Course work notes:

MODULE 10: DRAFTING, ADOPTING AND IMPLEMENTING MENTAL HEALTH LEGISLATION

Overall Learning Objective

The aim of this module is to develop an understanding of the key issues involved in drafting and enacting legislation and the steps to be taken to ensure effective implementation of legislation.

Rationale: The success of mental health legislation is critically dependent on the process for drafting and enacting as well as in having effective implementation strategies. Very often mental health legislation remains unimplemented because little attention is paid to the process of drafting, enacting and implementation. Many of the obstacles to implementation can be anticipated at the drafting stage and appropriate action taken to increase the chances that the legislation once adopted is brought into day to day practice.

2. Contents of the Module:

a. Introduction

b. Preliminary activities

c. Process of drafting mental health legislation

d. Adopting mental health legislation

e. Implementing mental health legislation

A. INTRODUCTION

Important practices for drafting, adopting and implementing mental health legislation are outlined and discussed on WHO Resource Book on Mental Health, Human Rights and Legislation (2005), some of which are summarized here, but it should be pointed out that these are only guiding principles; each country will follow its own established legal processes and procedures.

Box 1 outlines four stages that most countries will undertake in enacting legislation: preliminary activities, drafting legislation, adopting legislation and implementing legislation. This module discusses these steps.

BOX 1. PROCESS OF MENTAL HEALTH LEGISLATION	
Step 1. PRELIMINARY ACTIVITIES	▪ Identify country's principal mental health needs and barriers to mental health care ▪ Map legislation relating to persons with mental disorders ▪ Study international conventions and standards ▪ Review mental health legislation in other countries ▪ Build a consensus and negotiate for change ▪ Advocate for human rights and mental health legislation
Step 2. DRAFTING LEGISLATION	▪ Convene a drafting body/team ▪ Engage in extensive consultation ▪ Prepare draft for legislature
Step 3. ADOPTING LEGISLATION	▪ Submit to legislature ▪ Debate in legislature ▪ Mobilize public opinion/lobby legislature ▪ Sanction, promulgation and publication of legislation
Step 4. IMPLEMENTING LEGISLATION	▪ Develop an oversight agency and procedures for implementation ▪ Ensure proper training ▪ Engage in public awareness campaign ▪ Address human resources and financial issues

As with legislative content, the legislative process of drafting, adoption and implementation will depend on local norms and customs. In some countries, the first three steps can overlap in one single process where the activities outlines in box 1 are carried out in different sequences or simultaneously.

For example, in Chile, the following activities were undertaken during 2005 and 2006 as part of drafting and adopting a Charter of Rights and Duties of Patients. This Charter includes a section concerning persons with mental disabilities.

Stage 1 (January to December 2005):

- Chile's principal mental health needs and barriers to mental health care were identified
- International conventions and standards were studied
- Advocacy for human rights and mental health legislation was carried out

Stage 2 (January to June 2006)

- The Ministry of Health appointed a team for drafting the Charter.
- Consumer and family organizations, the National Commission for the Protection of Persons with Mental Disorders and the Ministry of Health Department of Mental Health advocated to include in this Charter the rights of persons with mental disability
- The Ministry of Health Department of Mental Health undertook activities to build a consensus and negotiate for change
- The draft was submitted to legislature

Stage 3 (July to December 2006)

Legislature started the first debates of the draft, and the Ministry of Health Department of Mental Health, with the cooperation of WHO and PAHO, carried out the following activities:

- Mapping legislation relating to persons with mental disorders
- Reviewing mental health legislation from other countries
- Building consensus and negotiating for change with different stakeholders
- Mobilizing public opinion and lobbying legislature

Stage 4 (2007 to 2008)

- Extensive consultation
- Debate in legislature
- Amendments were proposed by legislators
- The draft was passed by the Lower House of Parliament (Chamber of Deputies)
- The Ministry of Health Department of Mental Health, with the cooperation of WHO and PAHO published and disseminated a book about mental health and legislation in Chile based on the mapping done in 2006

Stage 5 (2009 to 2011)

- Debate in the Upper House of Parliament (Senate)
- Occasional debate in both Houses of Parliament
- Long periods without debates on the bill in Parliament (no political priority for the bill)
- Occasional advocacy for the law by consumer and family groups

Stage 6 (2012)

- January: Charter of Rights and Duties of Patients passed in Parliament, recognizing that people with disabilities have the same rights as any patient, and including a special section to protect some of their rights most vulnerable to transgressions
- April: Charter sanctioned and promulgated by the President of the Chilean Republic (signature of the President and the Minister of Health), and published in the Official Journal
- October: Charter came into force

Drafting, adopting and implementing mental health legislation should not be viewed as an event but as an ongoing process that evolves with time. This means that legislation should be reviewed, revised and amended after some years of implementation. Changes can be proposed in the light of new mental health needs in the country, the degree of satisfaction with the legislation, improvement in the treatment of mental disorders and international advances in the field of human rights and mental health. If there is a need of an amendment of the mental health legislation, the process should start again from step one.

It is difficult to specify the frequency when mental health legislation should be amended. However, a period of five to ten years seems appropriate, taking into account the experience of countries that have made amendments in this field, e.g. the United Kingdom and Canada. These periods can be longer in low and middle income countries.

An alternative solution is to make provision for the introduction of regulations for particular actions that are likely to need constant modifications. Regulations are not written into the legislation, which simply outlines the process for introducing and reviewing them. The legislation specifies who is responsible for framing regulations and indicates the broad principles on which they are based. Regulations thus lend an element of flexibility to mental health legislation.

Different stakeholders can advocate for a mental health law as well as initiate a process of drafting, adopting and implementing mental health legislation to accomplish the four steps outlined in box 1. In many countries it is the professionals in charge of mental health at the ministry of health who will have to carry out most of these actions and explain to the executive and legislature why a law (or an amendment) is necessary. In countries where consumer, family, advocacy or professional groups and organizations identify the need for mental health legislation, it is incumbent upon them to advocate initiation and development of new legislation (or a change to the existing law). Considering the stigma and discrimination of persons with mental disorders present in most societies and the cultural barriers associated, the role of consumer, family and other advocacy organizations is essential to achieve advances in mental health legislation.

