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Meeting the Needs of Persons With Mental Disorders Through Legislation

*Proceedings of a Regional Workshop on
Mental Health Legislation
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This document contains recommendations which serve as a guiding framework in the drafting or reform of law relating to mental health in the Member Countries of the South-East Asia Region. By providing the basis for a policy that is in harmony with international standards on mental health issues, it seeks to act as a reference document for policy-makers and legislators involved in the process of meeting the needs of persons with mental disorders through legislation.

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Preface

A regional workshop on mental health legislation was conducted from 24-27 May, 2001 in Galle, Sri Lanka. Organized by WHO Regional Office for South-East Asia in collaboration with the Ministry of Health, Sri Lanka, the workshop provided a forum to bring into focus important issues of mental health within the South-East Asia Region.

The programme of the workshop included presentations by eminent personalities of the medical and legal fields from within and outside the Region (see Annex 3). These resource persons provided valuable insight into the following topics:

- Historical evolution of mental health legislation
- Recent advances in mental health care
- Overview of the regional mental health problem
- Barriers to development of mental health care
- Role of legislation in addressing mental health issues
- International human rights instruments relating to mental health
- Applicability of international standards on mental health to domestic laws
- Scope and content of mental health legislation

Representatives of each participant country surveyed the current status of the mental health problem, with special emphasis on any laws relevant thereto, in their respective contexts. The culminating point of the workshop was a set of recommendations for a regional policy for mental health legislation.

1. INTRODUCTION

Mental and physical health care are two equally important basic necessities for human development. One without the other cannot possibly enable the fulfillment of a state's obligations in respect of the social welfare of its citizens. Unfortunately, though, in many countries, the provision of health care services concentrates largely on physical illnesses whereas the well-being of persons with mental disorders is relegated to the margins of health priorities. And yet, the gravity of the mental health problem is such that the issue cannot be ignored any longer.

1.1 What is the extent of the mental health problem?

- **450 million** people in the world suffer from various types of mental disorders.
- **1 out of 4** persons seeking primary health care suffers from mental disorders.
- **10%** of the global burden from noncommunicable diseases is accounted for by neuro-psychiatric conditions in low and middle-income countries.
- **5 of the 10** leading causes of disability worldwide are mental disorders.
- **70%** of cases of depressive disorders all over the world are either not properly diagnosed or treated.
- **High rates** of suicide and alcohol/drug abuse are of special concern to the South-East Asia Region.

Against this background, the immediate and genuine interest of governments and all parties concerned, including relevant authorities and interested community groups, is required if the needs of persons with mental disorders are to be met effectively. Although attitudinal changes in society with respect to persons suffering from mental disorders and generation of resources for improving mental health care as well as rehabilitation facilities are primary factors and legislation is only one of the means of solving the problem, nevertheless, **law reform plays a significant role in achieving the objective.**

Not only can the law contribute by fuelling those primary factors in reflecting how a nation views and prioritizes its mental health issues, it is the only recourse through which the needs of persons with mental disorders can be made justiciable and enforceable.

1.2 Why do we need mental health legislation?

- Mental health care has had a long history of neglect
- Stigma associated with mental disorders leads to discrimination
- Persons with mental disorders may lack the capacity to make informed decisions
- Prevalence of mental health problems in the society is increasing

Taking into consideration the subject matter dealt with in the presentations of resource persons and concerns raised by individual country reports on the present legal position on mental health during the Regional Workshop on Mental Health Legislation, the Regional Office for south-East Asia seeks to propose a regional policy on mental health legislation. The recommendations which arose from the outcome of the workshop and are reproduced herein are based upon the needs of persons with mental disorders, global developments on mental health, especially through international human rights law and, in comparison, the shortcomings of existing domestic situations and legislation (if any, at all) in the Region. They form the first decisive step towards 'meeting the need of persons with mental disorders through legislation'.

2. NEEDS OF PERSONS WITH MENTAL DISORDERS

Since the primary purpose of mental health legislation is to meet the needs of persons with mental disorders, it is first necessary to identify those needs. In doing so, it is imperative that equal emphasis is placed on mental health needs relating to promotional/preventive measures, care and after-care and creation of awareness. For if there is no prevention of mental health, the number of persons with mental disorders will increase; if there is insufficient care and after-care, patients will return for treatment; and if there is lack of awareness, the persons concerned will not realize that mental health care is necessary. The overall objectives of legislation can be achieved only if there is

cooperation and coordination between and among these three spheres in realizing the respective needs pertaining to each one of them. This issue will be considered under the two broad categories of medical/public health needs and civil/legal needs.

2.1 What mental health needs should be fulfilled?

(1) Medical/public health needs

- (a) **Promotion of mental health:** Improvement of mental health is becoming increasingly important and its responsibility extends beyond the health sector to various other sectors. Therefore, facilitation and provision of opportunities to promote mental health must be integrated within all service programmes.
- (b) **Prevention of mental disorders:** Prevention of mental disorders is an integral part of mental health services. This need should be addressed through community awareness and through clinical, counseling and educational services provided on a continuing basis.
- (c) **Mental health care and treatment:** Provision of a range of clinical services including outpatient, inpatient, day-patient and outreach facilities at primary, secondary, tertiary/specialized levels is important.
- (d) **Rehabilitation and social integration:** Persons who suffer from mental disabilities or do not fully recover from mental disorders require psychosocial interventions - both in the community and at residential facilities - so that the development of competencies needed to achieve their potential is secured.
- (e) **Access to mental health services:** A common problem faced by developing nations is the lack of resources to ensure that all persons have access to health care. Thus, in creating, facilitating and providing opportunities for persons with mental disorders to access the health system and experience equity in the distribution of services, community-based and decentralized mental health services are important.
- (f) **Quality of care** - Both technical and consumer aspects of the quality of mental health care should be made comparable with the quality of general health services:

- There must be no discrimination in the allocation of resources and training of personnel (doctors, nurses, social workers and community carers, including families) in relation to the mental health care sector.
 - Licensing and monitoring of mental health care facilities would contribute to maintenance of satisfactory standards of services.
- (g) **Involuntary care:** Provision of involuntary care and treatment is sometimes necessary for reasons of health and deterioration of conditions of persons with mental disorders. However, medical personnel should act in accordance with professional and human rights standards so that such patients are not subject to health, social, economic and other disadvantages and disabilities.

