MODULE 4: POLICY AND LEGISLATIVE FRAMEWORK FOR MENTAL HEALTH

COURSE WORK NOTES

1. Overall Learning Objective: To develop an understanding of mental health policy and the theoretical and practical interrelationships between mental health policy, service organization and legislation.

Rationale: To adequately address mental health and human rights of people with mental disabilities it is necessary to have a *co-ordinated effort* involving various stakeholders as well as *co-ordinated strategies and mechanisms* to achieve shared goals. This includes having a mental health policy, plans and programmes as well as mental health legislation. A formal mental health policy captures the vision and objectives for improved mental health and an implementation plan concretizes the policy and guides service delivery. Specific mental health programmes assist in accomplishing the policy objectives.

Mental health legislation on the other hand provides a legal framework for this to occur and its provisions are enforceable through the judicial authority of the country. Legislation also identifies specific human rights that people with mental disabilities are entitled to and lays down what must be done, or not done as the case may be, to achieve these rights. Where legislation has been drawn up through democratic processes it ensures that "the will of the people" is captured in law and will be implemented. Law (depending on local decisions of what should be included) can ensure that citizens with mental disabilities are afforded particular rights and access to mental health care and, importantly, it lays down legal procedures that need to be followed to promote these rights, services and structures.

An understanding of policy and plans is important for understanding the scope of mental health legislation. While factors other than policy such as international human rights standards are important in drawing up legislation, the policy also forms an excellent framework for the legislation. Conversely where human rights is emphasized in legislation, it promotes the implementation of policy and the organization of services from this perspective. Legislation and services must mutually reinforce each other. In this way human rights can be promoted. Legislation can reinforce the development and implementation of progressive mental health services and the way services are organized can optimize the promotion of human rights.

Module content

I) Defining mental health policy, plans, organization of services, legislation.
The terms "policy", "plan" and "organization of services" may be used differently in different countries. However to avoid confusion in this course we use these terms as

they are defined and used in the WHO Mental Health Policy and Services Guidance package (WHO htt://www.who.int/mental_health/policy/en/) A mental health policy is "an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for the future and helps to establish a model for action" (WHO module on Mental Health Policy, Plans and Programmes (updated version 2004). The policy describes what the government wants to achieve in mental health and defines the framework that will be used to achieve the vision and the objectives. The development of a mental health policy should follow a process involving consultation with stakeholders and careful examination of information regarding best mental health policy practices (See WHO module on Mental Health Policy, Plans and Programmes (updated version 2004).

However, a policy alone is insufficient to realise the goals contained in it and there also needs to be a comprehensive mental health plan. The plan is a "detailed pre-formulated scheme for implementing strategic actions that favour the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation (WHO Mental Health Policy, Plans and Programmes (updated version 2004". Such a plan allows the implementation of the vision, values, principles, and objectives defined in the policy. A plan usually includes strategies, time frames, resources required, targets to be achieved, indicators and activities.

There may also be a need for mental health programmes. These are interventions "with a highly focussed objective for the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation (WHO, Mental Health Policy, Plans and Programmes (updated version 2004". A programme usually hones in on a specific mental health priority.

The organisation of services is the way that mental heath is structured in a country to achieve the policy vision.(WHO, Organisation of Services for Mental Health, 2003) . Through policy, plans and programmes Health ministries can have a significant impact on the mental health of populations (WHO, 2005).

Law is usually made in forums of representatives of the people and administered through the courts (See Module 2 on basic understanding of law and legal systems.). In structures such as a parliament, congress or council, representatives debate what is paramount for mental health and pass and enact laws that ensure that goals and objectives (such as human rights or adequate access to care) are met. Law differs from policy in that transgressions are a legal offence, punishable by courts. In some countries the policy document may also be used in courts as it is a legal document and is binding on the government and service providers, however this is unlikely to have the same legal powers of enforcement and punishment that a law does. Mental health law can be used to promote and enforce a mental health service framework and protect the human rights of people with mental disabilities. As the WHO module on Mental Health Legislation and Human Rights says "mental health legislation is essential because of the unique vulnerabilities of people with mental disorders" (WHO 2003). Legislation usually contains the substantive and procedural imperatives for the realization of the country's goals for mental health. While failure to implement

policy may have moral and political repercussions and perhaps internal disciplinary consequences for those who have not implemented them, only laws have judicial consequences and, if found guilty, punishment against the persons or organizations concerned.