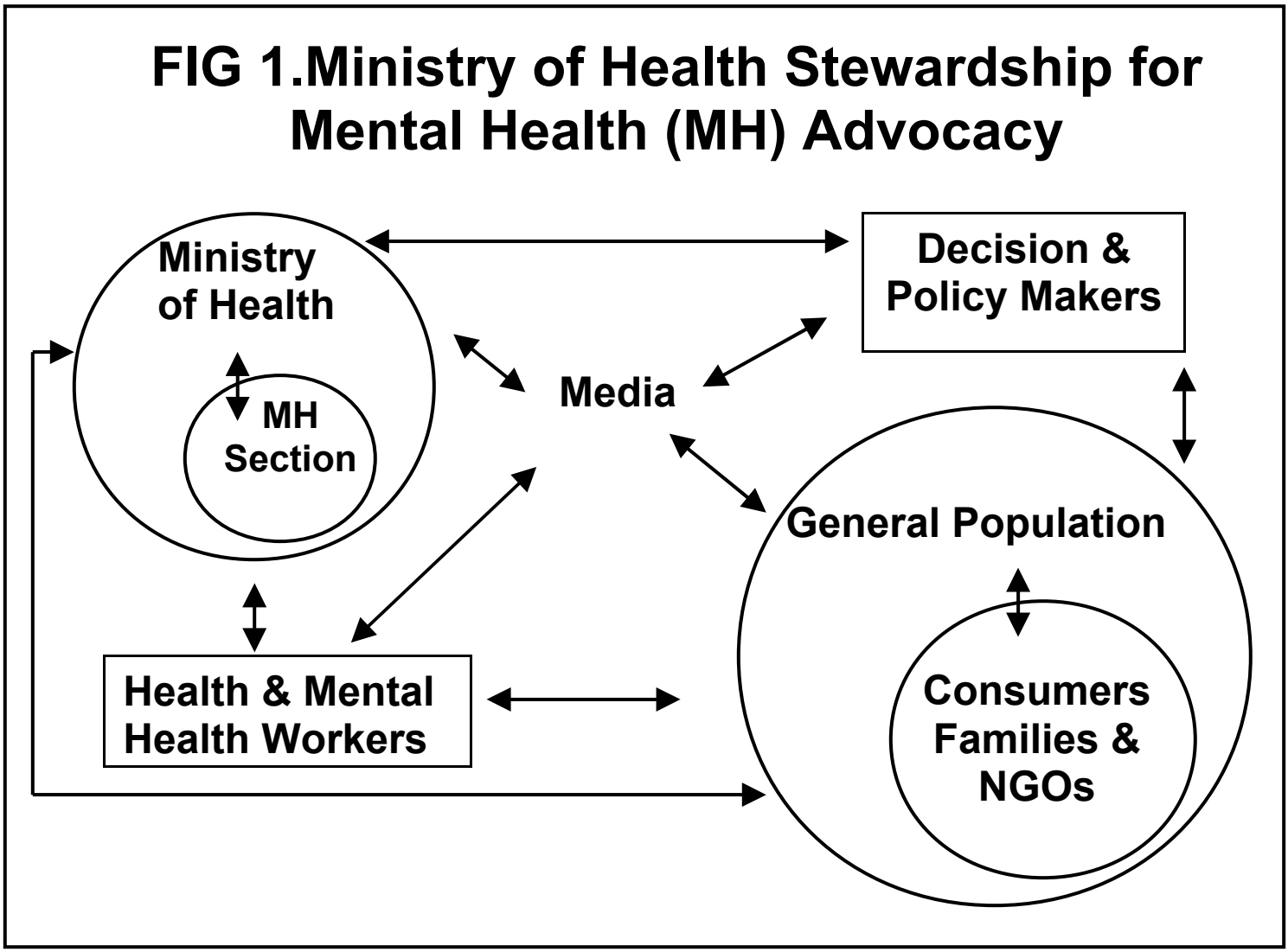
Figure 1 illustrates the multiple interactions between the different stakeholders that

can be involved in advocacy for mental health legislation[1]. Ministries of health can be important actors in the advocacy system. They can develop various initiatives in respect of different target populations. Each ministry of health is also a target for advocacy activities carried out by other stakeholders represented in figure 1. Furthermore, there are advocacy interactions inside the ministry of health between the mental health section and other health sections.

The arrows in Figure 1 illustrate the possibilities of reciprocal influences between stakeholders.

The particular circumstances in a country or region determine which stakeholders are the most influential. As a rule, the most active stakeholders in the mental health advocacy movement are consumers, families, nongovernmental organizations, some organizations of mental health workers and the mental health section of the ministry of health. The media, at the center of Figure 1, are utilized by all stakeholders as an important tool for their advocacy actions.

[1] *Advocay for Mental Health* (2003) World Health Organisation, Geneva.



Different circumstances and critical situations can also facilitate or precipitate the process of amending or drafting, adopting and implementing mental health legislation in a country. Box 2 illustrates this in an example from Scotland.

BOX 2. EXAMPLE: A NEW MENTAL HEALTH ACT FOR SCOTLAND[2]

Mental health was the subject of the first piece of legislation enacted by the Scottish Parliament after it was established in 1999. This was prompted by a challenge to the existing mental health law by a patient in a high security hospital who claimed that he could not be legally detained if no treatment were available for his condition. The legislative had to respond to this challenge and a debate ensued about the balance between public safety and human rights.

The conclusion of the debate was to nominate a special committee ("Millan Committee") to resolve on this and other issues that needed further analysis. The committee established the case for reform on the basis of consultation with consumers and carers. The committee achieved a broad consensus with the mental health community and specified ten key principles to be incorporated into the new act, which intended to shift the balance of legislation in favour of protecting the rights of persons with mental disorders The ten principles are:

1. "Non-discrimination": same rights as those with other health needs
2. "Equality": no discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion, or national, ethnic or social origin
3. "Respect for diversity": care according to individual qualities
4. "Reciprocity": an obligation to comply with a treatment imposes a parallel obligation to provide safe and appropriate services
5. "Informal care": wherever possible, care should be provided to persons with mental disorder without using compulsory powers
6. "Participation": service users involved in all aspects of their care
7. "Respect for carers": receiving information and having their views taken into account
8. "Least restrictive alternative"
9. "Benefit": any intervention should be likely to produce a benefit
10. "Child welfare": this should be paramount in any intervention

The first draft by the Executive gave rise to hundreds of amendments because some of the principles were omitted. The Scottish Association for Mental Health led an advocacy campaign with 64 organisations, which was decisive in restoring all the original principles in the draft legislation. The right to advocacy and carers' rights to information were clearly stated. The Mental Health Act was passed by the Scottish Parliament in March 2003 and came into effect in October 2005.

The initial question - that a person could not be detained without treatment being available - was resolved in the Act establishing the following conditions for compulsory detention in hospital:

[2] *Making the Connections: Human Rights and mental Health (2006).* Scottish Executive and British Council Scotland

- "The person has a mental disorder.
- Medical treatment is available which could stop their condition getting worse, or help treat some of their symptoms.
- If that medical treatment was not provided, there would be a significant risk to the person or to others.
- Because of the person's mental disorder, his/her ability to make decisions about medical treatment is significantly impaired.
- The use of compulsory powers is necessary."

B. PRELIMINARY ACTIVITIES

Before embarking on reviewing or drafting mental health legislation, there are a number of preliminary actions that can be useful in deciding the contents of the legislation. These include:

1.Identifying the country principal mental health needs as well as existing and likely barriers to mental health care

Reliable information about mental disorders in the country can be obtained from epidemiological studies; however these are not always available. In these circumstances, information can be obtained from quantitative data from treatment settings and qualitative information from focus group interviews with key informants. It is also critical to assess quality and the observance of human rights in both outpatient and inpatient facilities to ensure that future legislation respect and promote human rights.. A comprehensive assessment of mental health and social facilities can be achieved applying the *WHO QualityRights tool kit,* which is based on an extensive international review by people with mental disabilities and their organizations, and it has been pilot-tested in low-, middle- and high-income countries.[3]

The examples in box 3 illustrate some of the barriers that can be tackled by legislative efforts, and identifies priority areas for legislation.