(2) Civil / legal needs

- (a) **Preventing marginalization/discrimination:** Since a culture of stigmatization surrounds mental disorders, persons with mental disorders need to be prevented from being exposed to marginalization and discrimination on account of their mental health status. Such persons, especially those who are suffering from chronic conditions, should be allowed integration into the society in so far as the welfare of both parties may be secured. Deprivational laws discriminating against the civil and political rights of persons with mental disorders or any other policy which denies education to such children or employment to such adults or restrict rights relating to franchise, marriage, custody of children etc. without reasonable justification should be revised.
- (b) **Human rights:** Recognition, preservation and enforcement of human rights of persons with mental disorders are necessary. This includes **the** right to non-discrimination and all other rights founded upon the basic notion of the three-fold fundamental human rights, *i.e.* dignity, autonomy and liberty.
- (c) **Involuntary admission and treatment:** Involuntary mental health care is a complex issue where the needs of persons with mental disorders are associated with the following aspects
- Recognition of involuntary admission and treatment.

- Circumstances in which involuntary care and treatment are justified for the welfare of persons with mental disorders and/or the community.
 - Procedural provisions for the assessment and determination of such circumstances.
 - The distinction between involuntary admission and involuntary treatment since the sole purpose of involuntary admission must be care and treatment of persons with mental disorders, not their incarceration, and admission may not always be a prerequisite to treatment.
 - Provisions relating to competence to make informed decisions, capacity to give consent, conditions of seclusion and restraint, maximum period of involuntary confinement and other matters affecting the right to liberty of persons with mental disorders.
- (d) **Access to review:** Persons with mental disorders, by reason of the nature of their mental health status, are a vulnerable group requiring added safeguards in respect of their affairs. Such persons or their representatives should have access to review of decisions or acts of mental health care authorities affecting them.
- (e) **Regulatory mechanisms:** Provision of mental health care services should be subject to the procedural regulation of overseeing authorities, rules, codes of practice, etc. so that persons with mental disorders are enabled to sustain their right to due process.
- (f) **Care and custody** of person and property: Persons who are not competent to take care of themselves or their property as a result of mental disorders require guardianship of person and property. Due diligence should be observed in the appointment of such guardians in order to secure the best interest of persons with mental disorders.
- (g) **Needs of special categories of persons with mental disorders:**
- Criminal offenders and prisoners with mental disorders – Provisions for evaluating the mental health status in relation to competency to stand trial, criminal liability and continuance of sentences of imprisonment are required.
 - Persons particularly vulnerable to mental disorders – Where persons such as victims of war, children of migrant workers, street

children or those who are victims of political, domestic or any other type of violence or turmoil are concerned, special preventive and rehabilitative measures should be taken.

As much as the needs of persons with mental disorders as being paramount are emphasized, the needs of the community cannot be ignored. In instances where persons with mental disorders may be likely to inflict harm upon other persons in the community, protective measures should be imposed to ensure the welfare of the latter. However, the least restrictive alternative principle must be applied towards persons with mental disorders so that they are not unfairly disadvantaged. The combined need of the two groups, therefore, is to strike a reasonable balance between the needs of each other.

3. INTERNATIONAL DEVELOPMENTS

According to global developments in the medical field itself, the history of 'psychiatry' as a branch of medicine is a relatively recent one with its beginnings in the mid-19th century. Previously, persons with mental disorders were classified and persecuted along with homosexuals, prostitutes, political dissidents and others of so-called 'deviant' behaviour, and were the subject of supernatural and religious discourse. A scientific approach towards mental disorders emerged only in the 1830s and legal interest in persons with such disorders followed. However, in its initial stages, the law displayed concern only with regard to judicial incarceration of persons with mental disorders for public safety, administration of their property for the benefit of rightful heirs and criminal liability arising from the 'insanity' defense. Amidst this narrow perception of the mental health issue, violation of human rights of persons with mental disorders was excessive, mostly in the abuse of treatment procedure. In terms of recent understanding of facts, such as the possibility of simultaneous presence of a mental disorder and capacity within a patient and the misconception of regarding sanity or insanity as polarized opposites, mental health legislation should be a more complex and extensive exercise than one which merely deals with involuntary circumstances, criminal liability or proprietary concerns.

Therefore, international reaction to the needs of persons with mental disorders has primarily been within the framework of international human rights law as promulgated by the United Nations in its various international human rights instruments and the work of WHO. The international human rights response is essentially a perspective which positions the individual as the

focal point from which all rights, obligations and freedoms must flow; and this central focus on the individual is what makes human rights universal and applicable to everyone. While the issue of cultural relativism is acknowledged in extending what is thought to be of 'western' origin to the Asian context, it is important to embrace the universality, indivisibility, interdependence and inter-relatedness of human rights, reaffirmed at the 1993 World Conference on Human Rights and the Vienna Declaration that followed and give due consideration to these principles in the drafting or reforming of mental health legislation.

3.1 What is the role of international human rights law?

(1) *Prescriptive function*

- States are prescribed with positive duties for the promotion of fundamental human rights and freedoms of their citizens.
- Limits and structures the exercise of discretion by states, both substantively and procedurally, so as to prohibit certain types of behaviour on the part of care providers and institutions which nullify or have the effect of nullifying such rights and freedoms.

(2) *Protective function*

- Obligations are imposed upon states to protect fundamental human rights and limit the circumstances in which such rights can be derogated from, if at all.
- States are made to provide effective remedies in instances where those rights have been found to be violated, thereby assuring a measure of accountability for the manner in which decisions are made in respect of persons with mental disorders.
- It is essential to realize that the lesser the ability of persons with mental disorders to protect themselves, the greater their dependence on family, friends, advocacy organizations, etc. In the absence of such support groups, the burden shifts to states, governments and other functionaries. The need for legislative safeguards arises in this latter situation, thus highlighting the protective role of the law.

(3) Instrumental function

- A standard-setting mechanism where recommended norms of human conduct may include those seeking to change certain institutional perceptions, values and traditional beliefs, many of which are deeply entrenched even in the law, but are nevertheless inconsistent with international human rights law.
- Acts in an aspirational capacity by setting goals and creating expectations for both governments and societies in general.
- May also serve as a potent tool for mental health care administrators and affected groups in lobbying governments for the allocation of sufficient resources for the provision of necessary services and care.

(4) Interpretive function

- Acts as a message-giver to society by signifying the rationale of all the other functions of law.
- Terminology used in the drafting of legislation plays a significant role in re-directing narrow, conventional views on mental disorders and persons with such disorders which have long been ingrained within social attitudes.

3.2 What are the implications of the international covenant on economic, social and cultural rights?

“The State parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [and] the steps to be taken ... for the full realization of these rights shall include those necessary for ... [inter alia] the healthy development of the child, the prevention, treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” (Article 12)

“Every State party to the present Covenant undertakes to take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized by the present Covenant by all appropriate means including particularly, the adoption of legislative measures.” (Article 2)

If the scope and intent of these provisions on health in general are extended to the particular aspect of mental health, international human rights law may be interpreted as giving recognition to:

- the right to mental health
- prevention and control of mental disorders
- a child's right to development including mental well-being, thus promotion of mental health
- access to medical needs of persons with mental disorders
- enjoyment of the highest attainable standard of mental health
- the commitment of State parties as a binding obligation to progressively realize mental health goals
- the extent of that commitment as being in terms of the maximum of available resources
- adoption of legislative measures as a means of achieving the above-mentioned objectives.

