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MENTAL HEALTH CARE LAW:

TEN BASIC PRINCIPLES

DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE

WORLD HEALTH ORGANIZATION

GENEVA

ERRATA

Page 11
6. Right to be Assisted in the Exercise of Self-Determination

should read

"Description In case a patient merely experiences difficulties in appreciating the implications of a decision, although not unable to decide (...)."

Please note the word **not** above.

Page 13
Footnote 23

should read

"See item 9"

WHO/MNH/MND/96.9

MENTAL HEALTH CARE LAW: TEN BASIC PRINCIPLES

with Annotations Suggesting Selected Actions to Promote their Implementation

This WHO reference document lists and describes ten basic principles of mental health care law. It also provides annotations for their implementation in practice.

KEY WORDS: health legislation / mental health / mental health care / human rights.

Division of Mental Health and Prevention of Substance Abuse

World Health Organization

Geneva

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Foreword

This WHO reference document lists and describes ten basic principles of mental health care law. It also provides annotations for their implementation in practice.

It is largely inspired from a comparative analysis of national mental health laws in a selection of 45 countries worldwide conducted by WHO in recent years. Also, this selection of principles draws from the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* adopted by UN General Assembly Resolution 46/119 of 17 December 1991 (hereafter referred to as "UN Principles").

This instrument was primarily produced to address a need frequently and insistently expressed by Member States, experts and other interested parties. It consists of a straightforward account of key reference principles and implementation tips. The instrument aims to depict basic legal principles for the field of mental health with as little influence as possible from given cultures or legal traditions. Embodiment of these principles into the legal body of a jurisdiction in a format, structure and language that suit local requirements is best handled on an *ad hoc* basis by state authorities.

The result is by no means a model act. It does not exhaust the relevant principles specifically applicable to mental health care. Further, it is subordinated to more general principles generally applicable to health care at large, such as that of confidentiality.

As a result, it is meant to be considered by individuals in an official (e.g. lawmakers, public health managers, mental health care providers) or private (e.g. persons with mental disorders, family members, mental health advocates) capacity.

Special acknowledgments are owed to the National Institute of Mental Health (USA) for its important contribution which made possible the development of the project of which this document is an offspring.

We are also grateful to the Department of Health (UK), to the Foreign and Commonwealth Office (UK), to the Ministry of Justice (The Netherlands), to Friends of Switzerland (Boston) and to Swissair (Boston) for their respective generous contributions to the completion of projects which have led to the production of this instrument.

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Division of Mental Health and Prevention of Substance Abuse

1. Promotion of Mental Health and Prevention of Mental Disorders

Description Everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders.

Components This principle includes the following components:

(1) Mental health **promotion** efforts;
(2) Mental disorders **prevention** efforts.

Implementation *Selected actions suggested to promote this principle include:*

(1) Promoting behaviours which contribute to enhancing and maintaining mental well-being, such as those identified by WHO[1];
(2) Identifying and taking appropriate actions to eliminate the causes of mental disorders, such as those identified by WHO[2].

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[1]WHO, *Life Skills Education in Schools* (WHO/MNH/PFS/93.7A.Rev.1), Geneva, 1993; WHO, *The Development and Dissemination of Life Skills Education: An Overview* (WHO/MNH/PSF/94.7), Geneva, 1994; WHO, *Improving the psychosocial development of children: programmes for enriching their human environment* (MNH/PSF/93.6), Geneva, 1993; WHO, *Skills for Life - Newsletter* (WHO/MNH/NLSL/92.1, 93.1, 94.1, 94.2, 95.1), Geneva. 1992-1995.

[2]WHO, *Guidelines for the Primary Prevention of Mental, Neurological, and Psychosocial Disorders, Vol. 1 to 5* (WHO/MNH/MND/93.21-24, 94.21), Geneva, 1993.

2. Access to Basic Mental Health Care

Description Everyone in need should have access to basic mental health care[3].