BOX 3. EXAMPLES OF BARRIERS TO GOOD QUALITY MENTAL HEALTH

[3] World Health Organization WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities. Geneva, World Health Organization, 2012. http://www.who.int/mental_health/publications/QualityRights_toolkit/en/index.html

CARE THAT LEGISLATION CAN HELP TO OVERCOME[4]

1. A lack of mental health services in some areas or in the country as a whole.
2. The cost of mental health care is unaffordable to many, and health insurance offers partial or no coverage for mental health treatment.
3. The quality of care and the living conditions in mental hospitals are poor, leading to human right violations.
4. Regulations and checks concerning involuntary admission and treatment are usually lacking, and this is often associated with loss of liberty.
5. Stigma and discrimination associated with mental disorders negatively affect access to care, as well as the social integration of people suffering from those disorders.
6. Persons with mental disorders are denied basic rights such as social participation, cultural expression, voting, freedom of opinion, housing, employment and education.
7. Some social conditions or cultural practices damage the mental health of some population groups.
8. A lack of resources for mental health promotion and prevention.

2.Mapping Legislation relating to persons with mental disorders

Some countries have a long history of mental health legislation and mental health-related legislation, while other countries may be developing such legislation for the first time. The mapping of existing legislation will therefore be very different from one country to other. Specific mental health laws need to be carefully examined to ensure their conformity with the Convention on the Rights of Persons with Disabilities (CRPD, 2006). In addition, components of other laws, as they relate to mental health, need to be found and assessed. For countries with no specific mental health legislation, there are still likely to be laws that affect mental health which need to be identified and analysed.

Examples of laws that can be examined for mental health components:

- General health care legislation: It is important to analyse if the different provisions of this legislation establishes equity between persons with mental disorders and people with other health problems. Special clauses can also ensure the protection of vulnerable populations such as those with mental disorders and/or disability.

- Disability legislation: General provisions for the protection of rights of persons with disability can also be applied to those with mental disability. However, some legislation needs a specific clause stating that the law is also applicable to people with mental disability.

[4] Adapted from *Mental Health Legislation & Human Rights (2003).* World Health Organization, Geneva.

- Anti-discrimination legislation: Several countries have antidiscrimination laws for the protection of vulnerable populations, minorities and underprivileged groups. Such legislation can also be made applicable to persons with mental disorders and/or disability by specifically including them as beneficiaries.

- Housing legislation: Legislation in some countries can discriminate persons with mental disorders and/or disability in the allocation of housing, while in other countries it can give them priority in subsidized housing schemes.

- Employment legislation: Laws could include provisions for the protection of persons with mental disability from discrimination and exploitation in employment and equal employment opportunities.

- Education legislation: This type of legislation could also include provisions for the protection of children, adolescents and adults with mental disability from discrimination in education, facilitating as full integration to regular schools as possible.

- Social security: Some laws provide for disability pensions for persons with mental disorders and sometimes they include a specific clause to ensure that they are paid at a similar rate as pensions granted to persons with physical disability.

Occasionally it will be found that countries have adequate legislative provisions in existing legislation and the problem really lies in their implementation. In these cases, there may be little need to alter, modify, amend or introduce new legislation.

The WHO Checklist on Mental Health Legislation, which is an annex to WHO Resource Book on Mental Health, Human Rights and Legislation (2005), is a useful tool for mapping. Some of the main issues of this Checklist are summarized in Box 4.

BOX 4. EXAMPLES OF ISSUES TO BE CONSIDERED IN A MAPPING OF MENTAL HEALTH LEGISLATION
(adapted from WHO Checklist on Mental Health Legislation)

1Access to mental health care
2Rights of users of mental health services
3Voluntary and involuntary admission and treatment
4Seclusion and restrain
5Non-protesting patients
6Offenders with mental disorders
7Clinical and experimental research

8Oversight and review mechanism 9Police responsibilities 10Rights of families and other carers 11Competence, capacity and guardianship 12Discrimination 13Housing 14Employment 15Social security 16Civil rights 17Protection of vulnerable groups

An example of legislation mapping is the one carried in Chile in 2006, in a collaborative work between WHO/PAHO and the Ministry of Health. Using the "WHO Resource Book on Mental Health, Human Rights and Legislation" as guidance, the following legislations were reviewed:

- The Political Constitution of the Chilean Republic.
- Law 19.284 about Social Integration of Persons with Disability.
- Draft legislation that amends Law 19.284 about Social Integration of Persons with Disability.
- Law 18.600 about Mental Disability and its amendments.
- Draft legislation about Rights and Duties of People in Health Services.
- Draft legislation about Anti-Discrimination.
- Civil Code.
- Health Code.

3.Studying international conventions

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

As discussed in module 3, the International Covenant on Civil and Political Rights (ICCPR, 1966), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) and CRPD represent three key international instruments that have been ratified by the majority of countries in the world.
Countries that have ratified CRPD are obliged under international law to implement it. However, it should not be assumed that once the Convention has entered into force for a State, it has automatically become part of its national law. There exist two main approaches to the status of treaties within the domestic legal system, in

"monist" countries (i.e. Argentina, Chile, Croatia, Hungary, Mali, Niger, Qatar, etc.) the provisions of CRPD have direct legal effect and are applicable in courts of law, while in "dualist" countries (with two separate legal systems for national and international legislation) domestic legislation must be adopted to incorporate CRPD into the national legal system. In some monist countries, CRPD is recognized in the supra-constitutional rank, and in others as standing above national laws. But both types of countries are required to adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the Convention if they have ratified it.[5]

4.Reviewing mental health legislation in other countries

While each country has unique needs and circumstances and different legislative conventions, by examining laws from different countries there are a number of significant lessons that can be learnt with regard to the components and strategy generally included in legislation.

When examining another country's mental health law there may be certain provisions that are not applicable in one's own country. Thus they need to be modified and adapted to suit the social, economic and cultural situation. In reality, most mental health legislation may not fully reflect the high international standards set by CRPD and vary widely across the world. This picture is reflected in a study of mental health acts in 32 Commonwealth countries, which share the same common-law basis for legal systems, but exhibit profound differences in criteria for involuntary treatment. According to the authors, the main factors that may contribute to this variation are differences in value judgments regarding underlying principles, attitudes to mental disorder, and resource availability.[6]

The review should also critically examine the effect of legislation in improving the situation for those with mental health problems in those countries. The reasons for failure include badly drafted legislation, implementation difficulties because stakeholders refuse to co-operate and frequently due to legislative provisions, which do not take into account the practical realities in the country.

