

**REFORMING
MENTAL
DISABILITY
LAW IN AFRICA:
PRACTICAL
TIPS AND
SUGGESTIONS**

By
Peter
Bartlett
and
Vanja
Hamzic

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About the Authors, and Acknowledgements

This report is written by Peter Bartlett and Vanja Hamzic. Professor Bartlett is Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law in the School of Law at the University of Nottingham. He has served as consultant internationally on various projects concerning mental health law reform, most recently in Lesotho. Mr Hamzic is a doctoral candidate in human rights law at King's College London.

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Melvyn Freeman, psychologist and public health civil servant, Republic of South Africa and periodic WHO consultant regarding mental health law reform in Africa.

Kris Gledhill, Lecturer in Law, University of Auckland.

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Julius Lutaakome Kayiira, Executive Director, Mental Health Uganda

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A Note on Terminology

Describing the people at issue in this report is complicated. The traditional legal words, such as 'lunatics', 'idiots', and 'the mentally deficient', are now, rightly, viewed as insulting and stigmatising. This report uses the phrase 'people with mental disabilities'. This is not perfect, as it is often taken to include only people with intellectual disabilities or learning difficulties. That is not the intent here. It is intended to include in addition those people with psychosocial disorders or mental illnesses such as schizophrenia and depression. Where appropriate, these people are also referred to as 'service users', acknowledging their role in the health care and social services systems.

Introduction

61. The African Commission maintains that mentally disabled persons would like to share the same hopes, dreams and goals and have the same rights to pursue those hopes, dreams and goals just like any other human being. Like any other human being, mentally disabled persons or persons suffering from mental illnesses have a right to enjoy a decent life, as normal and full as possible, a right which lies at the heart of the right to human dignity. This right should be zealously guarded and forcefully protected by all States party to the African Charter in accordance with the well established principle that all human beings are born free and equal in dignity and rights. (*Purohit and Moore v the Gambia*, African Commission of Human and Peoples' Rights, 2003)

The aspiration expressed by the African Commission on Human and Peoples' Rights in the quotation above remains a distant hope for so many African people with mental disabilities. At the same time, the world is becoming ever more aware of the needs and rights of people with mental disabilities: the age of 'out of sight and out of mind' is, joyously, increasingly a thing of the past. Africa should be at the forefront of this movement. It is the African Charter on Human and Peoples' Rights, after all, that includes a special provision in article 18(4), providing people with disabilities enhanced rights:

18(4). The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.

This express acknowledgement of the rights of disabled people not merely to be free from abuse and discrimination but to be entitled to services is unusual, and gives disability issues a particularly powerful place in African international law.

Legal provisions are irrelevant, however, unless they are put into action. Sadly, too frequently, this is not yet the case in Africa. The facts in *Purohit v the Gambia* are all too typical: legislation left over from the colonial era, with few if any of the rights and protections that are required by modern international law, coupled with minimal service provision based in an institutional setting. The increasing frequency with which the WHO is asked by African governments to advise on legal and service reforms in Africa attests to a developing awareness of the need for change, but bringing about this change can be complicated in an African context. In part, this flows from a relative lack of financial and professional resources: health budgets are small, and there is generally very limited availability of medical and social services staff, community programmes and facilities. It is also, however, that the legal changes require the governments, service users, service providers and others involved in reforms to think about the care and treatment of service users in a much more developed legal framework than has been the case in the past. For people without legal training, this means that an understanding of the basic relevant law is required; for lawyers, this means considering how legal doctrine applies for service users, a client group not generally considered in law school.

Some very good materials exist to assist in this – most notably the WHO resource book on mental health, human rights, and legislation, *Stop Exclusion, Dare to Care* (Geneva: WHO, 2005) (hereinafter referred to as the WHO Resource Book). This resource book is available electronically,¹ and hard copies are also available from WHO's AFRO Office.² While it is a wonderful asset, it has some problems as a first step into the world of mental disability legislation. It runs to about 200 pages, and while the wealth of detail and ideas it provides are extremely helpful in approaching law reform in this area, it is somewhat daunting to people new to the field, who may find themselves lost in the detail. It is also written for an audience that is world-wide. While this is in part its strength, with its inclusion of examples of good practice from a wide variety of nations, it does mean that it does not have Africa particularly in mind. Finally, it was written before the United Nations Convention on the Rights of Persons with Mental Disabilities (hereinafter, the 'CRPD') came into effect, a limitation that will be discussed in more detail below.

This report is intended to address this gap in the literature. It is hoped that it will be helpful to all who are involved in legal reforms to mental disability legislation in sub-Saharan Africa.³ No legal background is assumed, and legal citations are kept to a minimum. Similarly, medical knowledge is not assumed. It is designed to sit alongside the other support materials, such as the WHO Resource Book, and cross-references to that source occur throughout the current text.

The starting point for the report is to detail what is required of mental disability law under international law generally, and under the African Charter of Human and Peoples' Rights in particular. It may well be appropriate for nations to go well beyond the minimum required by international law in designing their mental disability legislation, however, and to this end this report also gives pointers to good international practice when these are appropriate. Even this is likely to be insufficient however as a comprehensive guide to legislative reform. Legislators may well want to include provisions that reflect local conditions, and local approaches to care. As long as these are consistent with the international law – and generally, they will be – this is fine. As such, this report should be seen as a starting point, not a limitation.

