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A Systematic Approach to Developing and Implementing Mental Health Legislation

*Report of a Regional Meeting of Experts
New Delhi, India, 6-8 December 2004*

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**World Health
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1. INTRODUCTION

An expert meeting on developing and implementing mental health legislation for selected South-East Asian countries was held in New Delhi, India, from 6 to 8 December 2004. The meeting was opened by Dr Samlee Plianbangchang, WHO Regional Director, South-East Asia Region. The list of Participants and the Programme of the meeting are at Annexes 1 and 2 respectively.

Mental health legislation is essential for protecting the rights and dignity of persons with mental disorders, and for developing accessible and effective mental health services. Effective mental health legislation can provide a legal framework to integrate mental health services into the community and to overcome stigma, discrimination and exclusion of mentally-ill persons. Legislation can also create enforceable standards for high quality medical care, improve access to care, and protect civil, political, social and economic rights of mentally-ill individuals, including a right of access to education, housing, employment and social security. Furthermore, mental health law can establish guidelines through which a country develops its mental health policy, or reinforce previously established mental health policies that seek to provide effective and accessible mental health care through the community.

According to the WHO Atlas on Mental Health, there is no mental health legislation in over 25% of countries worldwide. Furthermore, of the countries which have mental health legislation, only half of the mental health laws were passed after 1990. Thus, most countries either have no mental health legislation, or continue to use mental health legislation developed prior to modern pharmacological advances that have made community-based care possible.

Recognizing the importance of developing effective mental health legislation, WHO, through extensive consultations with mental health professionals, experts, consumers and governments, developed a Resource Book on mental health legislation that provides interested parties with

information, background, explanations and justifications for developing mental health legislation that promotes the human rights and dignity of mentally-ill individuals and community-based mental health care. Furthermore, WHO has developed: (1) a checklist on "A Systematic Approach to Developing and Implementing Mental Health Legislation" that interested parties can use to research and evaluate their mental health laws, policies and regulations, and (2) a Guidance Instrument that enables interested parties to identify the types of mental health services available, the deficiencies in mental health services, the stakeholders that would be involved in drafting mental health legislation and the initial steps that should be taken to catalyze development of mental health legislation.

Member States that participated in this expert meeting were India, Indonesia, Sri Lanka and Thailand. Participants from the latter three countries were: (1) a senior official from the Department of Mental Health and (2) a lawyer or legal expert familiar with the country's laws, policies and regulations related to mental health care. Participants completed the WHO Checklist and Guidance Instrument and provided English translations of all relevant legislation prior to the meeting.

2. OBJECTIVES

General Objective

To assist Member States to develop and implement mental health legislation.

Specific Objectives

- (1) To discuss of the current status of mental health legislation in select Member States based on the WHO Checklist and the WHO Guidance Instrument.
- (2) To exchange experiences with Member States in developing mental health legislation.
- (3) To discuss proposals from participating Member States for a national-level workshop to be conducted in the country during 2005/2006.

3. UNDERSTANDING THE RELATIONSHIP BETWEEN MENTAL HEALTH, LEGISLATION AND HUMAN RIGHTS

Persons with mental disorders are exposed to a wide range of human rights violations. In many countries, mentally-ill individuals do not have access to basic mental health care and treatment they require. Violations within psychiatric institutions are rife, including degrading and harmful care and treatment practices and unhygienic and inhuman living conditions.

Besides numerous human rights violations within institutions, mentally-ill persons are crippled in their day-to-day lives by widespread discrimination, stigmatization and misconceptions about the nature of mental illness. This leads to exclusion and denial of basic rights, such as the right to shelter, food and education, to formal exclusion through government policies that deny the right to vote, marry, have children or own property. These policies and laws reinforce community, family and individual misconceptions of mental illness and intensify stigmatization, exclusion and economic disempowerment of mentally-ill individuals. Even laws which do not discriminate against mentally-ill individuals can harm the ability of mentally-ill individuals to access benefits, services and opportunities equally. Thus, employment laws that do not have a heightened sensitivity to the needs of mentally-ill persons may preclude access to simple employment opportunities and push mentally-ill individuals to the economic margins of society.

Legislation can represent an important and effective means to protect mentally-ill individuals and to empower them to access basic economic, social and political rights, both in institutional setting and in their communities. Thus, legislation can:

- prevent human rights violations and discrimination;
- promote autonomy and liberty of people with mental disorders, particularly against excessive institutionalization;
- promote access and provision of community-based mental health care, and
- protect the economic, social and cultural rights of mentally-ill persons.

Since many mentally-ill individuals cannot consent to medical treatment within or outside an institutional setting and often are involuntarily admitted to psychiatric facilities, basic safeguards to protect mentally-ill individuals from medically dangerous and unsanctioned treatment, excessive institutionalization or harsh conditions is particularly important. Countries in the Region have constitutions, laws, statutes, regulations and mental health policies that reinforce these standards, and are in the process of developing other laws, policies and regulations that contemplate additional human rights protections for mentally-ill individuals.

