Reforming mental health legislation across the Commonwealth

Mental ill health is estimated to affect one in four people worldwide at some time in their life according to the World Health Organisation (WHO). Human rights violations of psychiatric patients, they say, are routinely reported in most countries, including physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders and only 59% of WHO member states have dedicated mental health legislation.[1]

The WHO argues that mental health legislation is equally as important as mental health policy. Mental health legislation, when formulated according to human rights principles, provides a legal framework to address important mental health issues such as access to care, rehabilitation, integration of people with mental disorders into the community, the prevention of discrimination, upholding the full human rights of people with mental disorders, the provision of mental health services that promote access to care; and the promotion of mental health.[2]

Legislation, provides the legal framework for protecting individuals against human rights violations and also for providing mental health services that promote access to care. Reform of mental health legislation is urgent and essential because of the unique vulnerabilities of people with mental disorders who face stigma, discrimination, and marginalization which inhibit them from seeking care.[3] Policy and practice therefore needs to be based on a sound legal framework to protect people in need of care and the practitioners who provide that care.

Mental ill health is the third leading cause of disease burden in the world, predicted to be the leading disease burden by 2030.

The global economic impact of mental ill health is estimated to increase to US$ 6 trillion by 2030. Mental ill health is typically left off the list of non-communicable diseases (NCDs), however it alone is estimated to account for over US$ 16 trillion or one third of the overall US$ 47 trillion anticipated spend on NCDs over the next 20 years. Additionally, mental disorders are common co-morbidities of NCDs, infectious diseases, and poverty.[5]

The World Health Organisation report that:

- About half of mental disorders begin before the age of 14. Around 20% of the world's children and adolescents, regardless of culture, are estimated to have mental disorders. Regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources.
- Mental health issues are frequently hidden, ignored or stigmatised. Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. Mental disorders are a major risk factor for communicable and non-communicable disease. They can also contribute to unintentional and intentional injury.
- There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are one of the main barriers to providing treatment and care in low and middle income countries. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.
- War and other major disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.
- Few countries have a legal framework that adequately protects the rights of people with mental disorders.[4]

At the 66th World Health Assembly (WHA) held in Geneva Switzerland 20-25 May 2013, member states endorsed a Mental Health Action Plans 2013-2020 (WHA Resolution 66.8).[6] The resolution for a mental health action plan followed an earlier resolution at the 65th World Health Assembly (WHA 65.4)[7] which encouraged WHO member states to pay urgent attention to mental health services and adopt a 'rights based' approach to care and treatment.

The WHA Mental Health Action Plan[8] defines mental health as: *a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.* In relation to mental health legislation, the WHA Mental Health Action Plan notes that: *mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community (p.8).*

The Mental Health Action Plan 2013-2020 proposes that member states: *develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions (p.8).*

In 2012-2013, a research team from the Indian Law Society Centre for Mental Health Law and Policy (CMHLP) led by Dr Soumitra Pathare, Coordinator of the CMHLP, examined the mental health legislation of 46 Commonwealth countries to obtain an insight as to how mental health legislation across the Commonwealth complied with the United Nations Convention on the Rights of Persons with Disability (CRPD), the 'gold standard' for mental health legislation. The research was commissioned by the Commonwealth Health Professions Alliance and funded by the Commonwealth Foundation.

The report of the research was released in May 2013 at the meeting of Commonwealth Health Ministers in Geneva.[9] The theme of the meeting was mental health. The major findings of the research were that mental health legislation in many Commonwealth member states is not compliant with the CRPD; is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders; and denies the capacity of persons with mental disorders to manage their lives. It was noted that not all countries across the Commonwealth had signed or ratified the CRPD.

Table 1: CRPD status Commonwealth countries 2013

	Low	Low to middle	Upper middle	High	Total
Ratified	5	11	6	6	28
Signed	0	5	2	3	10
Neither	2	2	2	1	7

The provisions of the CRPD, were used to enable systematic comparison of legislation from different countries. Analysis was restricted to dedicated mental health legislation. Mental health legislation was sought from 53 of the 54 countries of the Commonwealth (the exception being Fiji). Mental health legislation was obtained from 45 countries and included in the analysis.

Mental health legislation was unable to be obtained from seven countries: Cameroon, Maldives, Mozambique, Rwanda, St Lucia, St Kitts and Nevis, and St Vincent's and the Grenadines, and an official English translation for the mental health law of Cyprus was also not available. Therefore these eight countries were not included in the analysis.

Research findings

Mental health legislation in 20 per cent of Commonwealth member states was enacted prior to 1960 before modern medical treatments became available and before many of the international human rights instruments came into force. Mental health legislation in only 11 per cent of Commonwealth member states specifically include provisions that state mental health care should be provided on an equal basis with physical health care.

Mental health laws in all Commonwealth member states allow involuntary admission to a mental health facility. Only half (51 per cent) of country mental health laws require the person to be discharged as soon as they do not meet the criteria for involuntary admission.