*II) **A framework for human rights oriented policy, legislation and service development.***

Violations and neglect of human rights can itself be harmful to mental health (See Module 3). For example confining a child in a "cage bed" for weeks or months on end may result in delays or impediments to emotional, cognitive and moral development. A person who spends a long period in custodial care may become "institutionalized" and unable to survive outside of the custodial setting (Goffman, 1961). Even an individual with no history of mental disorder may develop disorder as a result of human rights violations. For example it is not uncommon for a political detainee who is tortured to suffer post-traumatic stress disorder. Promoting human rights is hence a mental health goal in itself.

Mental health services can themselves promote or deny people human rights. For example the "cage beds" and long term institutionalization mentioned above need to be replaced with treatment and rehabilitation services that promote both mental health and human rights. Thus while the mental health law needs to outlaw practices which abuse human rights - such as cage beds and unfair limits of people's freedoms through institutional practices - the policy and plans need also to develop human rights friendly service alternatives.

A mental health policy, plan or even a law does not necessarily result in improved mental health outcomes or the promotion of human rights of people with mental disability. For example a policy or law may discriminate against a minority group or against women; it might limit access to care through centralization of services and a custodial approach; law may allow involuntary admission merely on the recommendation of a medical practitioner or conversely, without the recommendation of a medical practitioner and so forth. However where policy and legislation follow best practice examples and internationally established human rights standards, they can both be highly effectual in improving health and human rights.

One of the most important reasons why human-rights-oriented mental health legislation is vital is because of past and ongoing violations of human rights of persons with mental disabilities. People with mental disabilities are vulnerable to violations both inside and outside the institutional context. Even within their own communities and within their own families, for example, there are cases of people being locked up in confined spaces, chained to trees and sexually abused. A progressive mental health law can be an effective means of protecting the rights of people with mental disabilities. It can:

- Prevent violations and discrimination and promote human rights
- Encourage autonomy and liberty of people with mental disabilities

- Support access to mental health care and help to integrate people with mental disabilities into the community
- Ensure that people with mental disabilities have access to legal mechanisms, including mechanisms of review and appeal

III)The importance of policy and legislation for delivery of better health and human rights.

What must be done to achieve optimal mental health and human rights, how will it be done and who will do it?

Unless the above questions are systematically debated, informed by available evidence and structured into understandable and feasible frameworks, no services or highly chaotic services are likely to be provided. Policy, plans and legislation are different forms of structuring rights and services into well canvassed, focused and deliverable practices. The policy and legislation needs to have clearly defined roles and responsibilities for different players in the health care system, including healthcare professionals and government officials (Funk et al 2005)

i)*Mental health policy*

An explicit mental health policy is an essential and powerful tool to achieve better mental health outcomes for the community. In the field of mental health written policies are important because they:

- provide a general blueprint and lay a foundation for future action
- give mental health a priority that is consistent with the disease burden within a country
- improve procedures for developing and prioritising mental health services and activities
- Identify principal stakeholders in the mental health field and designates clear roles and responsibilities
- Facilitate agreement for action between various stakeholders.

The scope of mental health policy can be broad encompassing all issues affecting persons with mental disabilities such as housing, social welfare, employment and so on or can be restricted exclusively to mental health services. There are advantages and disadvantages of both approaches. A narrow focus does not comprehensively address the population's needs while it does have the advantage of a high degree of specificity and ease of implementation and evaluation.

Mental health policies can be integrated into a general health policy or there can be a specific mental health policy. Both approaches have their advantages. An integrated approach may be preferable because it favours the incorporation of promotion and prevention into the general approaches to health and decreases risks of discrimination and stigma. On the other hand mental health may get "lost" in general health

legislation and having specific policy that highlights mental health can be advantageous.

Mental health policies, just like mental health legislation should be consistent with and incorporate human rights standards. This means incorporating principles of deinstitutionalisation, integration into general health care, development of community based health services for example. A mental health policy and plan that is developed in close reference to a mental health law can encompass key strategies to implement this law.

WHO has suggested the following eight step process for developing a mental health policy (WHO 2004):

Step 1. Gather information and data for policy development

Good policy is dependent on information about the mental health needs of the population and the mental health system and services offered. The needs of the population can be determined from, for example, prevalence and incidence studies, determining what communities identify as problems and an understanding of help seeking behaviour. Establishing priorities for mental health must be done.

In addition, the current system for delivering mental health care must be well understood and documented. Knowing who delivers mental health, to whom and with what resources is an important starting point for developing a reasonable and feasible mental health policy.