4. CURRENT STATUS OF MENTAL HEALTH LAW IN INDIA, INDONESIA, SRI LANKA AND THAILAND

Prior to attending the expert meeting, participants from Indonesia, Sri Lanka and Thailand each completed the WHO Checklist and Guidance Instrument. Participants from the three countries presented their findings at the meeting. Earlier, the WHO Regional Office had conducted a comprehensive research study on current national mental health laws and policies in India. The findings of this research study were also presented.

India

Significant changes in Indian mental health law and policy have occurred over the last two decades. A new mental health policy, the National Mental Health Programme, was introduced in 1982 to encourage and develop community-based mental health care services. This was expanded and modified in 1995 through the introduction of the District Mental Health Programme, which sought to improve mental health care by training all government health professionals in the diagnosis, treatment and prevention of mental illness, upgrading government psychiatric hospitals and introducing psychiatry in the curriculum of all medical school.

New mental health legislation was enacted in 1987 through the Mental Health Act, which superseded the 1912 British Lunacy Act. The Mental Health Act was brought into force in 1993, and introduced greater regulatory oversight of psychiatric facilities through magistrates and state mental health authorities. Nevertheless, research demonstrates that the Mental Health Act

has not been implemented and that it does not adequately protect the human rights of mentally-ill individuals, does not guarantee a right to treatment and care for simple or complex mental illnesses, enables human rights violations of mentally-ill individuals and precludes effective oversight of admission, treatment, discharge and quality of care at psychiatric facilities. Besides enactment of the Act, other legislation has been introduced and enacted to protect and promote the rights and needs of mentally-ill individuals. This includes the following:

- The Persons with Disabilities Act (1995) enables state governments and the central government to provide mentally-ill individuals with housing, education, employment and social security benefits. However, it has been unsuccessfully implemented since the legislation does not have a mechanism to identify mentally-ill individuals who qualify for benefits.
- Juvenile Justice Act (2000), which creates a system of local child welfare committees to determine the best course of action for at-risk children; however, this often means involuntary admission of children without the basic safeguards guaranteed by the Mental Health Act.
- Protection of Human Rights Act (1993), which establishes a National Human Rights Commission charged with the authority to investigate human rights abuses of vulnerable persons, including abuses of mentally-ill individuals.
- Rehabilitation Council Act (2000), which establishes a strict and exclusive licensing system for rehabilitation professionals caring for mentally-ill individuals, thus excluding NGOs that provide the majority of rehabilitative care.
- National Trust Act (2000), which provides benefits to mentally ill individuals who are simultaneously afflicted by a second physical or mental disability.

Furthermore, there have been numerous Supreme Court and State High Court decisions over the last two decades that have exposed illegal detention and institutionalization of women, sub-standard facilities and services at government psychiatric hospitals, unlawful use of reception orders to detain a family member or spouse and housing of mentally ill, non-criminal individuals

in prisons and jails.¹ Many shortcomings have been substantiated by the National Human Rights Commission, which released a publication, *Quality Assurance in Mental Health Care*,² which describes sub-standard facilities and treatment in numerous government psychiatric hospitals.

Indian common law provides a patient with a right to informed consent and confidentiality of patient records, although the Mental Health Act only requires informed consent for experimental treatment. Furthermore, this is only a qualified requirement since informed consent is not required if the attending physician can show that the research is of direct benefit to the patient.³ Indian law severely curtails the civil and political rights of mentally ill individuals. Hindu and Parsi personal laws preclude the right of mentally ill individuals to marry and sanction divorce if the spouse is likely to remain mentally-ill; the 1950 and 1951 Representation of the People Act forbids mentally-ill individuals from voting and standing for elections. Property and inheritance rights are protected under Indian law although the legal determination of capacity to assume full control of one's property or to control one's inherited assets does not require the opinion of a medical professional, thus increasing the possibility that subjective bias could prevent individuals recovered from mental illness from controlling their own assets.

Indonesia

Comprehensive reform of Indonesian health legislation occurred in 1992 through passage of Basic Act of Health No. 9, which nullified all regulations, and directed development of new health regulations through the Department of Health. A new mental health regulation, written by the Ministry of Health in consultation with other government ministries was completed in 2002. It has been approved by the Ministry of Health and is currently with the Secretary of State for signature by the President of Indonesia, after which it will come into effect throughout the country. This will be difficult since Indonesia has undergone rapid decentralization over the last decade,

¹ For instance, in *Sheela Barse v Union of India*, 1995 No. 237/89 SC, the petitioner produced evidence of West Bengal magistrates issuing orders for committing non-criminal mentally-ill persons into jails without requiring medical certificates from doctors. Instead, the vast majority of orders were imposed through safe custody orders provided by police officers. These detention orders were not processed through application of the Mental Health Act, but through the Code of Criminal Procedure, which permitted detention of persons for up to three months. Upon completion of the three months, the detention orders were renewed, and this process continued indefinitely.