Components This principle includes the following components:

(1) Mental health care should be of adequate **quality**[4], i.e.:
   (a) preserve the **dignity**[5] of the patient;
   (b) take into consideration and allow for techniques which **help patients to cope by themselves** with their mental health impairments, disabilities and handicaps;
   (c) provide accepted and relevant **clinical and non-clinical** care aimed at reducing the impact of the disorder and improving the quality of life of the patient;
   (d) maintain a mental health care **system** of adequate quality (including primary health care, outpatient, inpatient and residential facilities);

(2) Access to mental health care should be **affordable** and **equitable**;

(3) Mental health care should be **geographically accessible**;

(4) Mental health care should be available on a **voluntary** basis, as health care in general[6];

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[3] *UN Principle 1(1).*

[4] *UN Principle 1(1)(2).*

[5] *UN Principle 1(2).*

[6] *UN Principle 15(1).*

(5) Access to health care, including mental health care, is contingent upon the available human and logistical resources.

Implementation *Selected actions suggested to promote this principle are:*

(1) Having a specific provision in the law which guarantees quality health care, preferably a general provision on health care applying to mental health by extension;
(2) Having medical practices in keeping with quality assurance guidelines such as those developed by WHO[7];
(3) Having quality assurance guidelines and instruments developed and/or adapted at national level by and for all qualified professionals or governmental bodies;
(4) Offering mental health care which is culturally appropriate;
(5) Calling for and taking into consideration the patient's assessment of the quality of care;
(6) Having treatments, decisions and measures regarding a person to whom mental health care is provided, documented in the person's medical record;
(7) Introducing a mental health component into Primary Health Care[8];
(8) Promoting health insurance programs (public or private) offering coverage to the widest possible number of individuals and which do not exclude but specifically include mental health care;

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[7]WHO, *Quality Assurance Mental Health Care: Check-lists & Glossaries, Volume 1* (WHO/MNH/MND/94.17), Geneva, 1994.

[8]*cf.* WHO, *The Introduction of a Mental Health Component Into Primary Health Care*, Geneva, 1990.

(9) Having a voluntary admission procedure incorporated into the mental health law scheme which is abided by in practice;

(10) Having mental health care geographically "accessible" according to WHO's indications, i.e.:

(a) by making basic mental health care available within one hour walking or travelling distance; and

(b) by making available the essential drugs identified by WHO[9].

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[9]WHO, *The Use of Essential Drugs* (TRS No. 850), Geneva, 1995; WHO, *Essential Drugs in Psychiatry* (WHO/MNH/MND/93.27), Geneva, 1993 . As of 1995, the following drugs (or drugs of the same family with similar properties) have been listed as essential drugs for the management of mental disorders: amitriptyline, biperiden, carbamazepine, chlorpromazine, clomipramine, diazepam, fenobarbitone, fluphenazine decanoate, haloperidol, imipramine, lithium carbonate and temazepam.

3. Mental Health Assessments in Accordance with Internationally Accepted Principles

Description Mental health assessments should be made in accordance with internationally accepted medical principles[10].

Components This principle includes the following components:

(1) Mental health assessments include:
   (a) diagnosis[11];
   (b) choice of a treatment;
   (c) determination of competence;
   (d) determination that someone may cause harm to self or others due to a mental disorder;

(2) Mental health assessments should only be conducted for purposes directly relating to mental illness or the consequences of mental illness[12].

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[10] *UN Principle 4(1).*

[11] *Internationally accepted medical guidelines for diagnosis are provided in: WHO, ICD-10 Classification of Mental and Behavioural Disorders - Clinical Descriptions and Diagnostic Guidelines*, Tenth Revision, 1992 (available in several languages); an example of a national diagnostic system of mental disorders with wide international acceptance is presented in: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-IV"), Fourth Edition, 1994.

[12] *UN Principle 4(5).*

Implementation *Selected actions suggested to promote this principle are:*

(1) Promoting clinical training in the use of internationally accepted principles;

(2) Refraining from referring to nonclinical criteria, such as political, economic, social, racial and religious grounds when assessing potential to cause harm to self or others[13]*;*

(3) Performing complete reassessments each time a new assessment is conducted;

(4) Refraining from basing an assessment only on past medical history of mental disorder[14]*.*

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[13] *UN Principle 4(2).*

[14] *UN Principle 4(4).*

4. Provision of the Least Restrictive Type of Mental Health Care

Description Persons with mental health disorders should be provided with health care which is the least restrictive[15].

