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

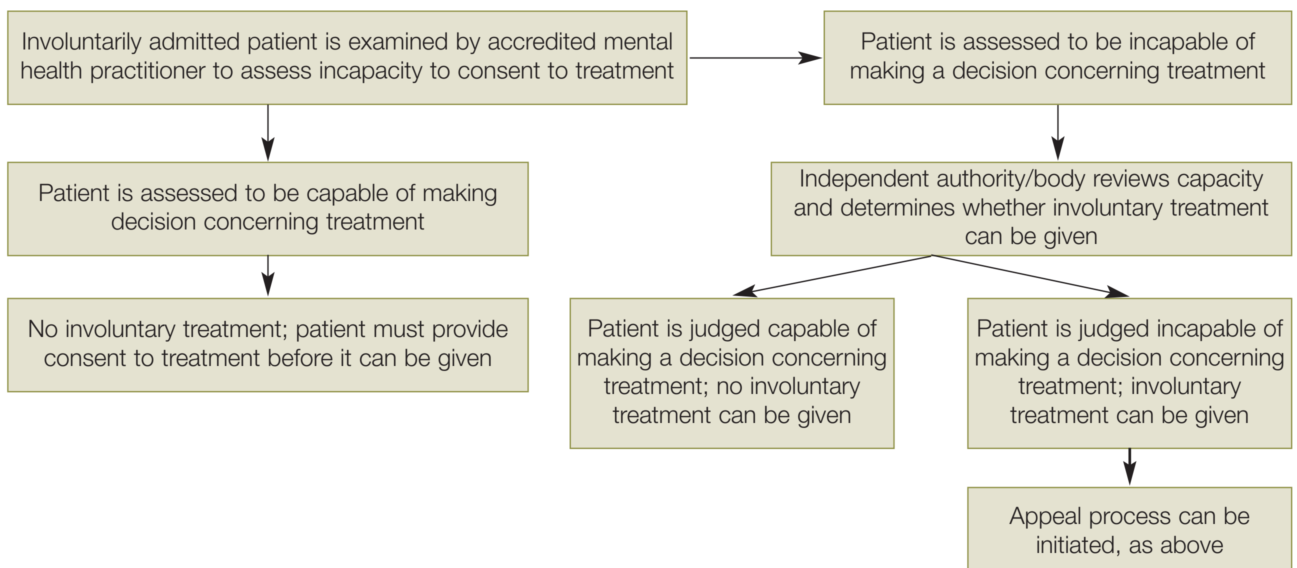
Patient must be discharged immediately

Appeal denied

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.**

12. Clinical and experimental research

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.

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[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.