² See National Human Rights Commission, *Quality Assurance in Mental Health Care* (1999)

³ See Section 81, Mental Health Act

effectively transferring most authority to district officers to implement health regulations. Since district officers differ in their ability and willingness to implement regulations, it will be difficult to introduce and enforce these regulations across Indonesia.

The new regulations:

- establish a structure for mental health services divided into three strata, with the primary level consisting of community-based clinics to treat mentally-ill individuals;
- assign responsibilities to various types of health professionals to provide mental health care;
- identify activities and authorize the Minister of Health to conduct programmes to prevent mental illness and to treat and rehabilitate mentally-ill individuals;
- establish how an individual may be admitted or treated for a mental illness;
- explain how mental health care will be financed (through national health insurance, national and local government funds and the private sector);
- describe the minimum requirements to establish a psychiatric facility;
- guarantee mentally-ill individuals the same rights provided to all Indonesians, including a specific right to health insurance;
- prohibit neglect of mentally-ill individuals and cruel and unusual treatment of mentally-ill individuals, including harsh restraint of mentally ill persons using wooden stocks;
- establish procedures to conduct a psychiatric assessment of criminal mentally-ill individuals; and
- provide good faith protections to health professionals providing psychiatric care and establish monetary penalties for violations of the health regulations.

Although they provide guidance on certain areas of mental health law, a review of the regulations through the use of the WHO Checklist reveals that many issues may still need to be clarified. This includes: procedures to

guarantee patient confidentiality and informed consent for medical treatment, procedures to guarantee patient protections if the patient is involuntarily admitted or treated, a judicial procedure to issue reception orders for admission of patients and an appeal mechanism for patients who wish to contest involuntary admission or treatment decisions, minimum facility standards (space, privacy, staffing) and protections against cruel and unusual punishment, particularly the use of certain medical treatments.

Until they are approved by the President, it is possible to amend or add to the regulations. However, it is unlikely that the Ministry of Health will change the regulations, and future activities will focus on sensitizing provincial and district officials and local health officers about the scope and purpose of the regulations.

Indonesia has also previously enacted legislation, entitled the Act Concerning Disabled People (1997), which provides some rehabilitation, social security and welfare benefits for mentally-ill individuals. It is unclear how this Act has been implemented in Indonesia, and whether benefits are reaching mentally-ill individuals.

Sri Lanka

As with other countries formerly under the British Commonwealth, Sri Lanka historically relied upon a British-style Lunacy Act, the 1873 Mental Diseases Ordinance (MDO). Unlike some other countries in the Commonwealth, Sri Lanka has not replaced the ordinance with a new mental health law. Reasons for continued use of the ordinance include: low priority of mental health within the Health Ministry, Parliament and the public, few interest groups, nongovernmental organizations or consumers devoted to supporting the rights of mentally-ill individuals or providing psychiatric care, and a belief amongst some members of the psychiatric community that legislation has little relevance to their profession.

Attempts have been made earlier by the Department of Mental Health and some psychiatrists, academics and lawyers to draft and enact new mental health legislation. However, each effort has been unsuccessful due to the general apathy described above. The draft legislations contemplate almost all areas of concern included in the WHO Checklist and utilized the WHO

Resource Book and Checklist as a resource. On the other hand, the ordinance is focused upon establishing regulatory procedures for institutionalized care, provides little human rights protections to mentally-ill individuals and does not reflect modern advances in psychiatric care.

Enacting new legislation will require efforts to enhance the engagement amongst all relevant stakeholders, a willingness of psychiatrists to sacrifice some autonomy, and enhanced monetary investments by the government and private sector to provide community-based mental health care.

Besides the Mental Diseases Ordinance, Sri Lanka previously passed a Rehabilitation Act (1996) that aims to provide rehabilitation and social security benefits to disabled persons, which includes mentally ill individuals. The effectiveness of the Act is unclear.

Thailand

Thailand has no formal mental health legislation. However it has one of the largest mental health departments in the Region. Furthermore, Thailand has implemented a variety of community-based psychiatric services through an effective mental health policy, a system of regulatory controls through a hospital accreditation scheme to enforce minimum hospital standards, a patient's rights declaration, which provides some human rights protections to mentally-ill individuals, and other laws, regulations and decrees that regulate mental health services and treatment of mentally-ill individuals, including criminal mentally-ill persons. There is a strong commitment in the Department of Mental Health to draft a mental health law over the next three years.

Thailand enforces minimum hospital standards through a hospital accreditation scheme, which nearly all private and public hospitals have adhered to. This ensures that minimum standards designated by the government are adhered to nationwide. Access to mental health care is facilitated through the '30 baht' health insurance system, which guarantees universal coverage for most medical procedures. The Constitution provides some human rights protections to mentally ill individuals. The most relevant legal standard is the Patient's Rights Declaration, which was written through a joint consultation process of the government, health professionals, consumer groups and human rights organizations. The declaration, which was originally

non-binding, stipulates numerous rights including a right to: receive medical treatment, informed consent, emergency medical care and confidentiality. The declaration is now legally enforceable, and has resulted in some legal actions to compel medical authorities to respect the basic rights guaranteed to patients therein.

