

Mental Health Legislation and Human Rights

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Mental health law & human rights

- Historical perspective
- Need to overcome informal systems
- How to promote voluntary treatment
- Int'l documents about involuntary treatments and HR
- Current legislations and practices:
 - Appropriateness & criteria
 - Procedures
 - Safeguards in particular conditions
 - Community orders

Mental Illness (MI) in history

- MI has been and is present under various forms and names in all cultures and times;
- All societies constructed theories and practices about MI (religious, spiritual, philosophical, medical, social etc...)
- Medicalization of MI is a relatively recent phenomenon
- Psychiatric institutions were established in Western countries at the end of 18^o century and then spread out worldwide

voluntariness and coercion

- Two different images at the birth of psychiatry:
 - Pinel frees the mentally ill from their chains
 - King George III is declared insane and involuntarily committed and treated



[1]



[2]

voluntariness and coercion



***Loi sur les aliénés n°7443 du 30
juin 1838***

- Legislation establishes a balance between
 - Individual freedom and rights to care
 - The needs of protection of the society

Success in harmonizing objectives

- Many examples in the history of psychiatry document that it is possible to harmonize these objectives
 - Providing care and empower persons with mental disorders
 - Providing protection to them and their social context



Bad pages in the history of psychiatry

- Unfortunately neglect and abuse can be found in the history of psychiatric institutions
- Societies must always be aware of this potential and act accordingly





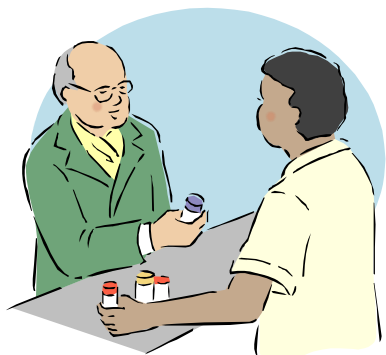
World Health Organization

- WHO mental health division established a section on policy, legislation, service planning and human rights (resp. Dr Michelle Funk)
- Legislation is a crucial instrument to promote better services, protection of human rights and empowerment of PWMD
- A WHO objective is that all countries have a psychiatric legislation, as many still don't have and run informal systems

Voluntary care

- Promotion of voluntary care & treatment in mental health practice
- Consent
- Non-protesting patients
- Validity of consent
- Proxy consent
- Advanced directives

Promotion of voluntariness



- Legislation can do a lot to promote voluntariness
 - Stating that outpatient voluntary treatment is the norm
 - Stating explicitly that voluntary admission is the norm
 - Ensuring privacy
 - Stating that consent can be withdrawn at any time

Validity of consent - 1

To be valid, consent must satisfy the following criteria (MI Principle 11):

- a) The person/patient giving consent must be competent to do so, and competence is assumed unless there is evidence to the contrary.
- b) Consent must be obtained freely, without threats or improper inducements.
- c) There should be appropriate and adequate disclosure of information. Information must be provided on the purpose, method, likely duration and expected benefits of the proposed treatment.
- d) Possible pain or discomfort and risks of the proposed treatment, and likely side-effects, should be adequately discussed with the patient.
- e) Choices should be offered, if available, in accordance with good clinical practice; alternative modes of treatment, especially those that are less intrusive, should be discussed and offered to the patient.



Validity of consent - 2

- f) Information should be provided in a language and form that is understandable to the patient.
- g) The patient should have the right to refuse or stop treatment.
- h) Consequences of refusing treatment, which may include discharge from the hospital, should be explained to the patient.
- i) The consent should be documented in the patient's medical records

Non-protesting patients (NPP)



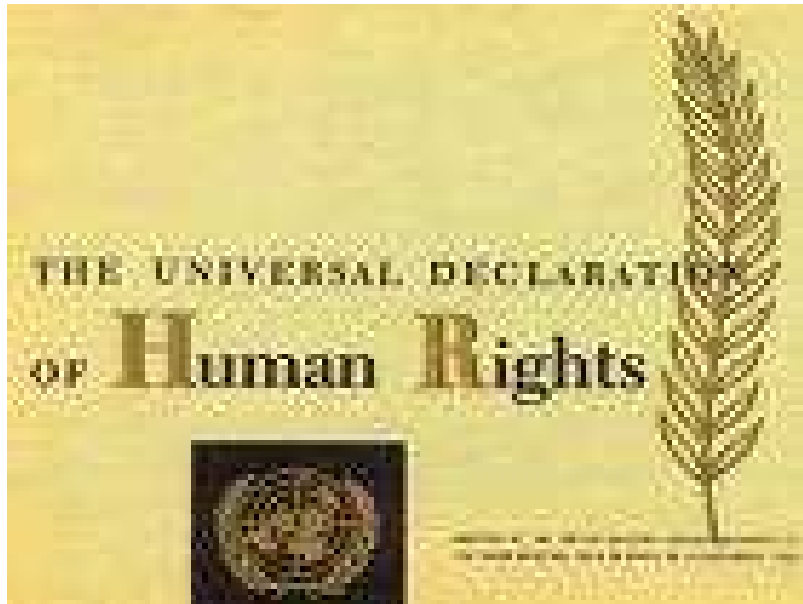
- NPP must be entitled to all rights
 - Notification
 - Confidentiality
 - Standards of care
 - Others
- Not considering rights of NPPs is a relevant source of “perceived coercion”