3.3 How has the international community responded to mental health in particular?

While several international instruments on human rights pertaining to physical/mental disability and, more specifically, mental health are illustrative of global concern in meeting the needs of persons with mental disorders¹, it is the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care", adopted by the United Nations

¹ These instruments are as follows:

- 1971 UN Declaration on the Rights of Mentally Retarded Persons.
- 1975 UN Declaration on the Rights of Disabled Persons.
- 1979 UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12 as expanded by Recommendation 24 of the CEDAW Committee which provides comprehensive guidelines and content requirements for mental health legislation with reference to specific vulnerable groups within society.
- 1982 UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- 1989 UN Convention on the Rights of the Child, Article 23.
- 1993 Standard Rules on the Equalization of Opportunities for Persons with Disabilities.
- 1999 Draft Resolution on Women and Mental Health, with Emphasis on Special Groups as formulated by the UN Commission on the Status of Women.

General Assembly in 1991 (UN Principles) that offers a detailed codification of human rights requirements to be observed in domestic mental health legislation. Some important features of the UN Principles are as follows:

- *Governing human rights principles* applicable to all states upon treaty-based or customary international human rights law form the basis for the UN Principles. Thus, at the very outset, Principle 1 reinforces the inherent right of dignity of the human person, the right to protection from harm, the right to non-discrimination and the right to autonomy with regard to persons with mental illness.
- The UN Principles apply to persons with mental illness, whether or not they are in a psychiatric facility, and apply to people in psychiatric facilities whether or not they are mentally ill.
- According to the general limitation clause, “the exercise of the rights set forth in the UN Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety or the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.” By implication, arbitrary or *ad hoc* limitations or limitations for any other socio-cultural reasons are ruled out without more.

Though not binding in international law, it is imperative that the UN Principles are utilized to their fullest extent as a set of guidelines in formulating regional legislation.

3.4 What are the standards set by the “WHO mental health care law – ten basic principles”?

Organizing the provisions of the UN Principles into 10 subject areas, the “WHO Mental Health Care Law – Ten Basic Principles” (WHO Principles) deals with the main themes of discussion on mental health legislation. These aspects can be viewed under the following categories:

- (a) **Respect for dignity, autonomy and liberty:** The WHO Principles in relation to this aspect are derivatives and expansions of the fundamental human rights entrenched in Articles 1 and 3 of the 1948 Universal Declaration of Human Rights (UDHR) and re-affirmed in the 1966 International Covenants on Civil and Political Rights and Economic,

Social and Cultural Rights (ICCPR and ICESCR), recognizing that “that all human beings are born free and equal in dignity and rights” and that “everyone has the right to life, liberty and security of person” as well as those governing human rights principles found in the UN Principles referred to above. Accordingly, some of the important concepts encompassed in the WHO Principles are:

- Treatment which is directed towards preserving and enhancing personal autonomy;
- Protection of the right to confidentiality and the right to respect of privacy;
- Minimum requirements that must be incorporated in involuntary admission procedures and treatment so as to preserve the right to liberty and autonomy;
- Treatment upon the free, informed consent of a patient only (which means that patients have the right to refuse treatment) and the circumstances in and processes through which such right to consent to treatment may be waived or derogated from, and
- Determinations on legal capacity and appointment of personal representatives to be made only after a fair hearing by an independent and impartial tribunal established by domestic law.

(b) **Professionalization of mental health services:** Giving voice to the obligations under Article 12 of ICESCR, discussed earlier, the WHO **Principles** prescribe standards which are relevant to the degree of professionalism required in the provision of the best available mental health care and services. They cover most aspects of institutional care, diagnosis and treatment of persons with mental disorders and set ethical standards for care providers including mental health practitioners:

- The determination that a person has a mental illness shall be made in accordance with internationally-accepted medical standards;
- Medication should meet the best health needs of the patient and shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others;
- Care and treatment of every patient shall be based on an individually-prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff, and

- The conditions in mental health facilities, including adequate professional staff and resources, must enable them to meet the needs of patients.
- (c) **Protection from harm:** Against the background of the non-derogable human right that “no one shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment”, (UDHR, Article 5 which is more specifically addressed in the 1984 Convention Against Torture) and in particular, the principle that “no one shall be **subjected** without his free consent to medical or scientific experimentation” (ICCPR, Article 7), WHO stipulates safeguards necessary for the protection of patients from harm, both at the hands of institutional care providers and others who may well be other patients or the community. Acknowledging the widespread abuse and neglect of patients by care providers/other patients/family members,
- the use of medications as punishment is prohibited with regard to all patients while psychosurgery and other intrusive or irreversible treatment of mental illness and sterilization are prohibited where involuntary patients are concerned;
 - strict limitations are placed on the use of restraint and seclusion;
 - the use of clinical trials and experimental treatment is prohibited subject to a narrow exception which applies in stringent conditions, and
 - in general, “every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or act causing mental distress or physical discomfort”.
- (d) **Least restrictive environment:** Reiterating universal rights relating to participation in cultural activities of society, education of children within normal schools, living and working in the community environment, etc., the WHO Principles articulate the ‘shifting paradigm’ where institutionalized care is replaced with a clear preference for community-based services for persons with mental disorders. The standard may be particularly relevant to those countries which lack adequate resources for adequate institutional care and is one that is commensurate with other human rights standards which emphasize the need to provide community care for disadvantaged and disabled persons as a conducive environment for both treatment and rehabilitation:

- It has been stated that “the development of programmes to support facilities in their care-giving roles and to reduce the pressure for out-of-home placements and supports, as well as to enable the steady reduction of institutional placements and their eventual replacement with a full array of community-based services and supports” is a long-term strategy that the states may wish to consider.
 - However, in recognizing that “every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others”, it is implied that the emphasis should be primarily on the needs of the patient with consideration to the physical safety of others in the designing of systems of care for mentally ill persons.
- (e) **Non-discrimination:** Exercise of rights without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or *other status* (which includes classification on disability) is a basic tenet of international human rights law and is reinforced in all UN generated human rights instruments. ‘Discrimination’ **means** any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights, and such rights are not merely civil and political rights, but also socio-economic rights.
- The very first WHO Principle envisages that “there shall be no discrimination on the grounds of mental illness”.
 - In the context of mental health care within an institutional framework, the applicability of this provision will mean that no person should also be unnecessarily kept within an institution when there is no longer any clinical justification for continued hospitalization.
- (f) **Due process of law:** Due process is elaborated upon in the WHO Principles in a manner consistent with the general role of the law in limiting discretion and protecting fundamental rights and **freedoms** of patients, both substantively and procedurally. Stemming from the core rights to freedom from arbitrary detention and to a fair hearing before an impartial tribunal, they specify detailed procedural requirements and safeguards in such matters as,

- Notice of rights
- Procedure for involuntary admission
- Administering treatment without consent
- Provision of independent and impartial reviews of the involuntary admission or retention decisions and the right of appeal to a higher court
- Legal representation
- Complaint mechanisms.