Needs can be determined by the following methods:

a) **Formal research:** Epidemiological studies in the general population and in special populations (e.g. schools and workplaces), simple epidemiological studies of people visiting health facilities, burden of disease studies involving the use of disability-adjusted life-years (DALYs), in-depth interviews and focus groups.

b) **Rapid appraisal:** Secondary analysis of data from existing information systems, brief interviews with key informants and discussion groups involving people with mental disabilities, families, carers and health staff.

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Step 2. Gather evidence for effective policy

Evidence can be obtained by visiting local services and reviewing the national and international literature.

a) **Evidence from a country or region:** The principal evidence comes from the evaluation of previous policy, plans and programmes. Pilot projects and local experiences are also excellent sources of information.

b) **Evidence from other countries or regions:** Evidence can be gathered most usefully from countries or regions with similar cultural and socio-economic features.

c) **Evidence from the literature:** Evaluations of national or regional mental health policies.

Step 3. Consultation and negotiation

The process of formulating and implementing a mental health policy is mainly political. To a lesser degree it is a matter of technical actions and resource-building. The role of the health ministry is to listen to the various stakeholders, very importantly including users/user organisations and families/family organistions, and to make proposals that blend their different views with the evidence derived from national and international experience. An active compromise of the majority of the key stakeholders may be required in order to develop and implement a mental health policy. Consultation and negotiation is a vital process and can help to secure political support for the policy.

Step 4. Exchange with other countries

Sharing experiences with other countries may help a country to learn about both the latest advances in more developed countries and about creative experiences and lower-cost interventions in less developed countries. International experts may also be helpful in this connection.

Step 5. Set out the vision, values, principles and objectives

When information has been gathered from a variety of sources through steps 1 to 4 the substance of the policy can now be set out by describing the vision, values, principles and objectives for mental health.

a) **Vision:** The vision usually sets high expectations for mental health, describing what is desirable for a country or region. However, it should be realistic, covering what is possible in accordance with the available resources and technology.

b) **Values and principles:** Different countries and regions have their own values associated with mental health and mental disorders but in essence they should reflect notions of equity and uphold human rights standards. During the process of formulating mental health policy it is necessary to discuss which values and guiding principles should be adopted.

c) **Mental health objectives:** The three overall objectives of any health policy (WHO, 2000) are applicable to mental health policy.

1. *Improving the health of the population***.** The policy should clearly indicate the objectives for improving the mental health of the population. Ideally, mental health outcome indicators should be used, such as quality of life, mental functioning, disability, morbidity and mortality. If this is not possible, process indicators can also be used, such as access and service utilization.
2. *Responding to people's expectations.* In mental health this objective includes respect for persons and a client-focused orientation.
3. *Providing financial protection against the cost of ill-health.* Among the issues of relevance to mental health are: equity in resource distribution between geographical regions; availability of basic psychotropic drugs; parity of mental health services with those of general health; allocation of an appropriate percentage of the total health budget to mental health.

Step 6. Determine areas for action

The next step is to translate the objectives of the mental health policy into areas for action. In order to be effective a mental health policy should consider the simultaneous development of several such areas. The areas to included may vary in different countries and regions and in different historical periods. The following areas have been involved in most of the policies developed over the last 20 years.

- Financing
- Legislation and human rights
- Organization of services
- Human resources and training
- Promotion, prevention, treatment and rehabilitation
- Essential drug procurement and distribution
- Advocacy
- Quality improvement
- Information systems
- Research and evaluation of policies and services
- Intersectoral collaboration

Step 7. Identify the major roles and responsibilities of different sectors

The main sectors required to take on specific roles and responsibilities include:

- Governmental agencies (health, education, employment, social welfare,
- housing, justice);
- academic institutions;
- professional associations;
- general health and mental health workers;
- consumer and family groups;
- providers;
- nongovernmental organizations (NGOs);
- traditional health workers.

Step 8. Conduct pilot projects

Before or during the development of a mental health policy the health ministry can contribute to this process by conducting pilot projects. These provide useful evidence as from the beginning of the process. They can demonstrate that new strategies function well in one or two places and that it is worth expanding them to the rest of the country or region in question. Pilot experiences can help to improve the formulation of policy if they show that some services are not very effective. They are also useful in connection with calculating the real costs of implementing a policy.

Mental health legislation

Developing legislation is generally a more complicated process than developing policy as it needs to go through the law making process in a country (See module 2). While policy can usually be made by the Minister/Ministry concerned following a consultation and negotiation process, law is a far more formal process usually debated and passed by the official representatives of the population in

parliament/congress/council. Nonetheless the first four steps of the policy making process ie gathering information and data, evidence, going through consultation and negotiation and exchange with other countries are also important steps in legislation development. However some of the focus of these processes would be different, examining issues relevant to legislation rather than policy (See Module 11).