Involuntary admission

- The core of MH legislation
- It impinges on:
 - Personal liberty
 - Right to choose
 - Potential for abuse
 - Potential for political use of psychiatry
 - Traumatic experience

Human rights documents

- UN HR system



- UDHR (1948)
- ICESCR (1966)
- ICCPR (1966)
 - MI Principles (1991)
 - European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
 - Declaration of Hawaii (1983)
- CRPD (2006-2008)
- Report on HR (2008)

A new situation

- Traditional approach
 - Stating and listing rights
 - Exceptions
 - Safeguards
- With CRPD
 - Mainstreaming
 - Stating and listing rights
 - Calling for active promotion
 - Nothing about exceptions

CRPD

- Purpose
- Definitions
- General principles
- General obligations
- Equality and non discrimination
- Women with disabilities
- Children with disabilities
- Awareness rising
- Accessibility
- Right to life
- Equal recognition before the law
- Access to justice
- Liberty and security of the person
- Freedom from torture or cruel, inhuman or degrading treatment or punishment
- Freedom from exploitation, violence and abuse
- Protecting the integrity of the person
- Liberty of movement and nationality
- Living independently and being included in the community
- Personal mobility
- Freedom of expression and opinion and access to information
- Respect for privacy
- Respect for home and the family
- Education
- Health
- Habilitation and Rehabilitation
- Work and employment
- Adequate standard of living and social protection

A new situation

- A paradigm shift?
 - Mainstreaming
 - Support vs. disability as ground for care
 - Affirmative action
- Secondary documents providing exceptions?
- Countries reservations
 - Fears of lack of care
 - Fears of lack of protection
- Different regional policies?

MI Principle 16 (1) and (3): Involuntary admission and treatment

1. A person may

(a) be admitted involuntarily to a mental health facility as a patient; or

(b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

MI Principle 16 (1) and (3): Involuntary admission and treatment

- 2. In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.
- 3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

Traditional approach

- Combined vs separate approach
 - Admission and/or treatment
- Criteria for admission
 - Need for care vs. dangerousness
- Procedures
 - Assessment
 - Application
 - Authority
 - Review
 - Discharge
 - Place (community?)

Traditional approach

- Safeguards in particular conditions
 - Admissions of children and adolescents
 - Treatment in emergency situations
 - ECT and psychosurgery
 - Major medical and surgical procedures
 - Seclusion and restraint
 - Clinical and experimental research

Who should make the assessment?

- Great variation among laws, depending on resources, qualification and priorities:
 - 1 physician
 - 2 physicians (or more: e.g. 3 in Ireland)
 - 1 psychiatrist + 1 physician
 - 1 psychiatrist
 - 1 accredited mental health worker (e.g. Canada)
 - 1 accredited mental health worker + 1 physician
 - [.....]



Length of stay

1.21 Statutory maximum duration of involuntary placement / statutory re-approval of decision

	<i>maximum length of initial placement</i>	<i>re-approval by</i>
Austria	3 months	3 months
Belgium	40 days for observation, 2 years for regular placement	after 25 days of initial observation, 15 days before end of individually ordered length
Denmark	not defined	3, 10, 20, 30 days, then monthly
Finland	9 months	3 months
France	not defined	HDT-procedure: 15 days, then monthly HO-procedure: 1 month, 3 month, 6 month
Germany	preliminary detention: 6 weeks regular placement 1 year, in obvious cases 2 years	preliminary detention: 6 weeks regular placement: 6 months (defined by Federal State of Saarland only)
Greece	6 months	3 months
Ireland	21 days	21 days, 3 months, 6 months, 12 months
Italy	7 days	7 days
Luxembourg	preliminary detention: 14 days	14 days
The Netherlands	preliminary detention: 3 weeks regular placement: 6 or 12 months	preliminary detention: 3 weeks regular placement: 6 or 12 months
Portugal	not defined	2 months
Spain	not defined	6 months
Sweden	4 weeks	4 weeks, 4 months, 6 months
United Kingdom	assessment order: 28 days treatment order: 6 months	28 days 6 months