Even in the light of these recent international developments, marginalization of the mental health problem has been apparent in the global sphere. For instance, not only did almost half a century elapse after the formulation of the Universal Declaration of Human Rights before particular attention was drawn towards the rights of persons with mental disorders, but some international human rights programmes which are being implemented at present still do not display specific interest in addressing the issue. Hence the crying need for effective domestic mental health legislation.

4. REGIONAL CONTEXT

Considering the global norms in mental health issues, it is clear that the world is moving away from a paternalistic approach to mental health care and replacing focus instead on individual empowerment. It is a rights-based outlook whereby persons with mental disorders or their representatives can themselves demand better quality care. This position of empowerment is also the tool against marginalization and discrimination on grounds of mental health status. Furthermore, the subject of mental health has been widened to encompass more than mere care and treatment of patients and to include aspects of promotion of mental health.

However, the existing conditions of mental health issues within the SEA Region do not, in most instances, reflect such international standards. Regional mental health legislation is one of those areas that lags far behind universally-accepted values and principles, even the most basic of those recognized by WHO.

4.1 What is the current position relating to mental health in SEAR Member Countries?

(1) *Bhutan*

- Mental health legislation does not exist, except in relation to criminal and civil procedure matters.
- There is Buddhist influence on law.
- There is a high prevalence of drug abuse, suicide and juvenile delinquency.
- A Drug and Substance Abuse Act is being formulated.
- A National Community Mental Health Programme was initiated in 1997. Its activities include advocacy meetings with state and nongovernmental agencies, training of health workers and educating the public.
- Currently, District Medical Officers are being provided with training on mental health care.
- There is a lack of infrastructure and mental health professionals; there is only one psychiatrist in the country.
- There is no provision for involuntary care and treatment.
- While there is no system of private health care, indigenous medicine is being practised extensively; very often, seeking allopathic treatment is a last resort.
- Even though the effectiveness of traditional systems of medicine is yet to be determined, legislation, which is in conflict with the general belief and culture of the people, may be difficult to implement.

(2) *India*

- The main legislation in the countries is Mental Health Act 1987.
 - 'Mental illness' is defined as any mental disorder needing care and treatment other than mental retardation.

- Despite this broad definition, the Act primarily regulates admission and discharge within psychiatric hospitals.
 - Grounds, procedure and authorities for sanctioning involuntary admission are laid out. (Determination of applications for involuntary admission is a judicial function.)
 - Uses current-day terminology and recognizes human rights of persons with mental illness, but primarily remains concerned with the institutionalization of persons with mental disorders.
 - Provides a procedure whereby guardians for the person and property of persons with mental disorders can be appointed.
- Persons with Disabilities Act 1996 –
- recognizes mental disorder within the definition of disability and is concerned with equal opportunity and non-discrimination in providing education, employment, social security, etc. to persons with disability. Also enables the *abilities* of such persons to be recognized.
- National Trust for Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 2000 –
- prompted with the objective of promoting social security of persons with such disorders, especially after the death of their parents, and allows people's participation in the management of the Trust.
- Other than the special laws discussed above, provisions affecting capacity and criminal liability of persons with mental disorders are found in legislation relating to contract, property, marriage, succession, elections and crimes.
- Judicial activism – the Supreme Court and High Courts of India have passed several orders upholding the basic care and treatment rights of persons with mental disorders.
- National Mental Health Programme – includes activities to prevent mental disorders, educate children with mental disorders through integration in normal schools, train personnel, provide essential drugs, improve recording and reporting systems, provide technical supervision and support and promote community participation and district-level decentralization.

- Challenges and concerns – normative initiatives in the field of mental health must be realized in the ground reality context. Also, the medical profession is concerned of the judicial role and licensing of private sector facilities under present laws.

(3) Indonesia

- Mental health legislation, like all other health laws, has been integrated into National Health Law 1992. (Previous legislation was Mental Illness Asylum Law 1897 and Mental Health Law 1966.)
- Other legislation – Narcotic Law, Psychotropic Law and Ministry of Health Regulation on Alcohol Beverages.
- Decentralized mental health services under Decentralization Law 2000.
- Recognizes the definition of 'health' as 'to live productively' and that mental health constitutes one-fifteenth of basic health.
- Provides for compulsory treatment of persons causing social disturbance.
- However, no compulsory treatment under Narcotic Law, but requirement for reports to be furnished by families is provided.
- Mental health care is provided in both mental and general hospitals, also drug dependency hospitals and clinics.
- Training programme currently being conducted for traditional healers in Bali.
- Concerns on mental health issues – lack of political will, human rights violations, barriers to development, standardization and needs of marginal groups (street children, victims of violence, etc.)
- Recently, the government has formulated a draft policy for mental health which is under consideration. It is based on the following sections:
 - Policy on community mental health programme
 - Policy on basic mental health services
 - Policy on referral mental health services
 - Policy on management of mental health resources

(4) Maldives

- No mental health legislation exists.
- Mental health treatment and rehabilitation is a new concept – until the last decade, only traditional methods of healing were used.
- Home for the Aged and Disabled established on separate island in 1977, where persons with mental disorders are also housed.
- National Committee for Welfare of the Disabled established in 1981 – functions include collection of data on disabled persons, establishing rehabilitative measures, awareness raising and development of integrated services for the disabled.
- Recent progress – free treatment and rehabilitation (though on a small scale as yet), participation of NGOs and government recognition of psychosocial issues contributing to mental disorders and the need to improve quality of mental health services.
- However, unmet needs include inadequate number of professionals - one psychiatrist only, no social workers and mental health problems dealt with by lay counsellors.
- Also, lack of awareness, research studies, trained personnel, infrastructure, resources and a professional body to monitor standards.
- No provision of care and treatment unless families of persons with mental disorders bring them to the notice of the authorities.
- A large number of persons with mental disorders are convicted in court without medical diagnosis and are often confined with common criminals.
- Families suffering from stigma are in denial of the benefits of modern methods of care and treatment.
- Neglect by medical profession and poor quality of services since there is no psychological treatment model to provide the basis for mental health care.
- Lack of awareness in the community causes reluctance to accept the return of rehabilitated patients.

(5) Myanmar

- No mental health legislation exists, except in relation to criminal liability.