Once a policy and/or legislation have been accepted/passed, they become the official documents that guide the way services are provided and the way people are expected/ compelled to behave. When effectively implemented "… coordinated government efforts to organize mental health services in the most effective way and protect the human rights of people with mental disorders can substantially mitigate the harm caused by mental disorders to individuals and societies" (Funk et al 2005).

What should and should not go into mental health legislation can be a tricky issue (See *WHO Resource Book on Mental Health, Human Rights and Legislation.* (2005a) World Health Organisation, Geneva.). It would be tempting to suggest that everything that is possible to go into legislation regarding the health, well-being and human rights of people with mental disabilities should be included in the legislation of every country and that it should be included immediately - whether in dispersed or consolidated legislation. However the reality for many countries is that even if there were laws that compelled the government or its citizens to do certain things they would not be able to do them due to various obstacles including lack of resources. Countries must therefore be realistic in what they put into legislation, so that the law doesn't merely become a wish list rather than the enforceable and respected part of society that it should be. Legislation that is not implementable makes a mockery of law itself in that the citizens of a country do not live by it and the authorities never enforce it.

This does not mean that the human rights of people with mental disabilities (especially non-derogable rights outlined in international standards) or key principles such as access to care and equitable care or due processes for admitting and treating individuals need not be included in country laws; they certainly should, but country realities must be considered in the mental health law reform process. In many countries a costing of the implications of the legislation has to be undertaken with notice of how the provisions will be paid for before a parliament or council will pass the legislation.

Some of the key areas around which a country may decide to legislate include:-

- Making mental health services accessible
- Making mental health services affordable
- Making mental health services acceptable
- Ensuring a range of human rights for patients (see Module 3)
- Ensuring a range of rights for families or carers
- Addressing issues of competence, capacity, supported decision making and appointments of guardians
- Processes for voluntary admission and discharge of patients
- Processes for admission and treatment of non-protesting patients

- Processes for admission and treatment of involuntary users
- Proxy consent for treatment
- Processes for involuntary treatment in the community
- Emergency situations
- Determinations of mental disorder
- Special treatments
- Seclusion and restraint
- Clinical and experimental research
- Oversight and review mechanisms
- Police responsibilities
- Mentally ill offenders
- Mentally ill prisoners
- Access to housing
- Access and treatment in employment
- Social security
- Civil issues
- Protection of vulnerable groups
- Mental health promotion and prevention

International human rights norms and standards, and particularly the UN Convention on the Rights of Persons with Disabilities, provides guidance on how these issues can be dealt with in law to ensure optimal protection of human rights for people with mental disabilities (see Module 3 for further discussion on this).

IV)Choosing separate or integrated mental health policy and legislation

Clearly if all the above are included in legislation this would be regarded as 'broad" legislation while the inclusion of only one or two of the above would be regarded as narrow legislation. Countries need to be careful in naming legislation that they do not inadvertently mislead the public. Perhaps if all the above are included in legislation then it would indeed deserve a title such as "Mental Health Act" as it covers a range of issues with regard to mental health. However legislation that deals for example only with processes of admission and treatment of people with mental disabilities into inpatient mental health facilities is only a relatively small part of mental health and therefore may better be termed something like "Admission and Treatment to Mental Health Facilities Act". This would facilitate the later (or even simultaneous) "Promotion of Mental Health and Prevention of Mental Illness Act" for example. For this reason some countries have a "Mental Health Care Act" or similar less inclusive titles.

Every country wanting to develop legislation needs to decide whether they wish to have separate mental health legislation or whether important mental health issues can be incorporated into other legislation. A combination of both of these approaches may also be possible (See *WHO Resource Book on Mental Health, Human Rights and Legislation.* (2005a) World Health Organisation, Geneva.).

Mental health issues can effectively be incorporated into legislation dealing with general health care, employment, housing, criminal justice, general human rights, disability, guardianship and other areas. Such incorporation may help to reduce stigma associated with mental health in that mental health is not dealt with as different from other health and/or disability issues and people with mental disabilities are not regarded as "other". This is likely to promote integration of people with mental disabilities into normal community life. According to the WHO Resource Book on Mental Health, Human Rights and Legislation this approach also increases the chances that the laws will be put into practice. On the other hand this resource book makes the point that in dispersed legislation it is difficult to ensure coverage of all aspects relevant to persons with mental disabilities. It also makes the point that the procedural processes involved in protecting the human rights of people with mental disabilities are usually quite detailed and complex and may be inappropriate in a law that does not specifically deal with mental health. Finally it is suggested that dispersed legislation may require more time in the legislature because of the need to be involved in amendments to numerous laws.