Other laws in Thailand provide protections and clarify the limited rights that are guaranteed to mentally-ill persons. Clear guidelines and regulations have been developed to assess whether a criminally mentally-ill persons is not mentally culpable for his or her crimes due to mental disorder, to delay or modify trials if the defendant is mentally incapable of defending him or herself at trial, and to release a mentally-ill person from prison to a treatment facility in certain circumstances if the defendant is mentally ill. Legal protections are provided to mentally-ill persons to prevent their entry into unconscionable contracts; however, the civil rights of mentally-ill persons are curtailed since the Civil Code does not permit the marriage of a mentally-ill person.

Finally, as in India, Indonesia and Sri Lanka, Thailand has enacted an Act on Rehabilitation of Persons with Disability that aims to provide disability and rehabilitation benefits to mentally-ill persons. However, the welfare and social security benefits provided to individuals have not been sufficient to overcome the personal and economic insecurity resulting from mental illness.

5. ISSUES RELATED TO DEVELOPMENT AND IMPLEMENTATION OF MENTAL HEALTH LEGISLATION

Following presentations, group discussions were held on development and implementation of mental health legislation. This allowed participants to share their experiences with others and to discuss strategies to overcome obstacles and address common problems. Some of the common themes that were discussed are introduced below.

5.1 Purpose of Mental Health Legislation

Mental health legislation plays an important role in implementing effective mental health services, particularly by utilizing political and popular will to reinforce national mental health policies. Enactment of mental health

legislation can improve funding of mental health services, create accountability for those responsible for providing mental health services and overcome bureaucratic gridlock to ensure compliance with mental health policies and directives.

Mental health legislation plays a central role in the protection and promotion of human rights. Participants at the workshop expressed some resistance to providing expansive protection of human rights through legislation, although most participants agreed that non-discrimination and freedom of choice were inviolable principles that must be protected through legislation. Mental health legislation can improve the right of individuals to access mental health care by legally mandating the development of community-based care, integrating mental health care into primary health care centres and facilitating a government or private sector guarantee of universal health insurance.

WHO and international guiding principles for mental health care mandate that all human rights, including the right to privacy, informed consent, confidentiality, freedom from cruel and unusual treatment and non-discrimination should be guaranteed through mental health legislation. Legislation that adheres to these guidelines may impose new obligations. Thus, legislation may be aspirational, and following enactment, best efforts should be made to progressively satisfy the goals and objectives of the legislation.

5.2 Relationship of Mental Health Law and Policy

Mental health law represents an important means of reinforcing the goals and objectives of mental health policy. Mental health law can influence the development and implementation of policy and the reverse is similarly true. Mental health policy often relies on a legal framework to achieve its goals, to protect rights and improve the lives of persons affected by mental disorders. Furthermore, government policy-makers, the private sector and civil society may be obliged, compelled or encouraged to overcome historical obstacles to pursue certain policy objectives. Thus, a law that promotes community-based care and treatment as a viable alternative to institutionalized care may provide policy-makers and civil society organizations with the necessary tools and flexibility to implement community-based programmes.

5.3 Implications of Developing Mental Health Law through Ministerial Regulations instead of Parliament-based Law

Implementing mental health legislation is feasible only if multiple stakeholders have participated in the process of publicizing, drafting and critiquing the law, so as to provide 'a sense of ownership' for what is eventually enacted. Nevertheless, in many countries in the South-East Asia Region, laws are not drafted through the traditional process of building democratic consensus amongst the public; instead laws are drafted and approved only within the ministry of health and in cooperation with other government ministries. Although approval usually requires the assent or input of various government ministries, the entire process occurs without public comment, input or critique. Furthermore, democratically-elected parliaments are not given an opportunity to approve the law, and would have to enact a supervening law to overcome any provisions which are unpopular. While government ministries may have the best interests of the public in mind, it is possible that government officials may not identify or address pressing problems that can only be revealed through consultation with a wide group of stakeholders. Furthermore, health professionals, consumers and other interest groups may resist the new regulations since they will not have participated in their formulation.

On the other hand, drafting regulations through a government ministry offers the advantage of ensuring expediency, and the legislation can be closely tied to a ministry's mental health policy. It is unlikely that these benefits outweigh the benefits of the alternative, namely fostering democratic discourse, dialogue and inclusion of multiple stakeholders.

5.4 Identifying and Involving Stakeholders in the Process of Drafting Legislation

WHO recommends involving multiple groups in the drafting and consultation process, including: government agencies (ministries of health, finance, law, education, employment, social welfare, justice, police and correctional services), academic institutions and professional bodies representing health care professionals, user group representatives and representatives of families, nongovernmental organizations, profit and not-for-profit agencies providing care services, politicians, legislators and opinion-makers, law enforcement

agencies, judicial authorities, religious authorities, organizations representing minorities and vulnerable groups and other relevant community groups, such as civil rights groups, employee unions, employer groups and welfare associations.