Even modern well-intentioned mental health legislation can fail to protect the rights of people with mental disorders. For example, a study carried out in 2002 in the 50 states of USA showed that half the bills related to protection from discrimination in persons with "mental illness" reduced rights instead of expanding them, 75% of the bills related to liberties contracted them and one-third of bills dealing with privacy

[5] United Nations Human Rights Council. Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General. January 26, 2009.

[6] Fistein EC, Holland AJ, Clare ICH, Gunn MJ. A comparison of mental health legislation from diverse Commonwealth jurisdictions. Int J Law Psychiatry. 2009 May; 32(3): 147–155.

rights diminished them. Another finding from this study was the fact that USA legislation frequently confuses “incompetence” with “mental illness”[7].

5. Building a consensus and negotiating for change with all stakeholders

Consensus building and negotiating have an important role to play not only in planning and drafting legislation but also in ensuring its implementation once it is adopted. A broad consensus is necessary because mental health legislation cannot be embraced by society unless misconceptions, misapprehensions and fears relating to mental disorders are addressed. Box 5 lists examples of stakeholders to be included in this process and examples of possible key issues of particular concern to them.

BOX 5. EXAMPLES OF STAKEHOLDERS AND KEY ISSUES TO BUILD CONSENSUS AND NEGOTIATE IN PLANNING AND DRAFTING MENTAL HEALTH LEGISLATION

STAKEHOLDERS	KEY ISSUES TO NEGOTIATE
1. Policy-makers, politicians and parliamentarians	Public safety, progressive legislation and compliance with international conventions ratified by the country (ie, the CRPD)
2. Government ministries: health, social welfare, law, labour, education, housing, finance	Protection of human rights of all citizens and resources for community support and social inclusion of PwMD
3. Consumers and family members and their organizations	Access to mental health services, being treated with humanity and respect and protection of human rights
4. Advocacy, civil rights, minorities and other nongovernmental organizations	Non-discrimination and protection of human rights
5. Professionals and their academic institutions and organizations: psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists	Threats to their autonomy and hegemony. Necessity to understand implications of new law on their own professions and practices. Conflicts of interest between different professions.
6. Public and private service providers	Access to mental health services, quality of care and financing of services
7. Religious organizations and congregations of particular communities	Protection of human rights of all people and ethical issues
8. Judicial authorities, including	Enforcement of international and national

[7] Corrigan PW; Watson AC; Heyrman ML; Warpinski A; Gracia G; Slopen N. (2005) Structural stigma in state legislation. Psychiatr Serv. 56(5):557-63

lawyers and legal representatives	mental health legislation
9. Police and correctional services	Maintaining public order; understanding their role and responsibilities in relation to new law
10. Wider community groups: employee unions, staff welfare associations, employer groups, among others	Stigma associated to person with mental disorders, public safety and access to mental health services

6. **Advocating for human rights and mental health legislation**

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

Throughout the world, people with serious mental disorders are viewed differently from those with physical illnesses. This is attributable partly to a perceived link with violence and partly to difficulties in sharing the abnormal experiences that are induced by some mental disorders. Members of the public wish to distance themselves from people with these problems, as shown by their reluctance to work with them, marry them, live close to them and have them as friends[8]. Few people understand that persons with mental disorders are entitled to the same rights as the rest of the citizens and that legislation is necessary to protect them.

Psychiatrists and mental health professionals, although well intentioned and oriented towards helping persons with mental disorders, may also share some of the stigmatizing attitudes of the general public. Moreover, these professionals could feel threatened by legislation that gives consumers new rights while they are treated in mental health services. Psychiatrists may resist new mental health legislation if they perceive it as undermining their medical authority. Resistance can also emerge from psychiatrists and other mental health professionals if they believe that there would be shortage of human resources to implement some of the mandates of the law and that their workload can become overwhelming.

Stigma about persons with mental disorders can also contribute to low prioritization of mental health legislation by some members of the executive and legislature.

There are many substantial issues related to human rights and mental health legislation that need to be advocated for. For example:

- Access to mental health care

[8] Leff J & Warner R. Social Inclusion of People with Mental Illness (2006). Cabridge University Press, Cambridge.

- Humane treatment in mental health facilities
- Independent review of involuntary admission and treatment
- Civil rights (right to vote, to participate, freedom of expression)
- Independent assessment of capacity
- Access to educational and employment opportunities

See modules 3 and 9 for further discussion of these rights.

It is important that the public is sensitized, informed and educated about mental disorders and the rights people with mental disorders are entitled to. On some occasions, stakeholders leading the legislation process may have to take an active role in defending persons with mental disorders whose rights have been violated and denouncing situations where these violations occur.

The mass media can play an important role in sensitizing and informing the public, eventually leading to changes in attitudes and behaviors thus facilitating the process of drafting, adopting and implementing mental health legislation[9]. However, the mass media often has a bias in selectively reporting violent incidents involving persons with mental disorders and in referring to them in pejorative terms. This has generally a negative effect on the attitudes of the public towards mental disorders and service consumers.

Mass media educational campaigns oriented to change public attitudes - reducing stigma towards person with mental disorders – do not necessarily produced positive changes, as some experiences in the UK and Canada have shown[10]. By contrast, other social marketing campaigns have been used successfully around the world in AIDS prevention, smoking cessation and other causes. Effectiveness of these types of campaigns can be increased by targeting appropriate messages to particular population groups that are relatively homogenous, conducting a needs assessment that gathers information about cultural beliefs, selecting specific objectives, messages and media, and continuous monitoring of impact [7].

As figure1 illustrates, consumers, families and other advocacy organizations can play a significant role in advocating for human rights and mental health legislation. Consumer groups, in different countries, have contributed to sensitizing the general public about their causes and educated and supported other consumers. They have made known cases of poor service delivery, poor access to care, involuntary treatment and other issues. Consumers have also struggled for the improvement of legal rights and the protection of existing rights[11].

The roles of families in advocacy overlap with most of those described for consumers. In addition to providing mutual support and services, many family groups have become advocates, educating the community, increasing support to

[9] *Advocay for Mental Health* (2003) World Health Organisation, Geneva.
[10] Leff J & Warner R. Social Inclusion of People with Mental Illness (2006). Cabridge University Press, Cambridge.
[11] *Advocay for Mental Health* (2003) World Health Organisation, Geneva.

policy-makers, denouncing stigma and discrimination, and fighting for improved services.

International organizations (i.e. European Court of Human Rights, the Inter-American Commission on Human Rights) can also play a role in advocacy by compelling States to modernize their mental health legislation to incorporate international human rights standards and principles[12].