(6) Nepal

- No mental health legislation exists.
- Constitutional provision for exists for protection of persons with mental disorders.
- However, existing laws are inadequate to deal with the mental health issue.
- Discriminatory civil laws – e.g. second marriage allowed for a male if wife is mentally ill.
- Provision of mental health care integrated with the general health system.
- Traditional medicine is popular – programmes for orientation and sensitization of traditional healers of mental disorders have been conducted.

(7) Sri Lanka

- Mental Diseases Ordinance of 1873 is applicable, but is outdated and limited.
- Assessment of persons suspected to be of 'unsound mind' by civil court inquiry. Judicial appeal available.
- Regulates admission, detention and discharge of both voluntary and involuntary patients, including prisoners.
- Maintenance of property of persons with mental disorders and appointment of guardians according to civil procedure law.
- Centralized system – 95% of patients are confined in the only mental hospital in the country.

- Although there is provision for inspection of mental hospitals, the conditions of the existing hospital are unsatisfactory – e.g. problems of overcrowding, no monitoring of care and treatment, etc.
- ‘Sahanaya’, a community-based mental health care centre established in 1983.
- Disabilities Act of 1996 – prohibits discrimination on grounds of mental disability.
- Law reform in process – draft legislation includes recognition of human rights of persons with mental disorders, regulation of care and treatment, establishment of a review body and provision for after care and rehabilitation.

(8) Thailand

- No mental health legislation exists, except Department of Mental Health Act (setting out responsibilities of the Department) and a Code of Practice on general health (includes patients, rights proclamation, rules, regulations, hospital procedure, etc.).
- Criminal laws (on competence and liability) and civil laws (on competence and administration of property).
- Involuntary admission and treatment is not authorized. However, one of the main reasons for not providing involuntary care is the lack of personnel.
- Decentralized mental health care services.
- Prevention and rehabilitation included in health care system.
- Number of social workers 10% of number of psychiatrists.
- In 1998, the number of persons with mental disorders increased, but suicides decreased.
- Mental health programmes – village-level intervention in prevention of suicide and development of school counselling.
- Seminar to review mental health issues was conducted – discussion on forensic and involuntary aspects.

- Profession prefers minimal judicial involvement – only for emergency situations, stipulation of duration of confinement, etc.
- Law reform in process – draft legislation includes vesting psychiatric facilities with legal duties and functions defined in order to enforce responsibility, procedure for preliminary examination, diagnosis and evaluation of patients, a review mechanism, monitoring progress of patients and establishment of a committee to oversee enforcement of legislation.
- Future plans – include review of situation by people in the community and educational and research activities on mental health issue.

4.2 What are the present problem areas of mental health in the region as a whole?

An overview of the regional context shows that the present situation regarding mental health impinges in many ways upon the most fundamental of all human rights principles of human dignity, liberty and security. As such, these are the areas that require specific attention in mental health legislation:

- Inadequate allocation of resources for mental health programmes - whether they be promotional, preventive or curative.
- Problems of access, especially since services are restricted to urban areas.
- Absence or inadequacy of mental health services resulting in persons with mental disorders being dealt with by other social structures – e.g. the criminal justice system.
- Lack of adequate processes for both involuntary admission and treatment.
- Lack of a formal diagnostic processes.
- Lack of formal process for determining 'capacity' or 'competence'.
- Lack of individual planning and participation in treatment programmes.
- Dehumanising and abusive conditions of treatment which include the use of seclusion and restraint without any clinical justification or

supervision and arbitrary use or misuse of medicine, particularly, ECT procedure.

- Lack of processes for classifying patients leading to situations where patients with different mental disorders are inappropriately confined together.
- Physical and mental abuse by other patients and staff within psychiatric facilities, including forced labour, with little or no remuneration and sexual abuse of women and children.
- Lack of periodic review for continued confinement or release of patients.
- Absence of procedural safeguards to ensure due process.
- De jure and de facto discrimination of persons with mental disorders.

4.3 What are the challenges in applying international standards to SEAR?

Although international parties to treaties monitor the performance of states upon presentation of country reports and enforce the obligations of states by way of hearing and determining complaints of affected parties, application of international values to national contexts is not always an easy task for several reasons:

- Diversity within the region itself – the multi-cultural nature within and between countries of the two sub-regions of South Asia and South-East Asia is such that each context is different to another, and the implications of any reforms would be similarly varied.
- Emphasis on socioeconomic rights rather than civil and political rights – Considering that SEAR comprises developing nations, it is rights relating to health, education, housing, employment, social welfare, etc. which need to be addressed more urgently, even though their implementation may be hindered by lack of resources.
- However, whereas socioeconomic development has been energized in South-East Asian countries, their South Asian counterparts show comparatively less progress.

- Common problems relating to civil and political rights – The effective guarantee of rights pertaining to democratic processes has been hampered mainly by unstable governments and political corruption within the region as a whole.
- Even though health services are being improved as a matter of policy, most often, there are no Constitutional guarantees for such a provision.
- A “community-based” as opposed to an “individual rights-based” value system – According to the developmental process of human rights in SEAR nations, the general trend has been to place stress on a system of rights that is to be exercised for the collective entity of society (e.g. right to health) and not with regard to the importance of individual existence (e.g. right to privacy).
- International instruments refer to ‘state’ commitments, but non-state actors, such as the private sector, are not vested with equal responsibility and accountability, although extension and balance of duties is necessary, particularly in the context of current privatization trends and other regional economic transformation that affect health services.
- Civil society is not sufficiently active in using international commitments to push for accountability from governments.
- Outdated substantive and procedural legal concepts in some domestic laws which contribute to the perpetuation of the mental health problem:
 - Restitution of conjugal rights by which a wife who has left the marital home, due to mental trauma, perhaps, may be forced to return to her husband as a matter of marital duty regardless of its possible negative implications to her mental health condition.
 - Abortion laws which disallow termination of pregnancy even as therapeutic action in cases of victims of rape or incest.
 - Non-recognition of domestic violence as an offence.
 - Application of the strict exculpatory defense of ‘insanity’ with no provision for a more flexible alternative of ‘diminished responsibility’ which would benefit more persons with varying mental disorders and yet only reduce the gravity of an offence.
 - Non-recognition of battered women’s syndrome as a mitigatory plea in the defense of provocation against the charge of murder.

- Inadequate legislation to combat child abuse – e.g. even forced child marriage is detrimental to mental health and development of children.
- Paternalistic approach of the Roman Dutch Law concept of ‘curae’ or care which limits individual autonomy whereas what is actually required is a support system by state and non-state actors which respects human rights.