Eighty per cent of mental health legislation in Commonwealth countries does not apply the principle of least restrictive alternative to involuntary admission. Only 9 per cent of Commonwealth member states promotes voluntary admission and treatment as the preferred alternative for treatment of mental disorders. While laws in 24 per cent of member states had some provisions promoting community care, no legislation met all the criteria to be rated as promoting community care and deinstitutionalisation.

Mental health legislation in only 29 per cent of Commonwealth member states gives persons with mental disorders the right to be informed of their rights when receiving mental health care or treatment. Only four Commonwealth member states had provisions for supported decision making including the provision of Advance Directives in their mental health legislation.

More than two-thirds of the mental health laws do not have a judicial/quasi-judicial body to review involuntary admissions and treatment.

Provisions for protection from cruel, inhuman and degrading treatment are included in the legislation in only 23 (51 per cent) countries. The informed consent of persons with mental disorders for participating in clinical and experimental research is specifically mandated in mental health legislation in only five (11 per cent) countries; mental health laws in only nine (20 per cent) countries include a provision on the protection of confidentiality; and only eight (18 per cent) countries include a provision on privacy for persons with mental disorders. Legislation in only three (7 per cent) countries specifically outlaws forced or inadequately remunerated labour within mental health facilities.

Very few laws have specific provisions for the involvement of families and care-givers. Legislation in 12 (27 per cent) countries provides for information to be given to families and caregivers; in 10 (22 per cent) countries families and care-givers are encouraged to participate in the formulation of treatment plans. The law in only one Commonwealth country mandates that users of mental health services are involved in mental health policy, legislation development and service planning.

Mental health laws in most Commonwealth countries provide very little protection to minors and children. Laws in only two (4 per cent) countries restrict involuntary admission of minors with mental health problems, and laws in only three (7 per cent) countries ban any irreversible treatments on children with mental health problems.

The word "lunatic" is used in the mental health laws of 12 countries; the term "insane" is used in the mental health laws in 11 countries; the term "idiot" is used in the mental health laws in 10 countries; two mental health laws use the term "imbecile"; and two mental health laws use the term "mentally defective". Overall 21 (47 per cent) laws use one of the above terms.

Research conclusions

The research concluded that mental health legislation in many Commonwealth member states is out-dated and does not fulfil member states' international human rights obligations toward persons with mental disorders and is not compliant with the Convention on the Rights of Persons with Disabilities.

Substantive and procedural provisions related to guardianship in mental health laws are particularly problematic in this regard. Many mental health laws reviewed in the report treat persons with mental disorders as needing protection rather than as subjects with rights. As a result, mental health legislation, instead of protecting the rights of persons with mental disorders, is likely to lead to violation of rights.

Mental health legislation in many countries is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders and denies the capacity of persons with mental disorders to manage their lives.

Provisions in and the language of mental health laws in many instances adds to negative perceptions and further stigmatisation of persons with mental disorders.

Most mental health laws pay little attention to protecting the rights of vulnerable groups with mental health problems such as minors, women, and minorities and the special needs of such vulnerable groups.

Additionally, many mental health laws in Commonwealth countries do not address the issue of (lack of) access to mental health care, in particular, making care and treatment easily available; provided in a manner which enhances the capacities of individuals and protects and promotes their rights; and enables them to live and participate in their communities.

Of concern was that there is little participation of persons with mental disorders and their families and care-givers in the development and implementation of legislation.

Research recommendations

1. Commonwealth member states should urgently undertake reform of mental health legislation.

2. Member states should ensure that the legislation meets their obligations under international human rights treaties, in particular the Convention on Rights of Persons with Disabilities.
3. Commonwealth member states need to thoroughly review all legislation to comprehensively address all civil, political, economic, social and cultural rights of persons with mental disorders.
4. Commonwealth member states should introduce provisions to promote supported decision making in mental health legislation.
5. Commonwealth member states must involve persons with mental disorders and care givers, apart from other stakeholders, in the mental health law reform process.

CNMF PROJECT

Following the release of the report, the Commonwealth Nurses and Midwives Federation (CNMF) successfully applied to the Commonwealth Foundation for a participatory governance grant to work with two Commonwealth countries to conduct an in-depth analysis of their mental health and other related legislation to assess its compliance with the CRPD and make any recommendations considered necessary following the assessment.

The overall aim of the project was that, within the two countries, the human rights of people with mental ill health are respected within legislation which empowers them, protects them, and cares for them.

Methodology

The project had three main strategies:

1. The first was the commitment of the Government to participate in the project and the establishment of a National Mental Health Advisory Committee (NMHAC) by the Government to oversee the project in-country. The project stipulated that the NMHAC had to include a user of mental health services and the carer of a person with a mental health disorder.

2. The second was the assessment of the country's dedicated mental health and other related legislation (such as employment, property, marriage, criminal etc) against the CRPD and consideration of the recommendations.

3. The third was the development and implementation of a communication strategy to educate politicians, bureaucrats, health professionals, relevant stakeholders, the media, and the general public about mental health issues particularly in relation to human rights.