Most participants noted that awareness of the importance of mental health legislation is lacking amongst the public and specific interest groups such as psychiatrists. Furthermore, many countries in the Region have few or no nongovernmental organizations, user groups and community groups specializing in mental health. Thus, it may be preferable initially to build social consciousness and encourage the development of advocacy and interest groups who focus upon provision of mental health services and protecting the needs and rights of mentally-ill persons. One mechanism to enable this process is to link domestic groups and individuals with larger international nongovernmental organizations that advocate on behalf of the mentally ill.

5.5 Implications of Resource Deficiencies When Developing Mental Health Legislation and in Incorporation and Enforcement of Human Rights Standards

In all countries in the Region, there are particular resource constraints that preclude the ability of ministries to provide universal mental health services. Thus, there has often been animosity or mistrust of human rights standards since many professionals and officials believe that human rights standards place excessive and unrealistic burdens upon a government to provide mental health services and protections. Most professionals and governments do acknowledge that some human rights protections, such as freedom from cruel and unusual punishment, are *non-derogable*, or human rights that may not be denied to any individual under any circumstance.

For other rights, human rights law recognizes the resource deficiencies and constraints that developing countries must face. Human rights law, with the exception of *non-derogable* human rights, which must always be fulfilled, provides for the principle of *progressive realization* of human rights, or that countries are obliged to move as expeditiously and effectively as possible towards the goal of fulfilling international human rights obligations. Thus, it acknowledges the constraints due to the limits of available resources but requires countries to show constant progress towards full realization of rights.

In fact, countries in the Region have demonstrated how to progressively realize the right to health for mentally-ill individuals in resource-deficient settings. In Thailand, health volunteers and monks are used to bridge the gap in mental health treatment, particularly in rural areas. Each village has at least one temple and monks are active in the community to provide information, support and care for mentally-ill individuals, alongside other basic social services. Similarly, the government has actively trained all doctors and nurses to provide basic mental health care to alleviate the shortage of psychiatrists, particularly outside urban areas. And the government has worked with prisons to identify mentally-ill prisoners who can be sent to local hospitals for necessary treatment.

5.6 Decentralization and its Implications for Provision of Mental Health Services and Basic Human Rights Standards

Many countries in the Region are undergoing a gradual process of decentralization of government and social services. This has many benefits, particularly in culturally, ethnically and geographically diverse countries where resources are often under or misallocated in remote areas. Furthermore, it reduces excessive costs incurred in maintaining a large, centralized bureaucracy, and allows for flexibility to be built into local social services and health programmes.

In the Region, Indonesia has undergone significant and rapid decentralization over the last decade. Similarly, Sri Lanka and Thailand have started the process of decentralization. In India, health is regarded as a state subject and the bulk of spending and regulation is through the state. However, the national government is empowered to pass legislation and spend funds to regulate and provide health care in the states.

Decentralization is an important trend that should be noted when drafting and implementing national mental health legislation. Since it is difficult for a centralized bureaucracy to ensure that all laws, regulations and policies are being followed, it is likely that many standards, protections and requirements will not be implemented in certain provinces or districts. This has been the case in India, where over a decade after enactment of the Mental Health Act most states have still not constituted a state mental health authority. Similarly, Indonesia has identified sensitization of provincial and

district health officers as integral to effectively implementing its proposed mental health regulation since considerable authority over budgets and implementation have been devolved to these officials. Participants from Sri Lanka and Thailand expressed similar reservations about the consequences of decentralization for enforcing national mental health legislation.

5.7 De-institutionalization of Mental Health Care through Law

Although some individuals require institutionalized mental health care, the vast majority of patients with common mental disorders only require outpatient mental health care. Prior to medical advances, legislation and policy reflected a preference to isolate and detain mentally-ill individuals, who were seen as a danger to themselves and others. Today, WHO actively supports movement of mental health care from institutional settings to community-based treatment. Countries in the Region have identified and implemented policies that can help support this trend, including creation of intermediate care centers in districts, training of all government doctors and nurses at primary health care centers to identify and treat mental illnesses on an out-patient basis, and recruitment of health volunteers, teachers, religious figures and social workers to provide information and support to mentally ill individuals.

The law can play an important role in fostering de-institutionalization. Most importantly, the law should reduce legal barriers and obstacles that patients must face to leave psychiatric hospitals and increase the legal protections and oversight of involuntary admissions into mental hospitals. Legislation can require governments to allocate more resources to mental health care, particularly to improve community-based services. This was done in Thailand through the Health Warranty Act, which integrated mental health care into community services provided by the government. Similarly, legislation could actively incorporate the nongovernmental sector into providing mental health care by easing licensing requirements for organizations providing community-based care and allocating government funds towards initiatives promulgated by NGOs. Furthermore, mental health legislation and policy can mandate the creation of halfway homes, employment assistance, lowering dependence of the family for discharge even while providing extension services to families and careers to facilitate exit from institutions.