Action for Mental Illness (ACMI), an Indian NGO, is a good example of advocacy for legal reforms. The group has been lobbying with the Ministry of Health extensively for the amendment of the Mental Health Act 1987 and a human rights orientated law since 2006. While being in constant dialogue with the ministry, ACMI also used legal action to push for reforms by bringing the case to the Supreme Court, sending out legal notices and writing petitions. In 2010, the ministry finally declared plans for the amendment of the law and assigned the Indian Law Society in Pune to the task. In the same year, ACMI organised a National Consultation of Users and Caregivers to influence the drafting process of the new Mental Health Care Bill. The group has also been lobbying with the Ministry of Social Justice and Empowerment for the review and amendment of the national Disability Act of 2005, a task which was taken on in 2010. Additionally, members of ACMI were invited to participate in the consultation for the drafting of a National Disability Policy. Due to its tireless legal activities and political lobbying, the group today is acknowledged by government stakeholders as an important consultation partner, representing the voice of persons living with mental illness and their families.[13]

B) DRAFTING MENTAL HEALTH LEGISLATION

1.Convening a drafting body/team

The process of drafting new legislation varies in different countries depending on the particular legislative, administrative and political structures. In some countries, a specially constituted drafting committee is appointed by the legislature, or the relevant ministry is given the task of drafting the law; other countries have a law commission or a similar body that conducts this function. In countries that lack well-defined structures for drafting new legislation, the mental health section in the ministry can play an important role.

The crucial point is not which body drafts the legislation, but rather, that there are significant and sufficient expertise contributing to the process to ensure that the bill

[12] Gable L, Vasquez J, Gostin L & Jiménez H (2005). Mental health and due process in the Americas: protecting the human rights of persons involuntarily admitted to and detained in psychiatric institutions. Pan Am J Public Health 18, (4/5): 366-373.

[13] Offergeld J. Action for Mental Illness India – a mental health advocacy initiative and its efforts to improve the living condition of persons living with mental illness and their families. Disability And Human Rights (2011). http://disabilityandhumanrights.com/2011/12/05/action-for-mental-illness-india-a-mental-health-advocacy-initiative-and-its-efforts-to-improve-the-living-condition-of-persons-living-with-mental-illness-and-their-families/

produced is thorough, comprehensive, reflects the interest of the consumer and their families as well as the competing ideologies, and has adequately considered all the available relevant information.

Some countries may choose to appoint a committee made up of a number of people who themselves are able to fulfil all the criteria and produce the draft. Other countries may appoint only one or two people to draft the legislation, with a mandate to draw on the skills of others with the relevant expertise and representing different interests. A mix of these two models is also possible. Box 6 illustrates the type of expertise needed in a drafting body.

BOX 6. EXAMPLES OF EXPERTISE NEEDED IN A DRAFTING BODY FOR MENTAL HEALTH LEGISLATION

1. A representative from the ministry of health, usually the professional in charge of mental health, who can chair the committee, act as executive secretary, coordinate or drive the process
2. Representatives from other ministries, specially justice and finance
3. Representatives of consumers, families and carers
4. Legislators
5. Representatives from mental health professionals
6. Lawyers with expertise in mental health and human rights
7. Experts with experience of working with minorities and other vulnerable groups

2. Engaging in extensive consultation

The draft of the proposed legislation must be put forward for consultation to all the stakeholders in the mental health field (see Box 5). Consultation has an important role to play in identifying weaknesses of the proposed legislation, potential conflicts with existing legislation, key issues inadvertently left out of the draft legislation and in identifying possible practical difficulties in implementation. Consultation also provides an opportunity for raising public awareness about mental health issues and for developing consensus positions between groups with different perspectives. Most importantly, systematic consultation can have a positive impact on the implementation of legislation.

Consumers are the primary beneficiaries of the law and their input and involvement is crucial. There is, at times, tension among consumers groups and groups representing family members of people with mental disorders in their orientation and ideological stance toward mental health treatment and legislation. It is important that the consultation process embrace all opinions in this regard. In many countries, people with mental disorders often feel completely disempowered and their opinion are generally not sought. The professional authority of doctors and other health workers is also often an obstacle to getting consumers' and families'

perspectives. The process of getting consumers' views is thus often far more complicated than simply requesting input; it may involve an intense training and empowerment process before valuable feedback is received.

There are two processes for consultation, written submissions from interested individuals and groups as listed in Box 5 and oral consultation with them. There could also be a combination of these two processes, such as a written submission followed by oral hearings with stakeholders whose responses necessitate further discussion and deliberation. The written and oral consultation methods have their advantages and disadvantages and hence a mixture of both is ideal. A combination of the two methods was used in the example from Chile described in Box 7.

BOX 7. EXAMPLE: CONSULTATION IN CHILE FOR A MENTAL HEALTH ADMINISTRATIVE DECREE

The Declaration of Caracas (1990) had a strong influence in Chile, setting up a process of analysis and reflection about the mental health policies and legislation. The country was in the process of returning to democracy after 17 years of dictatorship. The population was sensitive about social issues and human rights violations, although not specifically aware of human rights of people with mental disorders. The first national mental health policies and plan (1993) were formulated with an extensive participation of mental health professionals and included considerations about human rights of consumers and established the need for improving legislation.

In 1995, a task force was created by the Ministry of Health comprising mental health professionals and lawyers, with the objective of drafting a mental health law. Taking the social and political realities into account, the task force decided to change the administrative decree about voluntary and involuntary admissions, which dated from 1927. In 1996, a first draft was sent for written consultation to mental health professionals in all regions of the country, and in 1997, a second draft was discussed in oral consultation with representatives of family groups (at that time there were no consumer groups in Chile).

2.Preparing draft for legislature

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

Mental health laws should be written, as far as possible, in a manner that is easily accessible to the many people who may need to read and understand it, in language aimed at the general public rather than at legal experts.

The example from Ghana in box 8 illustrates some of the most important activities in drafting a mental health law.

BOX 8. EXAMPLE: GHANA DRAFTING A MENTAL HEALTH LAW

Ghana has had a mental health law since the latter part of the 19th century. The last major revision of the mental health law was in 1972. While the 1972 law was certainly a major improvement over the previous version, it strongly emphasizes institutional care and does not sufficiently protect people against involuntarily admission and other abuses. It is in this context that Ghana undertook a project to draft and implement new mental health legislation and requested the assistance of the World Health Organization (WHO) in order to make sure that this legislation reflects international standards.

The first steps have been to establish a drafting committee, to organize a workshop on Mental Health legislation and to carry out consultation with the main stakeholders. The committee is comprised of psychiatrists, nurses, officials from the ministries of justice and health, including the Director of the Traditional & Alternative Medicine Division as well as an official from the Commission for Human Rights & Administrative Justice. The committee undertook a detailed analysis of the 1972 law, using the WHO Checklist and examining reports of practical problems in its application. Nine drafts of the law has been written and throughout this process stakeholders, including representatives from mental health service user groups, human rights NGOs, professional groups and traditional and spiritual groups, were constantly consulted by the drafting committee. A draft of the law has been put into consistent legal language by the Attorney General's office and it will be submitted to Parliament soon for deliberation.

The role of regulation should also be considered during this process of preparing draft for legislation. In some countries, according to their legal system, regulations can provide flexibility to mental health legislation and contribute significantly to promote and protect de rights of persons with mental disorders.

Amendments to legislation are difficult due to the length of time, the financial costs and the complexities of extensive consulting with stakeholders. One solution is to make provisions in the mental health law for the establishment of regulations for particular actions that are likely to need frequent modifications. In some countries, the common practice is not to include specifics in the legislation but, instead, to leave them for regulations which are written after the law is passed by the legislative body.