Inevitably, therefore, certain social, economic, cultural and legal traditions differentiating the Asian region from the West will pose challenges and limitations to the total encapsulation of international human rights principles. In overcoming these regional barriers to development in the area of mental health, it may be necessary to perceive certain local conditions from outside the realm of ‘culture’ and more as purely ‘health’ issues. In addition, it must be remembered that the applicability of human rights permeates every aspect of mental health care and services. As such, policy-makers and legislators should not unduly restrict or ‘water down’ the scope of such rights in drafting mental health legislation except as permitted in the general limitation clause of the UN Principles. Ultimately, the driving force to ‘bring home’ international standards must then be the unquestionable universality of international human rights.

5. RECOMMENDATIONS

The regional policy on mental health legislation as recommended by WHO presents guidelines to be observed in determining the scope, content and nature of an ideal law relating to the subject. It identifies the elements of a comprehensive law on mental health and provides answers to fundamental questions of the policy-maker and legislator. The wider the scope of legislation, the greater would be the shift in emphasis from a restrictive ‘mental health care law’ to a comprehensive ‘mental health law’. However, it must be mentioned at the outset that while these recommendations are intended to give direction to domestic law reform at the macro-level, it is acknowledged that the socio-cultural realities of each country may have to be reflected in the micro-level legislative niceties. Each country should adapt the recommendations based on its own needs.

5.1 What should be reflected in the preamble?

- Framing of broad issues rather than the content of the legislation.
- Acknowledgement of the historical deprivation and marginalization of persons with mental disorders and, therefore, the need for action.
- Recognition of human rights of persons with mental disorders in relation to mental health in general, as articulated in international instruments.
- Emphasis on the provision of mental health care and treatment on an equal basis with other health services.
- Express reference that existence of a mental disorder in a person does not per se result in incapacity to give informed consent.
- Acknowledgement of the need to protect the welfare of the community.
- Guarantee of achievement of mental health objectives to the 'highest attainable standard' with the 'maximum of available resources'.
- Reflection of the need to interface the stance and intent of mental health legislation with other related laws – e.g. family law, abortion law, criminal procedure, etc.

5.2 What is the definition of 'mental illness'?

- The overall definition should be a disability-based model which, by its broad, flexible and "inclusive" approach, would give maximum benefit to all persons with any type of mental disorder, thus providing several entry points of legal assistance. The rationale is that a "mental disability" can be recognized objectively even by a person with a non-medical background (e.g. a judge) whereas a "mental disorder" is open to subjective interpretation and differing expert opinion.
- A narrow, rigid and "exclusive" definition, which is based on strict diagnostic classification and takes into account the probability of harm likely to be inflicted upon the person with a mental disorder or the community, may be applied in circumstances where the rights of such a person would be affected – e.g. involuntary admission and treatment.

5.3 What services should be provided?

- Determination of the range of mental health services to be provided should be according to the “needs” of persons with mental disorders and the particular community.
- The broad categories of services which should be provided are:
 - Promotion of mental health
 - Prevention of mental disorders
 - Care and treatment
 - After care and rehabilitation

(Promotional/preventive activity may be integrated with the general health services.)
- The specific services should include awareness-raising on mental health issues, training of professionals such as counsellors, therapists, nurses, social workers, other carers and also families of persons with mental disorders, and provision of counselling and legal guidance facilities, education and vocational training for mentally-disabled persons.

5.4 What are the important aspects of admission and treatment?

- Voluntary admission and treatment should not be an issue for regulation.
- Involuntary admission and treatment should be in accordance with international norms, particularly the UN principles and the WHO Principles.
- Involuntary care and treatment should be limited to circumstances where a person is diagnosed as suffering from a mental illness (the diagnostic procedure must be according to internationally-accepted standards) and:
 - (a) because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or other persons; or
 - (b) in the case of a person whose mental illness is so severe and whose judgment is impaired, failure to admit or retain that person is likely to cause a serious deterioration in his/her condition or prevent the

provision of appropriate treatment that can be given only by admission to a mental health facility.

Provided that when any of the above circumstances cease to exist, the involuntary care and treatment should be terminated.

- The primary decision-maker in the provision of involuntary admission and treatment must be a mental health care practitioner, subject to availability of appeal to a review body.
- Duration of confinement on admission and procedure relating to renewal of confinement orders should be in accordance with international standards. Continued confinement should be judicially authorized and such a duration must always be linked with the need for care and treatment after the expiry of the initial confinement period.
- In the event that a voluntary patient later becomes an involuntary one, the provisions relating to involuntary admission and treatment should similarly apply and *vice versa*.
- Recovery of 'capacity' or 'competence' should be a clinical decision based on 'relational impairment'. Therefore, appointment of guardians should be for selected functions of care and custody which are determined upon the contextual limitation of autonomy of a person with a mental disorder.
- Review and appellate mechanisms envisaged by international principles should be provided for matters arising from involuntary admission and treatment.

5.5 What are the rights of persons with mental disorders?

- The following rights should be recognized by either mental health or general health legislation:
 - Right to health (promotional/preventive aspect)
 - Right to health care, especially regarding access and opportunity
 - Right to respect and dignity
 - Right to non-discrimination, upon both present status and medical history of mental health – e.g. in education and employment sectors, in relation to political/civil rights, etc.

- Right to choice of health care provider as well as a second medical opinion.
- However, rights relating to certain issues are of *specific* concern to the subject of mental health, due to the vulnerability caused by the nature of the disorder:
 - Right to freedom from exploitation, abuse and harm
 - Right to legal representation
 - Right to confidentiality – the norm should be that past medical records of a person with a history of mental disorder should not be admissible in any legal proceedings except with the consent of such a person. However, the law of evidence may provide exceptions to this rule.
 - Right to consent – ‘informed’ consent should be obtained for admission and treatment unless special circumstances recognized by international standards justify that such a consent be waived. Where the person with a mental disorder is incapable of giving consent or sociocultural conditions involve family intervention, a relative or guardian may give consent on behalf of that person. Although written consent may not always be applicable (e.g. in the context of illiteracy or apprehension of signing unfamiliar documents), it is nevertheless the duty of the mental health practitioner to provide information which is required to be given prior to admission or treatment, as is the international code of practice.

(A formal process must be followed before transferring responsibility for consent to a person other than the patient – this entails conducting a fair hearing by an independent and impartial tribunal established by law, the right to be represented by a counsel at such a hearing, including the availability of such representation even where the patient does not have sufficient means to pay legal fees, ensuring that such a counsel has no conflict of interest and provision for periodic review of and appeal from decisions of such a tribunal.)