Components This principle includes the following components:

(1) Items to be considered in the **selection** of least restrictive alternatives include:
   (a) the disorder involved;
   (b) the available treatments;
   (c) the person's level of autonomy;
   (d) the person's acceptance and cooperation; and
   (e) the potential that harm be caused to self or others;

(2) **Community-based treatment** should be made available to qualifying patients[16];

(3) **Institution-based treatments** should be provided in the **least restrictive environment**[17] and treatments involving the use of physical (e.g. isolation rooms, camisoles) and chemical restraints, if at all necessary, should be contingent upon:
   (a) Sustained attempts to discuss alternatives with the patient;
   (b) Examination and prescription by an approved health care provider;

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[15] *UN Principle 1.*

[16] *UN Principles 3 and 7.*

[17] *UN Principle 9(1).*

(c) The necessity to avoid immediate harm to self or others;
(d) Regular observation;
(e) Periodical reassessments of the need for restraint (e.g. every half hour for physical restraint);
(f) A strictly limited duration (e.g. 4 hours for physical restraint);
(g) Documentation in patient's medical file.

Implementation *Selected actions suggested to promote this principle are:*

(1) Maintaining legal instruments and infrastructures (human resources, sites, etc.) to support community-based mental health care involving settings for patients with various degrees of autonomy;
(2) Taking steps to eliminate isolation rooms and prohibit the creation of new ones;
(3) Amending relevant legal instruments to remove provisions incompatible with community-based mental health care;
(4) Training mental health care providers in the use of alternatives to the traditional restraints to deal with crisis situations.

5. Self-Determination

Description Consent is required before any type of interference with a person can occur[18].

Components This principle includes the following components:

(1) **Interference** includes:
   (a) Bodily and mental integrity (e.g. diagnostic procedures, medical treatment, such as use of drugs, electroconvulsive therapy and irreversible surgery);
   (b) Liberty (e.g. mandatory commitment to hospital).

(2) **Consent** must be:
   (a) Given by the person involved, as may apply in keeping with cultures, after having obtained advice from any traditional decision-making unit (e.g. family, relative, work unit);
   (b) Free (of undue influence);
   (c) Informed (information to be accurate, understandable, sufficient for one to decide e.g. advantages, disadvantages, risks, alternatives, expected results, side-effects);
   (d) Documented in the patient's medical file, except for minor interferences.

(3) In case a person with a mental disorder is found to be unable to consent, which will typically be the case occasionally but

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[18] *UN Principles 1 and 11.*

not systematically, there should be a surrogate decision-maker (relative, friend or authority) authorized to decide on the patient's behalf and in the patient's best interest. Parents or guardians, if any, are to give consent for minors.

Implementation *Selected actions suggested to promote this principle are:*

(1) Presuming that patients are capable of making their own decision unless proven otherwise;

(2) Making sure that mental health care providers do not systematically consider that patients with a mental disorder are unable to make their own decisions;

(3) Not systematically considering a patient to be unable to exercise self-determination with regard to all components (e.g. integrity, liberty) because the patient was found to be unable with regard to one (e.g. authority for involuntary hospitalization does not automatically include authority for involuntary treatment, especially if the treatment is invasive);

(4) Giving verbal and written information (in an accessible language) to patients about the treatment; detailed verbal explanations should be provided to patients unable to read;

(5) Calling for the patient's opinion regardless of his or her ability to consent and giving it careful consideration prior to carrying out actions affecting his/her integrity or liberty; asking someone deemed unable to decide about his/her own good to explain the motives behind a given opinion may unveil legitimate concerns for consideration and, as such, promotes the exercise of self-determination;

(6) Abiding by any wishes expressed by a patient prior to becoming unable to consent.

6. Right to be Assisted in the Exercise of Self-Determination

Description In case a patient merely experiences difficulties in appreciating the implications of a decision, although unable to decide, he/she shall benefit from the assistance of a knowledgeable third party of his or her choice[19].

Components Difficulties may be due to various causes, including the following:

(1) General **knowledge**;
(2) **Linguistic** abilities;
(3) **Disability** resulting from a health disorder.