Consolidated mental health law is probably easier to adopt and enact. Especially if at a particular point one wishes to incorporate mental health into a range of laws where there were previously no mental health provisions, or where a change in policy direction requires change to a number of laws, it is likely to be more difficult to enable this than through a single law.

If a person needs for any reason to know "the law" with regard to people with mental disabilities then clearly a single law would be far easier to access than where provisions are dispersed in numerous laws. For example if a family member of a person with a newly diagnosed mental disorder wants to know how and where they can legally access services; what rights their family member and they themselves have; what they would need to do if they at some point in the future needed their family member to be admitted and treated on an involuntary basis; what processes would their family member need to go through; could the family member be given ECT without their consent; would they be put in seclusion for extended periods, how and when would they be discharged; to whom would they be discharged; how might they get employment; would they be discriminated against in gaining access to housing; what would happen if their family member committed a crime; will their family member still be able to marry and to vote? If they need to look in a range of legislations for answers to these questions, this could be highly frustrating.. Ideally, whether there is a consolidated law or many different laws, the country should assist users by bringing together all the important and relevant legal provisions into a single user friendly document that is widely distributed. Nonetheless some people may wish to interrogate the actual laws themselves and this is an entitlement of citizens. Many countries are now attempting to write legislation that is more accessible to lay people who do not understand complex legal terminology in order to bring the law closer to ordinary people and to demystify the common held perception that law is only to be read and interpreted by legal practitioners.

According to the WHO Resource Book on Mental health Human Rights and legislation "There is little evidence to show that one approach is better than the other.

A combined approach, involving the incorporation of mental health issues into other legislation as well as having specific mental health law, is most likely to address the complexity of needs of persons with mental disorders". (2005a pg 7)

The role and organization of mental health services in promoting human rights.

In most countries mental health services are neglected. Despite the high burden of disease and disability resulting from mental disorder (See Module 1), many people around the globe have little or no access to mental health care resulting in a major mental health treatment "gap". The global "treatment gap" has been estimated to be around 32% for schizophrenia, 56% for depression, 50% for bipolar disorder, 57% for generalized anxiety disorder, 57% for obsessive compulsive disorder and 78% for substance dependence (Kohn et al 2004). This gap is highest in developing countries.

For many people with mental disabilities services only become available if they become so disruptive and/or violent that the family or community are compelled to seek assistance because all other options have been exhausted. Assistance is often sought from the police to get the person to treatment. Often, the only services that are then available are in large custodial institutions that have only limited treatment and rehabilitation programmes. In fact 68% of all psychiatric beds wordwide are in such institutions (WHO Atlas 2005). Many people are forced to stay for prolonged periods in institutional care without their consent. This scenario also results in furthering popular beliefs that people with mental are highly disruptive and violent. Other reasons why many people stay in institutions is that families will frequently not take back the relative because of the stigma of mental illness and/or that they cannot take them back for economic reasons. The additional economic strain on the family arises not only because there is an additional person to feed and clothe and provide health care for, but also a family member may have to look after the person and hence cannot go out to earn.