Comment: Only Denmark, France, Portugal and Spain do not define a maximum duration of initial involuntary placements. In the remaining Member States, the maximum length of initial placements can vary from seven days to two years, depending mostly on regulations regarding re-approval or re-assessment procedures, which are established in all Member States. Those countries defining a maximum length of initial placements also allow premature termination of placements under certain conditions. For treatment and rehabilitation purposes, some Member States (Bel, Den, Fin, Fra, Ger, Ire, Neth, Spa), allow the interruption of involuntary placements for short periods (from several days up to several weeks).

- Big differences among countries
- Right to appeal for
 - Patients
 - Families
 - Legal representatives



Where?

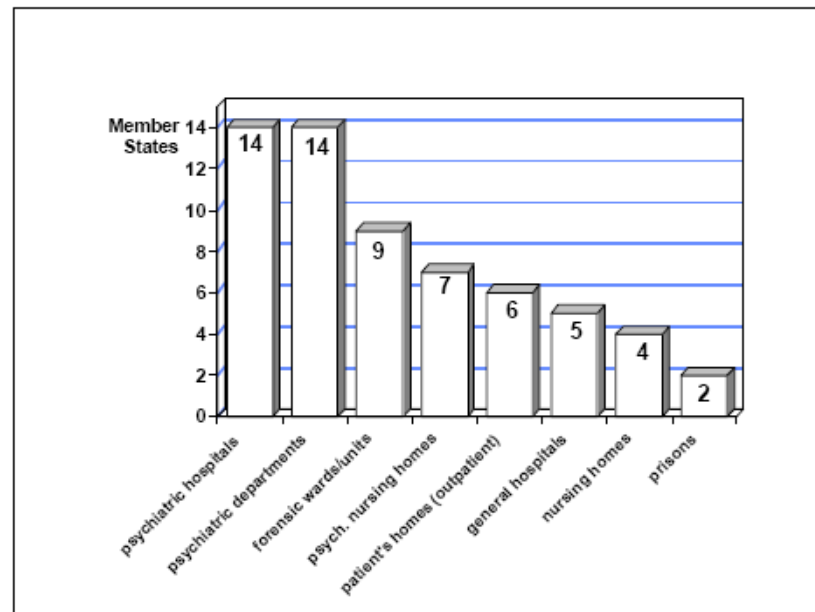


- Facilities where legislations may allow compulsory admission:
 - General Hospital psychiatric wards
 - Mental Hospitals
 - Forensic wards
 - Nursing homes
 - Residential settings
 - Prisons



Where in EU-15

2.4 Facilities for involuntary placement and/or treatment



* psychiatric hospitals:	all Member States except Italy
psychiatric departments at general hospitals:	all Member States except Luxembourg
forensic wards/units:	Austria, Belgium, Denmark, Finland, France, Germany, The Netherlands, Sweden, United Kingdom
psychiatric nursing homes:	Belgium (only for aftercare), Germany, The Netherlands, Portugal, Spain, Sweden, United Kingdom
person's home (involuntary outpatient treatment):	Belgium (only for aftercare), Germany (civil commitment), The Netherlands (only after initial inpatient episode), Portugal, Sweden
general hospitals:	Belgium, Denmark (for treating somatic co-morbidity), Italy, Spain, Sweden (for treating somatic co-morbidity)
non-psychiatric nursing homes:	Belgium, Germany (civil commitment), Spain, Sweden
prisons:	Belgium, Greece

Conclusions

- In order to develop effective and human rights oriented psychiatric services each country should have:
 - Appropriate mental health legislation
 - A comprehensive policy document
 - An action plan
- Mental health legislation is crucial as to the respect for HR as it establishes the balance between the rights of the individual and the level of coercion that can be used

Conclusions

- Informal systems should be abandoned
- Mental health legislation requires to be developed through a process that can be supported by int'l organizations and by WHO
- CRPD is likely to produce a rethinking of legislation in most countries.
- Countries who need to draft or revise their legislation could directly incorporate the changes needed

Further studies



Indian Law Society - WHO
Int'l Diploma
Mental Health Law & Human Rights
Oct 2009 - Oct 2010



Master in Mental Health Policy and Services
Sept.2009 – April 2011