Implementation *Selected actions suggested to further respect of this principle include:*

(1) Informing the patient about this right[20] at the moment he/she is faced with the need for assistance;
(2) Suggesting potential assistants (e.g. a lawyer, a social worker);
(3) Facilitating the involvement of the assistant, including offering assistance free of charge if possible;
(4) Promoting the establishment of a structure offering assistance to mental patients (e.g. ombudsman, patients' (users') committee).

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[19] *UN Principle 1(6).*

[20] *UN Principle 12.*

7. Availability of Review Procedure

Description There should be a review procedure available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers[21].

Components This principle includes the following components:

(1) The procedure should be available **at the request** of interested parties, including the person involved;
(2) The procedure should be available in a **timely** fashion (e.g. within 3 days of the decision)[22];
(3) The patient should **not be prevented to access** review on the basis of his/her **health status**;
(4) The patient should be given an opportunity to be heard **in person**.

Implementation *Selected actions suggested to promote this principle are:*

(1) Having a review procedure and/or a permanent Review Board created by legislation and which is operational;
(2) Establishing a state-managed office of representatives for mental patients with legal and ombudsman-like services.

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[21] *UN Principle 17.*
[22] *UN Principle 17(2).*

8. Automatic Periodical Review Mechanism

Description In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism[23].

Components This principle includes the following components:

(1) Reviews should take place **automatically**;
(2) Reviews should take place at **reasonable intervals** (e.g. each time a six-month period has elapsed);
(3) Reviews should be conducted by a **qualified decision-maker** acting in official capacity[24].

Implementation *Selected actions suggested to promote this principle are:*

(1) Appointing a review body to conduct this review;
(2) Requiring members of the review body to meet patients and review cases at a set interval;
(3) Entitling patients to meet the review body (this should be facilitated by the health authorities);

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[23] *UN Principle 17(3)(4).*

[24] *See item 8.*

(4) Requiring the review procedure to take place in full upon each occasion (the review body should ideally not be composed of the same person(s) if more than one automatic review occurs in a given case and it should not be unduly influenced by its previous decisions)[25]*;*

(5) Sanctioning defaulting body members (e.g. those failing to carry out the tasks for which they are appointed).

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[25] *UN Principle 4(4).*

9. Qualified Decision-Maker

Description Decision-makers acting in official capacity (e.g. judge) or surrogate (consent-giving) capacity (e.g. relative, friend, guardian) shall be qualified to do so[26].

Components To be qualified, decision-makers should be:

(1) **Competent**;
(2) **Knowledgeable**;
(3) **Independent** (if acting in official capacity);
(4) **Impartial** (if acting in official capacity).

Ideally, a decision-making body acting in an official capacity should be **composed of more than one person** (e.g. three) drawn from different relevant disciplines.

Implementation *Selected actions suggested to promote this principle are:*

(1) Providing initial and continuing training to decision-makers acting in official capacity and/or their assistants in relevant disciplines, including, as needed, psychiatry, psychology, law, social services and other disciplines;
(2) Disqualifying decision-makers with a direct personal interest in the determination at stake;
(3) Providing sufficient remuneration to decision-makers acting in official capacity to guarantee independence in carrying out their duty.

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[26] *UN Principle 17(1).*

10. Respect of the Rule of Law

Description Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis[27].

Components This principle includes the following components:

(1) Depending on the legal system of the country, the **body of law** may be found in different types of legal instruments (e.g. constitutions, international agreements, laws, decrees, regulations, orders) and/or in past court rulings (precedents);
(2) The law applicable is the **law in force** at the time in question, as opposed to retroactive or draft legal instruments;
(3) Laws should be **public, accessible and made understandable.**

Implementation *Selected actions suggested to promote this principle are:*

(1) Informing patients about their rights;
(2) Making sure that relevant legal instruments are disseminated (e.g. published, explained in accessible language in guides, if necessary) to interested members of the public in general and to decision-makers in particular;

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[27] *UN Principles, General Limitation Clause and use of expression "domestic law".*

(3) Providing training to decision-makers on the meaning and implications of the Rule of Law;

(4) Drawing from relevant internationally accepted human rights' documents, (e.g. UN Principles, current Ten Basic Principles) to interpret the body of law in force in the jurisdiction involved;

(5) Having the actual application of the mental health law scheme monitored by a control body independent from the health authorities and from the health care providers.