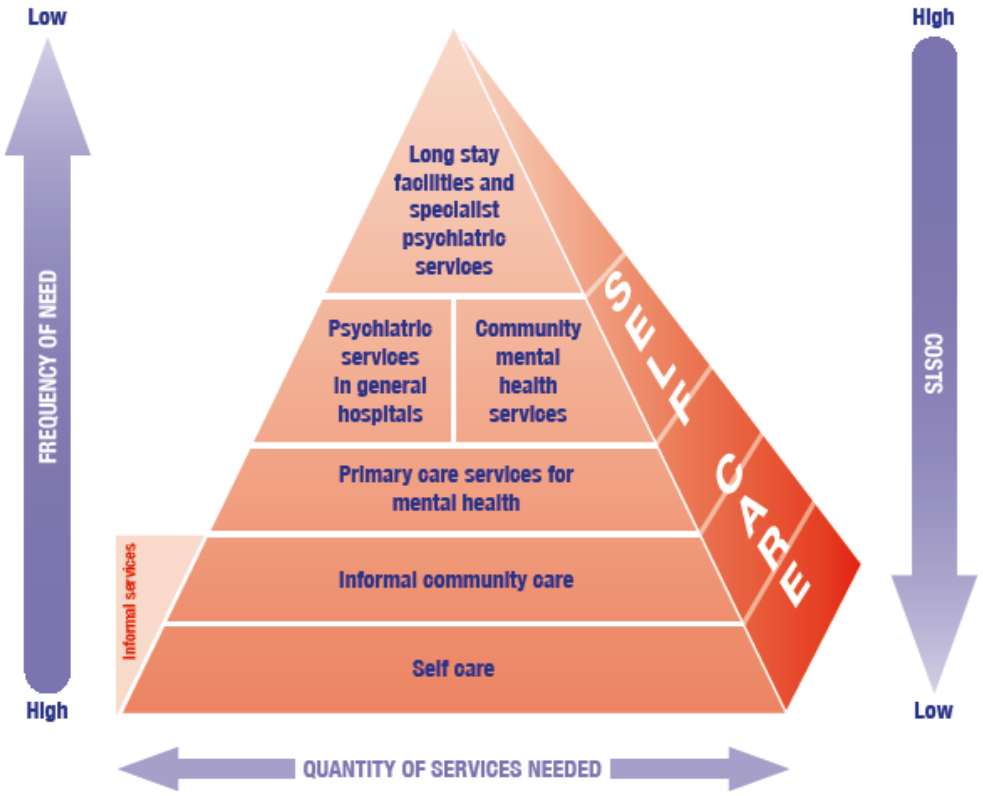
For many people voluntary care is either not accessible, available or affordable (WHO Atlas, 2005) and if it is, poor understanding of mental health and stigma and discrimination around mental health often prevents people from seeking assistance. Moreover when people have to travel long distances they are less likely to seek treatment. This is not only a problem of time but is also expensive in terms of transport costs, time off work and seriously disrupts routines.

Large institutions which segregate people with mental disabilities reinforce negative stereotypes and increases discrimination and low self-esteem. This in turn hinders recovery from mental illness. Moreover where in-patient treatment is provided far from where a person lives and works, it is difficult for family and friends to keep contact and support the person, resulting in even further hindrances to recovery.

In most developing countries where community care is available it is usually only medical care. While medication is necessary in most instances and its importance can never be overemphasized, for a number of patients this is insufficient. Rehabilitation programmes such as life skills development, occupational therapy, employment assistance and working with families and communities to integrate the ill person are

very seldom available. Moreover in many countries mental health services are not integrated into general health care. "Vertical" services often result in people not initially being identified as having a mental disorder, in people with mental disabilities not being treated as "whole" individuals who have physical as well as mental health care needs and increases the stigmatisation and "otherness" of people with mental disabilities.

The following WHO pyramid of the optimal mix of services appears to best meet the mental health needs of populations and promotes their human rights (Funk et al 2004; WHO Organisation of Services 2003).



This model suggests that for the majority of people "self-care" is sufficient and adequate. At some point in their lives most people experience being "down", have little energy or zest for life and do not function at their best levels. In the majority of cases though, people are able to pull through such periods using their own resources. At other points people may rely on "informal" community care such as religious organizations, friends and family to help them get through difficult times. They might be given "home remedies" or concoctions that have been passed down through generations as being helpful for various conditions. Example of "informal services" include traditional healers, village or community workers, family members, self-help and user groups, advocacy services; lay volunteers, religious leaders and day care services provided by non-professionals in their communities (WHO Organisation of services, 2003) However, for some people the conditions may persist or be more severe than can be addressed within the self-care or informal community care models.

It is suggested given that health "is a state of physical, *mental* and social well-being" (WHO Constitution 1946) that, wherever possible, a person should have their mental

health problem dealt with at a primary care level within the general primary health care services. A significant number of consultations in primary health care are mental health related (WHO 2001) and this level of care provides the most accessible and acceptable access to 'formal" health services. Where it is not possible to deal with the problem at this level, as in other areas of health care, the person should be referred to the next level of specialization. Services that may be offered at this level may include diagnostic, treatment and referral services for mental disabilities, home visits for the management of mental disorder, health promotion and prevention (for example at the clinic or at schools), interventions for trauma victims in the context of natural disasters and acts of violence (WHO Organization of Services, 2003).

Psychiatric services at the next level up consists of both in-patient and out-patient care. For some patients with a more severe or persistent problem than can be treated within primary health care, short term hospitalization in a psychiatric unit in a general hospital may be needed. This might be required following an initial manifestation of a problem - where it is necessary to admit the person to work up an accurate diagnosis and stabilize them - or following a relapse by an already known patient. In addition though, people may require longer term community care. This would usually be focused on community care programmes such as case-management or assertive community care, or specific interventions such as day-care, employment assistance, assisted housing, family support and so on. This level of care is particularly important where a country embarks on "deinstitutionalisation' of patients.

