

1. Introduction

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

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

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 Legislation in many countries is therefore outdated and, as mentioned above, in many instances takes away the rights of persons with mental disorders rather than protecting their rights.

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

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

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

This chapter covers five main areas:

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

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

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

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

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

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

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

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

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

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

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

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

3.1 Discrimination and mental health

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

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

3.2 Violations of human rights

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

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

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

Examples of inhuman and degrading treatment of people with mental disorders

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

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

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

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

3.3 Autonomy and liberty

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

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

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

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

3.4 Rights for mentally ill offenders

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

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

3.5 Promoting access to mental health care and community integration

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

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

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

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

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

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

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

4. Separate versus integrated legislation on mental health

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

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

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

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

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

Example: Amending all laws related to mental health in Fiji

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

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5. Regulations, service orders, ministerial decrees

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

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

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

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

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

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

6.1 International and regional human rights instruments

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

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

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

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

6.1.1 International Bill of Rights

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

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

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

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

The right to health, as embodied in various international instruments

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

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

- (i) *Availability*, i.e. health care facilities and services have to be available in sufficient quantity.
- (ii) *Accessibility*, which includes:
 - non-discrimination, i.e. health care and services should be available to all without any discrimination;
 - physical accessibility, i.e. health facilities and services should be within safe physical reach, particularly for disadvantaged and vulnerable populations;
 - economic accessibility, i.e. payments must be based on the principle of equity and affordable to all; and
 - information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues.
- (iii) *Acceptability*, i.e. health facilities and services must respect medical ethics and be culturally appropriate.
- (iv) *Quality*, i.e. health facilities and services must be scientifically appropriate and of good quality.

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

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

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

6.1.2 Other international conventions related to mental health

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

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

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

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

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

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

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

African Region

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

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

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

European Region

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

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

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

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

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

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

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

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

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

Region of the Americas

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

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

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

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

7. Major human rights standards applicable to mental health

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

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

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

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

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

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

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

8. Technical standards

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

8.1 Declaration of Caracas (1990)

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

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

8.2 Declaration of Madrid (1996)

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

8.3 WHO technical standards

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

Mental Health Care Law: Ten Basic Principles

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

WHO, 1996

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

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

9. Limitation of rights

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

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

The Siracusa Principles in summary

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

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

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

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

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

Context of Mental Health Legislation: Key issues

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