Another reason for the use of regulations in mental health is the need to implement urgent actions in order to correct some critical situation of human right violations of persons with mental disorders. This can also have the meaning of a political signal for the general public and different stakeholders, facilitating a process of advocacy for more comprehensive mental health legislation.

Those drafting the mental health law could consider writing provisions for what can be regulated and the process for establishing and reviewing regulations. In some countries, legislation specifies who is responsible for framing the regulations and the broad principles upon which these regulations are based. Regulations can also be established through executive decrees.

Some countries spell out only the key principles in a mental health law, and use regulations to specify the procedural details for implementing the provisions of the legislation.

Regulations can have different contents according to the legislative practice in different countries. The following subjects are some examples of what might be included in mental health regulations:

- Development of community-based mental health care: primary care centres and outpatient psychiatric centres.
- Accreditation of formal and informal mental health services.
- Management and administration of private and public mental health services and facilities
- Conditions in mental health facilities: welfare of patients, environmental safety and hygiene, privacy, communication with the outside world, informing patients of their rights, etc.
- Procedures for admission and treatment (voluntary and involuntary), including consent forms and forms for involuntary admission and treatment.
- Procedures for major medical and surgical procedures, including psychosurgery and other irreversible treatments.
- Procedures for seclusion and restraint of patients
- Oversight and review mechanisms, including appeal forms
- Role, duties and responsibilities under the mental health law for different stakeholders (health and mental health professionals, police, judges etc), including user-friendly information (flow charts, forms, etc)
- Procedures relating to persons with mental disorders who get involved with the criminal justice system

C) ADOPTING MENTAL HEALTH LEGISLATION

1.Submitting mental health legislation to legislature

The legislative process for adopting legislation is likely to be the most time consuming step and other priorities, especially in developing countries, may mean that mental health legislation is ignored or delayed in the legislature.

The legislative process for adopting new laws varies in different countries, depending on their legal traditions and political systems (see Module 2). Parliament or a sovereign, law-making body is ultimately responsible for adopting legislation in most countries. In some countries the national parliament may be the sole legislative body, while in other countries with a federal constitution, states or provinces within the country may be authorized to make laws in addition to the national legislature. In federal states, laws that affect mental health may be a national or regional responsibility, or a mixture where national laws cover principles and objectives and state/district/provincial laws provide detailed provisions and their application.

2. Debating draft bills in legislature

Many legislatures have subcommittees that carefully examine the legislation before is introduced into the main legislative body. These committees usually wish to receive inputs from various perspectives to assist them in making their decisions. They may hold public hearings, request specific inputs or require clarification on different aspects of the law. This often leaves room for the participation of mental health professionals from the ministry of health, consumer, family and other advocacy organizations. They can support the draft bill if it adequately protects the rights of persons with mental disorders or they can propose amendments if the bill require improvements.

The debate process can be long and labour-intensive. During this stage, legislators may propose amendments to the draft legislation. Ultimately, the decision to include or reject amendments is the prerogative of the legislature, but those responsible for submitting the legislation and the advocacy institutions and organizations will have to provide substantial guidance and inputs to lawmakers about the effects of the proposed amendments, with recommendations for accepting or rejecting them. The lack of agreement between different stakeholders may unnecessarily delay the debate in the legislature, as has been the case with the National Mental Health Law in China, where disagreement about the participating departments' respective responsibilities, lack of adequate criteria for the accreditation of psychological counseling and psychotherapy, and the criteria for compulsory admissions to hospitals, have delayed for 26 years the legislative process of discussion.[14]

[14] Xiang YT, Yu X, Ungvari GS, Lee EHM, Chiu HFK. China's National Mental Health Law: a 26-year work in progress (Comment). Lancet (2012), 379: 780-782.

3. Mobilizing public opinion and lobbying legislature

Mobilising public opinion is crucially important for encouraging legislators to debate and pass proposed mental health legislation. Obtaining the support of public opinion should be initiated as early as possible - ideally during the consultation process in the previous step. As mentioned before, media strategies can be useful for this purpose, and the professionals in charge of mental health at the ministry of health can provide journalists with material for news, reports and interviews. Workshops and seminars for key groups and organizations should be organized, where main components of the new legislation can be explained and discussed.

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

Another important activity to stimulate the process of adopting mental health legislation is to lobby members of the executive branch of government and the legislature. They need to be informed of the deficiencies in the existing legislation or the negative implications and consequences of not having mental health legislation. They need to understand the social needs that prompted the development of the proposed law and the principal ideas on which the draft is based.

Professionals in charge of mental health at the ministry of health, consumers, families and other advocates should conduct frequent meetings with key members of these institutions as well as with politicians from the full spectrum of political parties. It is helpful to periodically send them written documents containing information about mental health facts and good practices, and to ask their opinion about policy and legislative initiatives. Lobbying is essential during the entire process of legislation – and particularly in the adoption phase – to ensure that the proposed law is sent to the legislature and that it moves toward through the different stages of analysis, discussion and promulgation.

4. Sanction, promulgation and publication of new legislation

The purpose of this stage is to make the adopted law publicly known, and to announce it officially. The terms used here – sanction, promulgation and publication – may be different in different countries, but the functions are fairly general.

Sanction is the prerogative of the head of the State and usually means the signature of the official text of the law.

Promulgation is the official announcement of the adopted law by the issuing of a special Act.

Publication means printing of the text of the law in the official government publication.

Usually, the constitution or other legal requirement stipulates a period of time after publication before the new law can come into force. Sometimes, this date may be established in the text of the law itself. Such period of time is helpful for citizens to become familiar with the text as well as for making organizational arrangements, if necessary, for the operationalization of the law.

Delays can occur at all stages, from sanction to promulgation and publication. Professionals in charge of mental health at the ministry of health, consumers, families and other advocates will need to follow up with the relevant authorities to ensure that legislation which is passed by the legislature body actually become legally enforceable.

BOX 9. EXAMPLE OF BARRIERS AND OBSTACLES TO DRAFTING AND ADOPTING MENTAL HEALTH LEGISLATION AND HOW TO OVERCOME THEM	
Barriers and obstacles	**How to overcome them**
Low priority to mental health legislation by government, parliament and sectors outside the health sector.	Empowerment of organizations of consumers, families and other advocacy groups. Lobbying the executive and legislators. Informing human right violations of people with mental disorders through the mass media. Denouncing human right violations to international bodies[15].
Resistance from the general public to human rights-oriented legislation.	Sensitization, information and education of the public about consumers' rights and mental health legislation.
Insufficient expertise about drafting mental health legislation in the country.	Training of mental health professionals and lawyers. Technical support from WHO and international experts.
Tension between those in favour of a human rights-oriented legislation and those who emphasized public safety.	Formulating mental health law taking a needs-based approach (i.e. addressing consumer needs as well as the needs of society in general).
Conflicts between those who favour legislation solely concerning patients' rights and those who favour including also promotion and prevention.	Appoint representatives from both interest groups to the drafting body and favour the participation from both groups in the consultation process.
Tension between the rights and responsibilities of consumers and the rights and responsibilities of families.	Workshops with representatives from consumers and families groups to examine and discuss the key issues and interest of each group. Include both groups in the drafting body and consultation process.
Resistance from psychiatrists who perceive a new legislation as undermining medical authority.	Seminars on patients' rights and medical ethics with the participation of experts in these areas. Formulating the law from a consumer perspective and involving many sectors and disciplines in a consultation process with oral hearings.