For a small minority of people, as is evident from the pyramid, either highly specialized or long-term care may be needed. For example where a patient may exhibit a highly complex picture or be resistant to the usual treatments, they may need to be referred to a facility where highly trained and experienced staff are available. This would usually be a short term stay after which the person is referred back to the other levels in the pyramid. In those minority cases where long stay care is needed, including 24 hour nursing services, facilities should be made available for this. Wherever possible this should be avoided as it is both the most expensive level of care and where the person has the least freedoms and autonomy.

Specialized mental health services are likely to also be needed with regard to, for example, child and adolescent mental health care and forensic mental health. Children and adolescents are not "small adults" but have unique mental health needs. It is recommended that countries to set up specialized services for children and adolescents that require psychiatric or psychological interventions. For the most part these will not be in-patient facilities, though some beds may be needed so that children and adolescents are not housed with adults.

People who are sent from courts of law to either establish whether they can stand trail or who are ordered by the courts for mental health care and treatment also require a more specialized service to be provided, but this also falls within the small number that need services at the apex of the pyramid.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes "the right of everyone to the enjoyment of the highest attainable

standard of physical and mental health". Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD) expands this, stating that “persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability”. In accordance with General Comment 14 of the ICESCR, mental health services should be organized so that they are.

a)*Available* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.

b)*Accessible* health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimentions:

- Non-discrimination
- Physical accessibility
- Economic accessibility (affordability)
- Information accessibility

c)*Acceptable*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health of those concerned.

d)*Of good quality.* Health facilities, goods and services must be scientifically and medically appropriate and of good quality. (WHO, 2002)

The CRPD also requires that State Parties provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health (Article 25(a)). (see Module 3 for further discussion on this)

Prevention and promotion in mental health

Health services, including mental health services, should not just treat and care for people when they fall ill, but should, wherever possible, prevent people from becoming ill in the first place and promote their mental well-being. A substantial amount is now known about preventing mental illness (WHO 2001) and a human rights oriented mental health service needs to institute adequate programmes in this regard. This includes the early detection of problems as well as specific interventions aimed at preventing or reducing the incidence of mental disorder.

V)Policy as a framework for legislation and vice versa.)

“Mental health law represents an important means of re-enforcing the goals and objectives of policy”. (WHO 2005a pg 2)

The above statement suggests that the policy direction and framework for a country usually precedes the legislation. In other words the values, principles, objectives and the vision for mental health are established prior to drafting the legislation. However

it is possible that legislation may precede policy or that the two processes occur simultaneously. Whichever direction is chosen, the most important thing is that they should complement and reinforce each other, rather than contradict each other, pull in different directions or bear no relation to one another. New policy is likely be redrafted more often than new legislation (around every 5 years for policy compared with every 10 years for legislation) therefore the policy should generally lead legislation. However where there are fundamental new developments in mental health policy that are perhaps contradicted by the law it is crucial to pass amendments to the legislation so that the policy and law move in the same direction.

Where policy precedes legislation the drafters of the legislation will know exactly what the overall vision and direction for mental health is and what the legislation is expected to achieve. For example if a country decides that the three main goals for mental health are the promotion the human rights of people with mental disabilities, making quality services accessible, available and acceptable through an integrated primary health care approach and supporting the discharge of people from custodial to community care, then it is clear that legislation needs to follow this framework. A consultation process would still be needed (see module 11), but this will primarily be concerned with how to make the law function in the interests of these objectives rather than establishing the priorities for mental health as such. In drafting the legislation a specific section of human rights may need to be formulated, but in addition the policy emphasis on a human rights approach must also inform issues such as the procedures required to admit a person without their consent and impact on where and how this person is treated. It must be noted that policy and legislation are both critically important functions for improving mental health in a country.

Mental health law is not an alternative to the policy. The law on its own cannot achieve quality mental health care and a well developed policy is a pre-requisite to providing a framework for quality mental health care.

Any draft law, whether based on existing policy or not, would need to go through the parliament or council of representatives who would have the final say over what is accepted. The lawmakers would need to inform themselves on the policy issues and obtain public comment before passing the law. Of course, if the policy directions have been thoroughly consulted and compromises already reached and an acceptable policy exists, this will facilitate the law-making process.

Once a law has been passed it creates obligations of both government and the public. Policy that may have not have been implemented effectively by government or which may have given way to other priorities without legislation, would following the passing of the law, need to be implemented with haste so as not to be in breach of the law. Members of the public or health workers who may have been resistant to changes brought about by a policy and not effectively implemented the policy would similarly be obliged to act in terms of the law.