5.6 What protections are afforded to the community?

- The test of determining 'serious likelihood of immediate or imminent harm' posed to the community by a person with a mental disorder should be the governing principle.
- A person with a mental disorder and who is likely to pose such a threat to the community may be confined in a psychiatric facility only for the purpose of providing treatment. Therefore, where treatment of such a person is not necessary, the circumstance would require detention or protective custody within an alternative facility, subject to similar substantive and procedural safeguards as applicable to involuntary admission.
- Acknowledging the socio-cultural reality that stigma often leads to families avoiding persons with mental disorders from seeking treatment, thereby posing a threat to the community, and that involuntary treatment within the community cannot be compelled, public education and awareness programmes should be conducted on the dangers involved by such an action. Since the prevalence of this situation is mostly in the context of substance-abusers, incorporating legislative provision would depend upon the definition of "mental disorder" and the availability of other laws to address the issue (e.g. narcotics law).
- Provision should also be made for vagrants, who most often, are persons with mental disorders.

5.7 What is the approach towards criminal offenders and prisoners with mental disorders?

- Criminal offenders and prisoners with mental disorders should be entitled to the same rights and protections as afforded to other persons with mental disorders.
- However, care and treatment of such persons should be provided within their respective centres for detention or imprisonment.
- Abuse of the defense of insanity should be dealt with by existing criminal law provisions.

5.8 What are the procedural mechanisms involved?

- Community care should be the preferable procedure to be followed. In any event, the least restrictive principle should be applied.
- Organization of mental health services should be decentralized.
- Coordination between mental health and social care services should be ensured. (However, such a measure may have to be considered in relation to the overall policy regarding health care in general.)
- A multi-disciplinary advisory body must be established to oversee implementation of functions aimed at securing *all* the needs of persons with mental disorders – this includes medical and psychosocial needs as well as human rights guarantees.
- Generation and allocation of resources must be facilitated. Although it may not be realistic to address this aspect through mandatory provisions, legislation should reflect prioritization of the issue by acknowledging obligations imposed upon the state and recognizing the importance of adequate resources for the progressive realization of mental health goals.

5.9 Other matters on content of legislation

- Although the prevalence of mental health treatment through traditional practices is acknowledged in the socio-cultural context of the Region, no reference should be made to such practices since definitional problems are likely to arise on what exactly is meant by “traditional healing”. Regulation of this branch of medicine cannot be addressed by mental health legislation in particular, but would depend upon individual country policy and the definition of ‘medical practitioner’ under general health legislation. However, it must be noted that the UN Principles require diagnoses to be made ‘in accordance with internationally-accepted medical standards’ (Principle 4) and, therefore, the need arises to develop capacity to perform such diagnoses. Thus, it is only after resolving these issues that an attempt may be made to address the question of traditional medicine within mental health legislation itself (e.g. giving recognition to such practices in the preamble or any other provision).

- Regulation of services within the private health sector, especially where involuntary admission and treatment are concerned, should be addressed. However, the general health policy of a country should be considered in matters such as licensing of psychiatric facilities, etc.
- Determination of mental competence of public officials is not an issue for mental health legislation but should be addressed by laws of employment.
- Safety and protection of mental health care providers from persons with mental disorders should be within the purview of other laws – e.g. Workmen’s Compensation Law.
- Inclusion/exclusion of military psychiatry is a matter solely within the discretion of individual country policy.

5.10 What is the nature of legislation to be applied?

- ‘Staggered’ adoption of legislation may be utilized where it is not possible to implement all recommendations at once since an elaborate law in the absence of minimum services would render its operation futile. However, in the targeting and prioritization of objectives, the following aspects deserve immediate consideration:
 - Equity of provision of mental health care.
 - The least restrictive principle to be observed as the basis of care and treatment.
 - Guarantee of human rights of persons with mental disorders, especially those which require the imposition of prohibitions on certain conduct of others.
- Acknowledging that socioeconomic rights are increasingly becoming the subject of judicial interpretation and determination, legal provisions should not leave it discretionary, but *mandate* states and governments to fulfill their obligations in respect of developing policy and infrastructure to achieve mental health goals.
- Long-term objectives with short-term strategies should be provided for – e.g. utilizing the benefit of ‘minor legislation’ by facilitating certain functions through regulations rather than laws.

- Mainstreaming basic concepts such as non-discrimination within other laws may prove to be useful for purposes of easy reference provided that the parent mental health legislation makes reference to such provisions.
- The provision for mental health legislation by a separate enactment or integration within general health law is a discretionary matter to be determined upon individual country policy. In making the final decision, the following issues should be taken into account:

Justification for exclusive mental health legislation	Justification for integration within health legislation
<ol style="list-style-type: none"> 1. Directs deliberate focus onto a hitherto neglected area of health, including the attraction of resources towards the subject. 2. Scope of application is large on the 'disability' based definition of 'mental disorder' and the amplitude of services involved, particularly promotional and preventive aspects. 3. Caters to a context where there is no existing legislation or reference to rights in respect of general health. 4. Mental disorders are not only of health/medical concern but are connected to psychosocial matters and have a direct impact on society in contrast to most physical illnesses. 5. Traditionally, other laws exclude the subject – e.g. in relation to criminal liability, care and custody of person and property, etc. 	<ol style="list-style-type: none"> 1. Causes reverse discrimination by excluding persons with mental disorders in a special category. 2. Does not justify why other illnesses are not similarly excluded. 3. Integration has proved to be successful in certain countries.

5.11 Important points in enhancing the process of adopting the above recommendations

- Engaging intersectoral cooperation in the policy-making process, especially with the involvement of consumers and families at the grass-root level as well as the representation of nongovernmental disability rights organizations. Such consultation with a broad group of interested and affected parties in drafting legislation is a recommendation which has also received attention in the Standard rules on the Equalisation of Opportunities for Persons with Disabilities.
- Identifying and concentrating first on the most critical needs which should be primarily addressed in order to ease the burden of allocation of funds.
- Lobbying legislators, legal advisers to governments and other relevant authorities to gain support in the law-making process.
- Sensitizing society on the needs of persons with mental disorders, particularly health, administrative and judicial authorities which will be concerned with the application and enforcement of the law.
- Creating awareness of the law and its implications among the general public.
- Ongoing evaluation of the effectiveness of legislation.

6. CONCLUSION

If you are committed to the cause of 'meeting the needs of persons with mental disorders through legislation', we urge you to adopt the regional policy for mental health law reform. It is a policy that your representatives themselves have recommended after much deliberation and discussion at the recently-concluded regional workshop. The recommendations are witness to the fact that we have overcome professional apprehension of and resistance to the need for a law at all, one of the initial concerns which overshadowed activism on mental health legislation, and thus have recognized that the law is a 'rallying point' which affords a neutral space for all interested parties to come together for a common cause. It is now in your hands to ensure that new mental health legislation in the countries of the SEA Region makes a positive change in our lives.