[15] Hillman AA. (2005). Human rights and deinstitutionalization: A success story in the Americas. Pan Am J Public Health 18, (4/5):374-379.

D) IMPLEMENTING MENTAL HEALTH LEGISLATION

Implementation difficulties can be anticipated from the stage of drafting legislation and corrective measures can be taken to promote implementation. Poor attention to implementation has meant that in many countries 'law in the books' and 'law in practice' are rather different

1. Developing an oversight agency and procedures for implementation

As with the drafting of legislation, responsibility for overseeing implementation of a mental health law can take numerous forms. Moreover, different functions of the legislation may be undertaken and monitored by different institutions. Whatever oversight agency is established, or whichever body is given this role, some of the following functions are crucial for implementation of mental health legislation:

- Monitor implementation
- Maintain statistics
- Develop rules and procedures for implementation
- Prepare standardized documentation instruments for recording and monitoring implementation
- Inspection of mental health facilities
- Review institutional practices
- Ensure a proper process of training of mental health professionals, introducing certification procedures if necessary
- Maintain a register of accredited professionals and facilities
- Make periodic reports and recommendations to the government for improvements to the law and services
- Grant and withdraw accreditation to professionals and facilities
- Impose administrative and financial penalties for violation of legislative norms
- Close facilities which persistently violate human rights of persons with mental disorders.

For example, the two types of regulatory bodies described in module 8 – the review body and the monitoring body - can carry out some of these functions to ensure that the various legislative provisions are being met. Refer back to module 8 for further discussion of these bodies.

The review body is a judicial or quasi-judicial body that oversee involuntary admission to hospital, involuntary treatment and other restrictions of rights in persons with mental disorders. In many countries, courts are the preferred option to carry out this function due to their easy accessibility and clear legal status. However, the role of the courts in a number of countries has been questioned because judges tend to confirm the medical recommendations without applying independent analysis to the process.

An alternative to a court procedure is the establishment of an independent and impartial court-like body with a judicial function. The fact that this body can be specifically created for this purpose and is comprised by selected members with expertise is considered to make a more competent body for this purpose than a court. It is advisable that this quasi-judicial body includes at least an experienced legal and an experienced mental health professional, as well as at least one "non-professional" person reflecting a community perspective.

The monitoring body is a non-judicial body to oversee the well-being and human rights of persons with mental disorders within and outside mental health facilities. This body could be given the tasks of conducting regular inspection of mental health facilities and periodically reviewing institutional practices to ensure that safeguards contained in legislation are being implemented and patients' rights are being protected. This body may also have to hear complaints, provide guidance and monitor intrusive and irreversible treatments. It does not operate as a court and only makes recommendations.

For effective functioning of the monitoring body, it should be composed of mental health, legal and social work professionals, representatives of consumers and their families, advocates and lay people. In some countries, religious authorities are also given representation. Women and minority groups should receive adequate representation.

In many countries these two bodies are completely independent of each other, have members with different expertise and have unique powers and functions. In other countries, especially those with a paucity of financial and human resources, both institutions are combined into one body which has both the judicial and monitoring function.

The oversight agencies should be able to assess whether the various legislative provisions are being met. If these bodies report directly to the responsible ministry, the latter can be kept informed of the extent and effectiveness of implementation. This should not, however, preclude the government itself from setting norms, standards and indicators to establish whether the provisions of the legislation are being met. Necessary steps need to be taken if the legislation is not being properly implemented.

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

Box 10 shows examples of oversight agencies in two countries, Portugal and

Scotland.

BOX 10. EXAMPLES OF OVERSIGHT AGENCIES FOR MENTAL HEALTH LEGISLATION

PORTUGAL[16]

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

SCOTLAND[17]

The new Mental Health Act, which came into effect in October 2005, continues the general protective functions of the Mental Welfare Commission and gives it new powers that enable it to maintain and develop its role in protecting the rights of service consumers and promoting the effective operation of the new act. These include monitoring how the act is working, encouraging best practice, publishing information and guidance and carrying out visits to patients, investigations, interviews and medical examinations, and to inspect patient records.

The new Act replaced the Sheriff Court with a new Mental Health Tribunal, which has the function of deciding on compulsory treatment based in the hospital or in the community. Each Tribunal has three members: a legally qualified person, a doctor with experience in mental health and a third person with other skills and experience. It is possible that the third person could be a service user or carer.

However, in many countries effective oversight mechanisms are absent, and some advocates have utilized international and regional human rights systems and organizations for redress. Although the jurisprudence of these bodies is in its infancy, the African Court on Human and People's Rights and the Inter American Court on Human Rights have all ruled on matters related to the rights of people with mental and psychosocial disabilities. The European Court of Human Rights

[16] *WHO Resource Book on Mental Health, Human Rights and Legislation*. (2005) World Health Organisation, Geneva.

[17] *The New Mental Health Act, What's it all about. A Short Introduction (2005).* Scotish Executive, Edinburg, www.scotland.gov.uk

has a more developed case-law on rights issues, and the European Committee on Social Rights has decided on two collective complaints concerning the education of children with intellectual disabilities. The European Committee for the Prevention of Torture also visits all places of detention—including psychiatric institutions—within member states, and reports its findings and recommendations.[18]

2. Ensuring proper training

Health professionals as well as people with mental disorders and their families, and advocacy organizations working on their behalf are frequently ill informed about the changes brought about by new legislation. In some instances, they may be informed of these changes but remain unconvinced about the reasons for these changes and hence do not act in accordance with the law.

Guidebooks about the mental health legislation can help the different stakeholders to reach adequate knowledge and understanding of its dispositions. They could provide detail or guidance about interpretation. Algorithms could also be developed that clearly illustrate processes, such as involuntary admission and treatment, and indicate which forms are needed at which stages.

- **Consumers, families and advocacy organizations:** It is critical for these individuals and/or groups to know what the legislation says, and, specifically, to know their rights. The importance of involving them through the whole process of drafting and adapting mental health legislation has been emphasized. The proper implementation of the law also requires the active participation of well-informed consumers, families and advocacy groups. Organizations representing them can play an important role in the process of training consumers and families about how to defend their rights according to the mental health legislation.

  In countries where these organizations are not well established, the professionals in charge of mental health at the ministry of health should implement an active strategy supporting them, with actions such as technical support, funding, evaluations of their functions and enhancing alliances and coalitions[19].