5.8 Right to Informed Consent, Use of Patient's Rights Declarations and the Tension Between Physician Autonomy and the Human Rights of Mentally-ill Persons

Protecting the rights of mentally-ill individuals means that certain standards, obligations and restrictions are placed upon how facilities operate, how services are provided and upon the authority of the physician. Thus, protecting human rights means that all physicians and psychiatrists must cede some decision-making authority and autonomy to protect and empower patients.

Participants noted that many psychiatrists are reluctant to cede their autonomy, and consider codes of medical ethics and physician judgment sufficient to protect the rights and dignity of mentally-ill individuals. One traditional source of friction that exists between patients and physicians is with respect to informed consent, or a patient's right to make a fully informed decision as to whether or not they wish to receive medical treatment prescribed by a doctor. In many countries in the Region, and particularly with respect to mentally ill individuals, treatment decisions are either made unilaterally by the doctor or only in consultation with the family. If an individual does not concur with the treatment, a doctor may feel compelled to place the family interest above the interest of the individual. International human rights principles state that all patients have a right to make an informed decision concerning their medical treatment, and only patients with diminished capacity due to age or mental incompetence may require physicians and families to act as a substitute decision-maker in the patient's best interests (and with an independent reviewing authority to ensure that the patient's best interests are taken into account). Here, there is obvious friction between the community/family decision-making model advanced in many countries of the Region, and the universal human right that enables individuals to make informed decisions.

Thailand has sought to balance these competing values. A consensual drafting process created a patient's rights declaration that delineates the rights of patients. The declaration guarantees the right of patients to make fully informed medical decisions, except in the case of emergencies. Doctors, families and patients still work concurrently to determine the best course of action for a patient's health, but patients are provided with an absolute right

to protect their own health if they believe their health will be jeopardized by a certain course of action.

5.9 Use of Good Faith Clauses

Good faith clauses are legal provisions that provide some form of legal protection, or immunity, to individuals who have a legal duty to others. In the absence of a good faith clause, a psychiatrist treating a mentally-ill individual will be liable in negligence, or legally accountable, for his or her actions if the doctor did not exercise reasonable care that would be expected of a doctor in that locality, and results an injury to the patient.

A good faith clause alleviates a doctor or psychiatrist of some or all liability for their actions even if they are found to be negligent, reckless or intentionally harmful. The extent to which a doctor or psychiatrist is protected depends upon the scope of the good faith clause. Thus, if a patient is injured by a doctor's actions and if a good faith clause is legally enforceable, a patient has to determine whether the doctor's actions exceeded the scope of protection provided by the good faith clause.

Good faith clauses are recognized as justifiable under limited circumstances, but should be restricted in scope and application to situations which encourage medical personnel to intervene where they would be hesitant to act because of legal risks and potential liabilities. However, in some countries in the Region, good faith clauses often go beyond these limits. In India, the Mental Health Act (1987) includes a good faith clause for all government officials and employees charged with responsibility for carrying out provisions of the Act or providing care. But the good faith clause in the Mental Health Act goes beyond mere protection for actions in limited situations, and is written to potentially extend to all actions performed by relevant personnel, as long as they can be shown to be rationally related to the furtherance of the Mental Health Act. This could mean that grossly negligent actions that result in human rights violations could be excused if a defendant can demonstrate some nexus with providing care and treatment. The good faith clause in the Mental Health Act, however, does not protect against medical negligence under tort law. Thus, even if a cause of action cannot be pursued under the Mental Health Act, common law still provides patients with other protections.

5.10 Regulatory Mechanisms to Enforce Minimum Hospital Standards

To ensure that minimum hospital standards delineated in law, regulations or policy are upheld, countries develop regulatory systems. These systems vary depending on how frequently regulations permit investigation of hospitals, the minimum standards that must be followed, the breadth of the regulations, the penalties or types of punishment a regulatory authority can issue and the composition (independence) of the regulatory authority. In the South-East Asia Region, there is a wide variety of regulatory authorities that have had varying degrees of success.

For example, India relies upon a licensing system that is enforced by state mental health authorities, each of which devises its own rules based upon guidance provided by the 1987 Mental Health Act and the central mental health authority. Psychiatric hospitals and clinics are supposed to apply to the state mental health authority for licenses to operate. Subsequently, the state mental health authority can require renewal of the license. The state authority can require clinics to have a minimum number of beds and medical personnel and certain medical and diagnostic equipment to obtain and renew a licence. Besides issuing licences, the authority appoints boards of visitors that make monthly visits to all licensed hospitals to review facility standards and patient files. Although the Board can issue recommendations, it has no actual enforcement power. This system has been largely unsuccessful primarily because most states have failed to form a state mental health authority to issue licences and conduct oversight through boards of visitors. A functioning state mental health authority is not necessarily a guarantee of effective oversight. Licensing does not provide sufficient oversight of the hospital's operations since there is no interaction after issuance of the licence, and licence renewals are spaced apart too widely to have sufficient bearing on daily operations.