Make, enact and enforce law to –

- promote mental health and prevent mental disorders;
- provide and regulate mental health care, treatment, after care and rehabilitation;
- ensure human rights of persons with mental disorders;
and which will –
- benefit all persons suffering from any type of mental disability;
- stipulate clear and accurate definitions;
- provide for flexibility, subject to guidelines;
- be realistic, yet instrumental and aspirational;
- reflect cost-effectiveness; and
- most importantly, deliver the message –
“Dare to Care – Stop Exclusion” - today

Annex 1

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* Coordinator of the Workshop

Annex 2

PROGRAMME

24 May 2001

Inaugural Ceremony

- 7.00 – 7.05 p.m. Welcome address by Dr A.M.L. Beligaswatte, Director-General, Health Services, Ministry of Health, Sri Lanka
- 7.05 – 7.10 p.m. Address by Dr Kan Tun, WHO Representative, Sri Lanka
- 7.10 – 7.15 p.m. Address by Dr J.M. Bertolote, Team Coordinator, Management of Mental and Brain Disorders, Division of Mental Health and Substance Dependence, WHO/HQ Geneva
- 7.15 – 7.25 p.m. Address by Hon. W.D.J. Seneviratne, Minister of Health, Sri Lanka
- 7.25 – 7.55 p.m. Keynote address by Hon. Justice Mark Fernando, Judge, Supreme Court of Sri Lanka
- 7.55 – 8.00 p.m. Vote of thanks

25 May 2001

Working Sessions:

Co-Chairman:

Mr R.K.W. Goonesekera

- 8.30 – 9.00 a.m. Registration
- 9.00 – 10.30 a.m. **Session 1: Introductory Session**
- 9.00 – 9.15 a.m. Introductory remarks – Dr Vijay Chandra
- Objectives of the workshop
- 9.15 – 9.35 a.m. Historical development of mental health legislation
- Dr J.M. Bertolote
 - Rationale, focus, emphasis and new challenges
- 9.35 – 10.00 a.m. Recent developments in mental health care –
- Dr K.A. Kumar
 - Concepts, intervention approaches and organization of mental health care
- 10.00 – 10.30 a.m. Discussion

11.00 a.m. – 12.30 p.m.	Session 2: Development of Mental Health in the Region
11.00 – 11.15 a.m.	Mental health care in the region - Dr N. Mendis Access, quality, cost and appropriateness
11.15 – 11.30 a.m.	Barriers to development of mental health care – Dr N. Mendis <ul style="list-style-type: none">▪ Political, social, cultural, economic and institutional
11.30 – 11.45 a.m.	Role of legislation in improving mental health care - Mr Rohan Edrisinhe <ul style="list-style-type: none">▪ Protecting rights of incompetent patient▪ Protecting human rights of mentally ill▪ Improving mental health care▪ Protecting rights of the community
11.45 a.m. – 12.30 p.m.	Discussions
1.30 – 3.00 p.m.	Session 3: Country Presentations A 10-15 minute presentation by each country on the following issues: <ul style="list-style-type: none">▪ Current status of mental health legislation, including components in other legislation▪ Met and unmet needs of patients▪ Abuse of mental health legislation by the state, community, family and medical profession▪ Is the abuse positive abuse or abuse by neglect/lack of services?▪ Obstacles to implementation of mental health legislation
1.30 – 2.45 p.m.	Presentations by – <ul style="list-style-type: none">▪ Thailand▪ India▪ Sri Lanka▪ Myanmar▪ Maldives
2.45 – 3.00 p.m.	Discussion
3.30 – 5.00 p.m.	Session 4: Country Presentations (contd)
3.30 – 4.45 p.m.	Presentations by – <ul style="list-style-type: none">▪ Bhutan▪ Nepal▪ Indonesia
4.45 – 5.00 p.m.	Discussion

26 May 2001

- 9.00 – 10.30 a.m. **Session 5: International Law and Mental Health Legislation**
- 9.00 – 9.30 a.m. International Perspectives – Mr Clarence Sundaram
- UN/WHO/Regional international instruments relating to mental health
- 9.30 – 10.00 a.m. Regional perspectives – Prof S. Goonesekera
- Applicability of international instruments to domestic legislation on mental health
- 10.00 – 10.30 a.m. Discussion
- 11.00 a.m. – 12.30 p.m. **Session 6: Essential Components of Legislation**
- 11.00. – 11.20 a.m. Content of legislation – Dr J.M. Bertolote
- Health rights: promoting mental health, ensuring access to and quality of mental health care
 - Human rights: recognizing right to respect and dignity of mentally ill
 - Community rights: protecting rights of the community
 - Civil rights: ensuring due process of the law
- 11.20 – 11.40 a.m. Scope of legislation – Prof A. Dhanda
- Mental health legislation by a separate enactment or through incorporation in other laws?
 - Do countries need to adopt all reforms at once or enable staggered adoption?
 - Do countries need to adopt all components or only selected areas?
 - Should legislation relate to only care and treatment or all aspects? (e.g. social, education, employment needs of the mentally ill etc.)
- 11.40 a.m. – 12.00 p.m. Discussions
- 12.00 – 12.30 p.m. Development of individual country legislation – Dr Vijay Chandra
- Issues, challenges, processes and priorities
- 1.30 – 3.00 p.m. **Session 7: Group Discussions**
- Group A**
- Bhutan
 - India
 - Indonesia
 - Maldives
 - Myanmar

Group B

- Nepal
- Sri Lanka
- Thailand

3.30 – 5.00 p.m.

Session 8: Group Discussions (contd.)

27 May 2001

9.00 – 10.30 a.m.

Session 9: Development of Country Mental Health Legislation

- Country presentations focusing on the appropriateness components, processes, adoption and implementation of legislation

Presentations by –

- India
- Nepal
- Sri Lanka

11.00 a.m. – 12.30 p.m.

Session 10: Development of Country Mental Health Legislation (contd.)

Presentation by –

- Bhutan
- Indonesia
- Maldives
- Myanmar
- Thailand

12.30 – 1.00 p.m.

Conclusions

- SEARO recommendations and conclusions

Annex 3

LIST OF PRESENTATIONS

Honourable Justice Mark Fernando, Judge of the Supreme Court of Sri Lanka, delivered the Keynote Address at the Inaugural Ceremony, while presentations during the working sessions were delivered by:

- Dr. J.M. Bertolote, Team Coordinator, Management of Mental and Brain Disorders, Division of Mental Health and Substance Dependence, WHO/HQ Geneva.
- Prof. Amita Dhanda, Professor of Law, University of Hyderabad, India.
- Mr. Rohan Edrisinha, Senior Lecturer, Faculty of Law, University of Colombo, Sri Lanka.
- Prof. Savitri Goonesekera, Vice Chancellor, University of Colombo, Sri Lanka.
- Dr. K.A. Kumar, President, Indian Psychiatric Society.
- Dr. Nalaka Mendis, Professor of Psychiatry, Faculty of Medicine, University of Colombo, Sri Lanka.
- Mr. Clarence Sundram, eminent legal practitioner on mental health and human rights issues, U.S.A.