- **Mental health, health and other professionals:** It is necessary to ensure special training of these professionals, including lawyers, judicial system, police, social workers, teachers, among others. Joint training activities, where professionals from health and non-health disciplines are able to interact with each other, can create a better understanding of the human rights of people with mental disorders and application of mental health legislation.

[18] Drew N, Funk M, Tang S, Lamichhane J, Chávez, E, et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet, 2011;378, 9803:1664 – 1675.
[19] *Advocay for Mental Health* (2003) World Health Organisation, Geneva.

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

3. Engaging in public awareness campaign

A sustained programme for public education and increasing public awareness can also play an important role in implementation. Stigma, myths and misconceptions associated with mental disorders lead to discrimination and limitation on human rights, and can represent obstacles to effective implementation of human-rights-oriented legislation.

Disseminating information about the rights provided in the new legislation can help to change public attitudes towards people with mental disorders. Both the media and consumers, families and advocacy organizations can play a useful role in this process.

4. Addressing human resources and financial issues

New mental health legislation will need funds and additional human resources for implementation. Adequate budgetary provision should be made for the activities that are necessary, such as the review and monitoring bodies, training of consumers, families, advocacy groups and health and non-health professionals, printing of documents, public awareness campaign and the necessary changes to mental health services as required by the legislation.

Additional human resources and funding for all the activities listed above should be provided well in advance of the date the new mental health legislation will come into force. If this is not done properly there is a risk of resistance to the implementation of the law by some stakeholders.

For example, in Ireland, the Irish Division of the Royal College of Psychiatrists welcomed the publication of a new Mental Health Act in the year 2001, highlighting the importance of this legislation for enhancing the protection of patients that are involuntarily detained. However, they made critical comments about some of its provisions and stressed the need for extra resources - including human resources – for implementing the proposed new procedures. Some of the most important requests for resources from the Irish Division were the following:

- Funding for the day to day running of the Mental Health Commission as well as the allocation of resources at local Health Board levels to ensure full compliance with the regulations and statutory obligations of the local bodies in their dealings with the Commission

- Financial resources to ensure systems are put in place: resources for training of staff, medical, nursing and administrative, and resources in terms of human resources and time.

- Considerable time allocation to ensure the Mental Health Tribunals can carry out their task.

- Extra consultant psychiatrist posts since these professionals will be taken from his/her clinical work to participate on "independent reviews".

- Two consultants psychiatrists per catchment area to ensure continued quality of patient care and compliance with "second opinions"

- Extra allocation of resources to fund human resources and time for administrative and clerical staff to undertake the duties of the new Mental Health Act.

Five years after these requests were formulated and when the new mental health legislation came into force (November 1st, 2006), the Irish Division of the Royal College of Psychiatrists were still opposing the Act, stating that the resources were not in place yet to support the aims, spirit and detail of the legislation. The two medical organizations of Ireland have also expressed concern about the shortage of resources to implement this new legislation.

South Africa is another example of the challenges to implement mental health legislation in real life. The Mental Health Care Act No. 17 of 2002 marked a significant step forward in addressing mental health as a major public health issue and protecting the human rights of people with mental illness. Three main challenges were identified: 1) "to systematically address the lack of resources for mental health care, and begin to plan appropriate services for mental health"; 2) to develop information systems to monitor the mental health services that they do deliver and to become transparent and accountable in this regard; and 3) to improve quality assurance measures for mental health care among both psychiatric and general hospitals.[20]

BOX 11. EXAMPLE OF BARRIERS AND OBSTACLES TO IMPLEMENTING MENTAL HEALTH LEGISLATION AND HOW TO OVERCOME THEM

Barriers and obstacles	How to overcome them
Lack of coordinated action in the implementation of mental health legislation (absence of a centralized agency or authority overseeing the process of implementation).	Ensure that an oversight agency (e.g. a specific monitoring body or the mental health review body) is appointed to monitor the implementation process, by having this included in the text of the law.
Most consumers and families are not	Education and training of consumers

[20] Lund C, Stein DJ, Flisher AJ. Challenges faced by South African health services in implementing the Mental Health Care Act (Editorial). SAMJ (2007), 97 (5) : 352-353.

aware of major changes in protection of their rights since the mental health law came into effect.	and families about the rights of people with mental disorders. Dissemination of guidebooks and leaflets about the mental health law. Empowerment of organizations of consumers, families and other advocacy groups.
Mental health, health and other professionals are unaware, or resist the provisions of mental health legislation.	Training of mental health and health professionals and lawyers should include explanations on the provisions of mental health legislation. Seminars on patients' rights and health ethics with the participation of experts in these areas.
Shortage of mental health human resources to implement some of the mandates of the law.	Mental health training should be provided to general health professionals and staff [2122]. Training and support to consumers and family groups to enable them to provide community care.
Insufficient funding to develop the mechanisms needed to implement the law (e.g. advocacy, awareness-raising, training, monitoring and review bodies).	Negotiation for additional funding should be done simultaneously with the process of drafting and adopting mental health legislation.

[21] *Organization of Services for Mental Health* (2003) World Health Organisation, Geneva.

[22] *Human Resources and Training in Mental Health* (2005) World Health Organisation, Geneva.

Core Reading

WHO Resource Book on Mental Health, Human Rights and Legislation. (2005) World Health Organisation, Geneva.

Advocacy for Mental Health (2003) World Health Organisation, Geneva.

WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities. Geneva, World Health Organization, 2012. http://www.who.int/mental health/publications/QualityRights toolkit/en/index.html

Hillman AA. (2005). Human rights and deinstitutionalization: A success story in the Americas. Pan Am J Public Health 18, (4/5):374-379.

United Nations Human Rights Council. Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General. January 26, 2009.

Additional reading

WHO International Digest of Health Legislation(IDHL) online database. (http://www.who.int/idhl)

Drew N, Funk M, Tang S, Lamichhane J, Chávez, E, et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet, 2011;378, 9803:1664 – 1675.

Making the Connections: Human Rights and mental Health (2006). Scottish Executive and British Council Scotland

Gable L, Vasquez J, Gostin L & Jiménez H (2005). Mental health and due process in the Americas: protecting the human rights of persons involuntarily admitted to and detained in psychiatric institutions. Pan Am J Public Health 18, (4/5): 366-373.

Organization of Services for Mental Health (2003) World Health Organisation, Geneva.

Fistein EC, Holland AJ, Clare ICH, Gunn MJ. A comparison of mental health legislation from diverse Commonwealth jurisdictions. Int J Law Psychiatry. 2009 May; 32(3): 147–155.

Corrigan PW; Watson AC; Heyrman ML; Warpinski A; Gracia G; Slopen N. (2005) Structural stigma in state legislation. Psychiatr Serv. 56(5):557-63

Xiang YT, Yu X, Ungvari GS, Lee EHM, Chiu HFK. China's National Mental Health Law: a 26-year work in progress (Comment). Lancet (2012), 379: 780-782.

Lund C, Stein DJ, Flisher AJ. Challenges faced by South African health services in implementing the Mental Health Care Act (Editorial). SAMJ (2007), 97 (5) : 352-353.