On the other hand, Thailand relies upon a hospital accreditation system where a central accreditation authority sets minimum standards for medical facilities and oversees whether each hospital meets those standards. Although the accreditation board cannot prevent a hospital from operating, the threat of losing accreditation is taken seriously and hospitals strive to meet the standards set by the accreditation board. This helps ensure that minimum standards to protect the rights and dignity of mentally-ill individuals are upheld.

These are two examples. There are many types of regulatory systems to enforce minimum standards in mental hospitals. Ultimately, stakeholders should examine systems in their country and in other similarly situated countries and determine which regulatory system is best suited to them to ensure that all patients receive high quality medical care and human rights protections in mental hospitals and clinics.

6. FOLLOW-UP ACTIVITIES

Following presentations and group discussions, each country and the WHO Secretariat formulated strategic plans to advance country-designed initiatives to develop, modify or implement mental health legislation.

India

Based upon the research presented by WHO/SEARO and input provided by participants, emphasis will be placed on identifying the most egregious violations of human rights and legal obstacles that hinder development of community-based care. Discussions should also be held to determine whether provisions mandating fitness to stand trial should be amended, and whether electro-convulsive therapy (ECT) should be completely abolished as a treatment tool. Debate should also be held to determine how to widen access to mental health care, and how to protect mentally-ill individuals more effectively from human rights violations. Further discussions should also be held on whether a new mental health act should be developed, as prepared by some interest groups, or whether amending sections of the current mental health legislation would be more effective.

Indonesia

The current mental health regulation is in the Secretary of State's office, and will become law when approved and signed by the President. If the regulations are enforced, the first priority would be to sensitize public and government officials throughout the country about the content of the regulations and their ramifications for medical practitioners, public health planners and consumers. Since Indonesia has undergone rapid decentralization over the last few years, it is particularly important that district-level managers are properly notified of the content of the new legislation.

The participant from Indonesia also discussed the possibility of amending the currently proposed regulations. However, this is not likely since it could mean that the amended legislation would not return to the President's desk for a long time thereafter.

Thus, priority will be placed upon sensitizing health officials about the new regulations and how they will operate at provincial and district levels. The first workshop would be held where the 30 provincial heads in Indonesia would be invited to a sensitization workshop in Jakarta; thereafter, each provincial head could conduct a similar workshop in each province with the relevant district officers. To facilitate sensitization workshops at the district level, WHO and the Ministry of Health could sponsor a workshop for health officers of districts.

Sri Lanka

Participants noted that there have been significant efforts amongst a few psychiatrists, mental health professionals, lawyers and WHO consultants to develop a new mental health law. However, most stakeholders and persons of interest who should participate in drafting a new law have been apathetic, and are not familiar with WHO standards, materials and expertise. Thus, the first priority should be to develop a wider base of individuals who can participate in the process of drafting a new law.

Secondly, there are efforts to develop a new mental health policy in Sri Lanka to expand service delivery throughout the country. Participants prefer drafting a new mental health policy prior to drafting new mental health legislation. Above all, it is most important to sensitize the public and stakeholders about the importance of an effective mental health law and policy.

Thailand

The participants noted that they are in the preliminary stage of developing mental health legislation. To advance efforts to develop legislation, they would like to organize meetings in the ensuing year with all relevant stakeholders, including psychiatrists, lawyers, health officers, medical councils, hospital accreditation boards, general practitioners, patients, relatives, advocacy

groups, social activists and human rights organizations. Meetings would be well-publicized to focus public attention and discussion upon mental health legislation. Throughout this process, the government would act as a facilitator between the different interest groups. To provide stakeholders with all relevant information, the participants would like to translate the WHO Resource Book into Thai.

The new legislation would focus primarily upon accessibility, standards of treatment and human rights protections; the participants would like to provide little direct input except for reservations, concerns and input about involuntary admission.

During the second year of this process, legislation would be drafted with the participation of the same interest groups, and with exposure and publicity through mass media. They would like the process to be transparent to all parties concerned and the public.

During the third year, the draft legislation would be presented to the Parliament. Here, WHO support could be an important step in the legislative process.

7. SUMMARY

An intercountry expert meeting on developing and implementing mental health legislation was held in New Delhi, India, from 6-8 December 2004. Development of effective mental health legislation involves the participation of multiple stakeholders within each country. This meeting was a first step to enable leaders and catalysts of any such effort to identify the current status of their mental health legislation, the priorities and problems with developing mental health legislation, and potential activities which could be pursued over the next few years with WHO's assistance and participation.

The expert meeting consisted of a mixture of presentations and discussions and emphasized international human rights standards, national laws and policies relating to human rights and mental health, the content of mental health law and the process for developing, reviewing and implementing mental health legislation.