Objectives

The specific objectives of the project were that there would be:

- Increased awareness and cooperation by Government of the need for mental health legislative reform.
- Increased communication and dialogue between the NMHAC, Government, and other stakeholders around mental health reform issues.
- Increased understanding by the NMHAC of the need for mental health legislative reform and a commitment to pursuing necessary reform.

Findings

In the two participating countries, the NMHAC was established by Government who also appointed the Chair. A prerequisite for the assessment of the mental health and related legislation and follow up of the recommendations was Cabinet approval. In each country, the NMHAC undertook the preparation of a memorandum to Cabinet to obtain approval, which was subsequently obtained. Mental health and related legislation and policy was identified by members of the NMHAC and soft copies obtained for analysis. The analysis was conducted by a team from CMHLP led by Dr Pathare.

Country 1

Country 1 had ratified the CRPD and therefore had a legal obligation to ensure its domestic legislation, including mental health legislation, is in compliance with obligations under the International Conventions and Treaties it had ratified which included the CRPD.

The assessment of the mental health and related legislation found that the current mental health legislation was not in compliance with articles of the CPRD which deal with: equal recognition before the law (article 12); access to justice (article 13); liberty and security of person (article 14); freedom from torture or cruel, inhuman or

degrading treatment or punishment (article 15); protecting the integrity of the person (article 17); living independently and being included in the community (article 19); respect for privacy (article 22); and habilitation and rehabilitation (article 26). The assessment concluded that, as the fundamental premise of the current legislation was completely at variance with the fundamental premise of the CRPD, it would be easier to draft new legislation compliant with the CRPD than try to amend existing legislation.

The assessment further recommended that persons with mental illness, their care-givers, and representative organisations, are part of the consultation and law drafting process. Additionally, the issues of access, prevention, care, treatment, rehabilitation, quality of care, and protection of CRPD rights needed to be specifically addressed as well as other non-health areas, such as discrimination in employment, marriage, education, and housing. Finally, the new legislation needed to incorporate models of supported decision making, and specifically address the mental health needs of children and older persons.

Country 2

Country had not signed or ratified the CRPD and consequently is not bound by it. However several other international treaties and conventions which had relevance to mental health legislation had been ratified. Additionally, the National Policy on Mental Health required a framework for periodic review of legislation in line with local, regional and international trends in good mental health practices; and the Public Health Act directed the health officer to "take all lawful, necessary and reasonably practicable measures to ensure equal access and equity to health care services for all including those with mental illness" which is in line with international best practice.

On assessment, Country 2's mental health legislation was found not to comply with the CRPD in a number of important respects. The Act was written in such a way that voluntary care and treatment were the exception while involuntary detention was the norm. Definitions used outdated terminology while the classification of persons with mental disorders was illogical and arbitrary. Many of the sections violated international human rights principles such as equality before the law, access to justice, and due process and were open to potential abuse by individuals as well as institutions. Additionally, there were no provisions for review of decisions or appeal against decisions.

The assessment concluded that it would be extremely difficult to amend the Mental Health Act to bring it in line with international conventions and standards as the Act was premised on a custodial solution and exclusion of persons with mental illness rather than a rights based approach to care and treatment.

In both countries, the NMHAC accepted the assessment report and recommended to the Minister for Health the repeal of the existing Act and the writing of new legislation. Drafting instructions were drawn up for both countries and after extensive stakeholder consultation, new legislation was drafted and submitted to Parliament for ratification.

Contributing factors

One of the most important factors contributing to successful project outcomes in both countries was the support given to the project by the Minister for Health and the Ministry of Health, particularly the Permanent Secretaries for Health. As legislation requires the endorsement of the respective Ministry for it to progress successfully through parliament, the support of the relevant government ministry is essential. The governments of both countries, through their Ministries of Health and other government departments, also supported the work of the NMHAC by releasing participants to attend in work time.

The commitment and dedication of the members of the NMHAC in both countries was also critical to the project proceeding to its agreed outcome. The experience and expertise of the consultant to the project from the CMHLP with an in depth knowledge of the CRPD at its translation into mental health legislation was also critical to the success of the project. The vision of the Commonwealth Foundation in funding the project and their patient support throughout the implementation of the project was also critical to its success.

Challenges

In both countries, progress of the project was slower than anticipated largely because the external project manager, the Chair, and members of the NMHAC all had other commitments. Should the project be replicated in other countries, the appointment of a part-time in-country project manager two days a week would eliminate this challenge.

Political changes in both countries also delayed progress of the project with changes in Health Ministers, and elections which led to a change in Government. Although this caused delay, the commitment to writing new mental health legislation remained.

Modern service provision for people with mental health disorders needs to be based on a legislative foundation that provides protection for service recipients and service providers and which meets the 'gold standard' of the CRPD. This project, to assess existing mental health and related legislation against the CRPD and follow through with amended or new legislation which meets the requirements of the CRPD, has demonstrated that the methodology used can efficiently and effectively achieve this objective. Key to success is the support and involvement of government; and the establishment of an in-country committee and dedicated project manager to oversee the project.

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