In some countries policy will follow rather than precede legislation. In these circumstances it is usually the legislative authority that defines the overall directions for mental health following consultation and debate. Once these directions have been

made law, policies follow within this legal framework. This way around one avoids situations where policy is changed but is prevented from being implemented by laws that have not (perhaps yet) been changed. For example a country may make a policy decision that allows voluntary mental health patients to be seen in the same way as any other voluntary patient with any other health problem in a health setting. The law, on the other hand, might state that patients with mental health problems may only be admitted into and treated in psychiatric hospitals. Theoretically even if the legislation may be more than 50 years old and the policy decision has been made in terms of modern international standards of best practice law is always "stronger" than policy, Situations such as this should be avoided wherever possible and though the law may not be easy to change every effort should be made to have it changed. Laws that are simply disregarded by citizens undermine the value of the rule of law.

Given that legislation must be taken through often complex law making processes, it usually takes longer to pass law than to make policy. It is also far more difficult to change than to change policy. While amendments to law are always possible, one needs to be particularly careful to ensure that what is included in law is indeed what is needed for better mental health and well-being and the "best" procedural ways to do things.

VI)Mental health policy and legislation as "sides of the same coin".

It has been demonstrated above that mental health policy, plans, programmes, service development and legislation are complementary to achieving better mental health in a population. When policy and legislation are not in unison and pull against one another or bear no relation to one another, the results are likely to be chaotic. In this section we look briefly at a few areas where policy and legislation differ yet supplement each other in reaching mental health objectives.

Issue	**Policy**	**Legislation**
Background	Will usually include available information on mental health status of the population, resources, best practice and other information that informs the policy.	Will often have a preamble that provides some background to the particular legislation. (Usually less detailed background than a policy).
Human rights	Informed by human rights principles	•Stipulates specific human rights for people with mental disabilities. •Human rights oriented procedures outlined. •Judicial or quasi-judicial authority may be set up •May provide for a formal human rights inspectorate.

Organization of services	•Detailed systems for providing mental health care and areas of action are laid out. •How mental health promotion and illness prevention may be stipulated.	Legal framework for the organization of services (and possibly for prevention and promotion) is set out.
Situations when people may need support in making decisions concerning their affairs	Unlikely to be included	Processes for supported decision making and guardianship and administration of person's affairs usually laid out.
Intersectoral collaboration	Partners identified together with what each needs to do	Legal structure for intersectoral collaboration (e.g. a mental health council) outlined
Mentally ill offenders	May define where mentally offenders will be admitted and how they will be treated once admitted	Procedures for assessing whether an offender should stand trail, diversion from the criminal justice system, dealing with progress reports on offenders, discharge etc all documented.
Offenses and penalties	Usually not specifically included but non-compliance may:- •Have political repercussions for government. •Result in internal disciplinary processes	Offences clearly stated in legislation and offenders can be tried in a court of law and prosecuted

VII)Political will, resources, participation, recourse to courts of law and penalties.

Both policy and legislation require a significant amount of political will and allocation of resources to be successful. In the first instance without political commitment neither policy nor legislation is likely to be passed at all. Usually the political head of

health (the Minister or equivalent) requests that a policy or legislation be developed (or at least they respond positively to a suggestion that this be done). Processes must then be put in place for consultation and drafting. In the case of legislation the political head of health needs to see the importance of new or amended legislation, to prioritize this and will need to drive the process through parliament or council. Where there is no political commitment the process is stalled even before it begins. Even the process of policy and legislative development needs some resources, but to make the policy or legislation effective usually requires some additional resources. While at times the additions may be short term, for example "double funding" may be needed for a time, while patients are being discharged from custodial to community care, in other instances the funding may require a long term commitment. It is possible that in legislation mechanisms for the funding of the Act may need to be included.

Where legislation has been passed and not adhered to, individuals, families, advocacy groups, non-governmental organizations or others can invoke the law and bring charges against whoever it is that is transgressing the law.

Conclusion

Policy, plans and legislation are all important drivers of human rights of people with mental disabilities and of the organization of services to provide care, treatment and rehabilitation to those who need it. It is strongly recommended that countries have both mental health policy and legislation that complement one another. Policy and legislation should both be thoroughly reviewed with regularity (policy every 3-5 years and major legislation review every 10 years). In addition some legislative amendments may be required between times to make sure that the legislation does not contradict policy. Through regular review new developments in the field can be incorporated and problems that are identified in both the policy and legislation can be rectified.

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