Annex 1

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Annex 2

PROGRAMME

Monday, 6 December 2004

0830 – 0900	Registration
0900 – 0930	Introductory talk on mental health legislation and WHO tools available to develop mental health legislation: Ms Nathalie Drew
0930 – 1000	International standards relating to mental health legislation Dr Soumitra Pathare
1000 – 1030	Discussion
1030 – 1100	Inauguration by Regional Director
1115 – 1130	Status of mental health legislation in Member States Dr. Vijay Chandra
1130 – 1230	Analysis and discussion of Indian mental health legislation through application of WHO checklist on Mental Health Legislation and Manual Rohit Malpani
1330 – 1430	
1430 – 1500	Discussion
1530 – 1730	Country presentation (Sri Lanka) <ul style="list-style-type: none">• Background information on mental health resources, services and needs (based on Guidance Instrument Part-I)• National mental health legislation (current and proposed) based on WHO Checklist on Mental Health Legislation

Tuesday, 7 December 2004

0830 – 1030	Country presentation (Indonesia) <ul style="list-style-type: none">• Background information on mental health resources, services and needs (based on Guidance Instrument Part-I)• National mental health legislation (current and proposed) based on WHO Checklist
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- 1100 – 1300 Country presentation (Thailand)
- Background information on mental health resources, services and needs (based on Guidance Instrument Part-I)
 - National mental health legislation (current) based on WHO Checklist
- 1400 – 1700 Group discussion on each item on the Checklist on Mental Health Legislation

Wednesday, 8 December 2004

- 0900 – 1030 Group discussion on each item on the Checklist on Mental Health Legislation (continued)
- 1100 – 1300 Planning of national-level workshops
- 1400 – 1700 Open discussion.

Annex 3

OPENING ADDRESS BY DR SAMLEE PLIANBANGCHANG, REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

Distinguished Participants, Colleagues, Ladies and Gentlemen,

It is with great pleasure that I welcome you all to the WHO Regional Office for South-East Asia. This workshop on “A Systematic Approach to Developing and Implementing Mental Health Legislation”, I am sure, will be of great help to Member States in developing or updating their mental health laws.

As we are aware, the field of mental health has undergone substantial changes in the last several decades. The era of ‘lunatic asylums’ is over and we are now well into developing strategies to deliver community-based mental health care. Accordingly, WHO’s priority now is to work with Member States to develop their strategies on community mental health.

As we embark on the path of community mental health, we also need appropriate laws, regulations and rules to implement the requisite community mental health programmes. Appropriate laws will not only provide a legal framework for implementation of the programmes, but also ensure sustainability of the programmes in countries.

According to the WHO Project, ‘ATLAS: country profiles on mental health resources’, only 50 per cent of all the Member States in the world have modern mental health legislation. In our Region, only two Member States, India and Indonesia, have enacted new mental health legislation in the last fifteen years. This compares to 75% of the countries in the European Region and 33% in the African Region who have passed mental health legislation between 1991-2001. However, many of our other Member Countries, including Bangladesh, Nepal and Sri Lanka are actively trying to update their laws.

Most Member States have provided mental health care through promotion of benevolent traditions and customs that recognize the human

dignity of mentally ill individuals. At the same time, there have been some abuses of mental health laws, such as, imprisonment of innocent people by declaring them as 'insane' or annulling a marriage by declaring a woman 'mentally ill'.

With the changing moral values of society, we can no longer depend on the kindness of either the judiciary or the medical profession to protect the human dignity of mentally ill persons. Thus, modern mental health legislation which recognizes the advances in medical sciences and, at the same time, protects human rights assumes a vital role.

The WHO Resource Book on Mental Health Legislation has been developed by a panel of experts from around the world. This describes how to write legislation that can help mentally ill individuals overcome the many barriers that impede their right to humane and dignified care and treatment.

Any modern mental health law must preserve to the greatest extent possible, the individual's right to voluntary admission and discharge from mental health facilities, protect an individual's right to informed consent, guarantee the least restrictive form of care and also guarantee appropriate medical services to each person. How each Member State will implement such legislation given the limited resources available needs careful consideration.

We must also consider the issue of stigma against persons with mental illness which leads to discrimination and isolation of the patients and frequently his/her entire family. This deprives the patients of effective medical care, further aggravating an already serious situation.

Although the situation may not seem very good for persons with mental health problems in our Region, there are many positive and supportive cultural aspects. The deeply spiritual and religious traditions and strong family ties of populations in the Region help the prognosis of mentally ill patients. The collective family decision-making is unique to our culture, but some will argue that only the patient alone has the right to decide. I am sure, you will discuss this important issue of consent in your deliberations.

I am delighted that the four Member Countries participating in this workshop will critically review their own mental health legislation based on

the WHO resource book. This analysis of your own laws with regard to what is good about the legislation and what could be improved and how to move this process forward is an important first step. WHO, I assure you, will be a strong partner with Governments in moving this agenda forward.

I hope your deliberations will further strengthen efforts in your own countries to promote a wider discussion that can stimulate development and implementation of modern mental health legislation.

In conclusion, I wish you success in your deliberations and a very pleasant stay in New Delhi.

Thankyou