directive requesting a specific drug
Sally knows that when she starts to feel a certain way, it's really important to begin treatment with a low dose of drug X. During her first episodes of mental illness she became very unwell and was hospitalised. Recently she shifted to a new city and is unsure whether her new doctor really respects her own knowledge of her condition.
She decided to prepare an advance directive, which states that if she has another episode she wishes to be prescribed drug X by her GP, rather than waiting for psychiatric referral. While Sally's request will be respected by her clinicians, the drug will be provided only if clinically appropriate at the time.

How do I go about making an advance directive?

It's not difficult to make an advance directive. You don't need a lawyer. In fact, you have the right to make an advance directive without involving anyone else in its preparation. However, taking the following steps will help ensure that your advance directive is respected, and the decisions contained within it acknowledged and acted upon.

- If possible, make your advance directive in writing rather than verbally. State your preferences as clearly as you can, then sign and date it.
- If you prepare your advance directive with the help of your clinician or another health worker, he or she can verify that you are competent and sufficiently informed about your stated preferences, and can help you clarify the type of situation you intend your directive to cover.
- If you involve your family or whanau in preparing your advance directive, or at least inform them of it, they will be better equipped to support you and to advocate for your wishes in a crisis.
- Regularly review and update your advance directive so that it reflects any changes in your condition or your preferences, and is viewed by clinicians as still representing your wishes.
- Keep a copy of your advance directive yourself, and give copies to your family or support persons, and the clinicians most often involved in your care.

Will my advance directive always be followed?

No. When deciding whether or not to follow your advance directive, your clinician will consider five questions:

- Were you competent to make the decision when you made the advance directive?
- Did you make the decision of your own free will?
- Were you sufficiently informed to make the decision?
- Did you intend your directive to apply to the present circumstances, which may be different from those anticipated?
- Is the advance directive out of date?

The Code of Health and Disability Services Consumers' Rights sets out your right to be fully informed, make an informed choice, and give informed consent. However, your advance directive will not override the ability of your clinician to authorise compulsory treatment if you are subject to a compulsory treatment order under the Mental Health (Compulsory

Assessment and Treatment) Act 1992. The Mental Health Act also directs the responsible clinician to attempt to get your consent to treatment even though he or she may give you treatment without your consent.

It may still be worth having an advance directive if you are subject to a compulsory treatment order because it will give your clinician an indication of your wishes.

Example of an advance directive refusing drug X.

I ______________________ do not wish to receive drug X under any circumstances. I have discussed this decision with my psychiatrist, Dr ____________________, who has explained my treatment options and the expected benefits, risks and side effects of drug X.

I confirm that I have made this decision of my own free will and that, unless revoked by me, it is to apply for the next ______ years.

Date _________________________________

Signature _____________________________

I confirm that _______________________ is competent at the time of making this advance directive.

Date _________________________________

Clinician ______________________________

Mental Health Commission:
Phone: (04) 474 8900
Fax: (04) 474 8901
Email: info@mhc.govt.nz
Website: www.mhc.govt.nz

HDI Health and Disability Commission:
Ph/TTY: (09) 373 1060
Fax: (09) 373 1061
Freephone: 0800 11 22 33
Email: hdc@hdc.org.nz
Website: www.hdc.org.nz