That said, the requirements of international law are binding on governments. Certainly, we often hear that 'rights are not absolute.' The truth of that statement depends on what the statement is taken to mean. Certainly, international law itself often allows for some flexibility as to how it is implemented. The intention is that a workable system should be able to be developed. Thus international law contains a right to the best attainable standard of health. Some flexibility is provided to countries as to how they will meet that obligation, so long as they meet it; and solutions in Africa may well look very different from solutions elsewhere in the world. Further, the extent of some rights is subject to interpretation by the courts, and may indeed develop over time. This is particularly significant for present purposes for two reasons. First, the African Court of Human and Peoples' Rights is still relatively new, we cannot yet be entirely sure how it will rule on issues relating to mental disability. While the African Commission on Human and Peoples' Rights has existed for

¹ http://www.who.int/mental_health/policy/legislation/policy/en/ (accessed 15 June 2010). Available in English and French.

² For hard copies, please contact Therese Agossou (agossout@who.int).

³ The report does not discuss the potential relevance of Sharia law in the Islamic countries of North Africa.

longer, it has said little so far about mental disability rights, apart from the Purohit case noted above. The precise scope and approach of the Banjul Charter is therefore a matter of some speculation. Second, the CRPD is also a new document, having come into effect only in 2008, and the UN body that will adjudicate on matters relevant to it has only just been established. Once again, it is not yet clear how it will interpret the CRPD. If the claim that 'rights are not absolute' is a reference to these uncertainties and flexibilities, it is uncontroversial. That said, it is not correct to say that conventions and treaties are mere 'guidance' to governments: the instruments are international law, and international law is binding. Increasingly, there are international courts and tribunals that hold nations to account for failure to meet their obligations. Once the nation has signed and ratified a convention or treaty, there here is no room to 'pick and choose' which parts of the law will be implemented: the convention or treaty is binding on the country.

While it is not the place of this report to promote a specific set of values beyond the requirements of international law, a few overall comments about the direction of legislation and policy regarding service provision for people with mental disabilities may be helpful. The overwhelming international consensus has long been that service users should be involved in the determination of what services will be provided to them, and the development of their treatment programmes. Community alternatives to hospitalisation are preferred, and when compulsion has been required either for admission or for treatment, it has long been the position that it ought to be the least restrictive alternative available for the individual.

The preference for community alternatives and non-coercion are now part of international law in countries that have ratified the CRPD.⁴ The CRPD further represents an ideological shift in international law relating to mental disability, however. Where previous international law had viewed mental disability (here, as always in this report, with this term including both people subject to mental illness and people with intellectual disabilities) as within the province of the medical profession, the CRPD sees issues in terms of a general failure of society to accommodate people with disabilities (including people with mental disabilities), through the provision of appropriate social and legal supports. Its terms are not about providing people with mental disabilities with a special regime to ensure that medical professionals can fix their disabilities; it is instead about building a society in which people with disabilities can live, even if they remain disabled. Consistent with this, it provides not merely for a right to live in the community, but also for example rights to education, to political participation, to an adequate standard of living, and to participation in cultural and sporting activities. This does not, of course, mean that medical support is excluded from the CRPD. The right to the best attainable standard of health is contained expressly in the convention, as article 25, and many (most?) people with mental disabilities who have had contact with medical services view medical services as essential to their well-being. Instead, it means that the focus of international law in the area has broadened well outside its previous scope of controlling hospital admissions, enforcing treatment, and ensuring minimal standards of institutional care.

Legal compulsion – the police officer at the door, waving the Mental Health Act, for example – is not the only kind of compulsion. Often, people with mental disabilities will be highly vulnerable because

⁴ See, in particular, article 19. A copy of the CRPD, and a list of the countries that have signed and ratified it, may be found at <http://www.un.org/disabilities/default.asp?id=150>.

of the combination of their social and economic situation with their mental disability. The result is that, even if not compelled by formal law, they may feel that they have no choice but to do what they are told. A person with mental disability given an ultimatum by her family that she must go to hospital may feel she has no choice and enter a hospital 'voluntarily', particularly if she has lived with the family before that admission. These enforced choices are also compulsion. A 'voluntary' admission will not be perceived as voluntary by a service user, if there are in practice no options provided for that person. The objective of a good statute and policy should be to minimise this compulsion as well, and to encourage real involvement and real choices for service users. Certainly, African traditions provide for duties of individuals, service users included to their families, and these duties are indeed enshrined in Articles 27 and 29. By these same articles, however, their family members owe corresponding duties to them, providing them where possible with non-institutional care.

These new approaches provide particular possibilities for Africa. Rates of care in hospitals and similar institutions are low in Africa, by international standards. While the law must make provisions to ensure the well-being, dignity and appropriate care of persons in these institutions, strong communities, strong traditions of emphasising family relationships and minimal traditions of institutionalisation make Africa a promising site for community service development.

Thinking About Substance: What Does the Law have to Cover?

Frameworks for Law Reform

National law relating to people with mental disabilities is subject to the frameworks applicable to all laws. It must, for example, be consistent with the national constitution of the legislating country. This is important not merely in the sense that any restrictions imposed on people with mental disabilities must be consistent with constitutional protections relating to legality, but also in the sense that people with mental disabilities have the same rights under national constitutions as other citizens do. If the constitution provides the right to vote, for example, that applies equally to all citizens, including those with mental disabilities. One of the key roles that mental health law often has is realising the rights that people with mental disabilities are supposed to have anyway, as citizens.

Domestic law must also be consistent with international law. The range of applicable international law in this area is described elsewhere,⁵ so this report will keep jurisprudential analysis of the various treaties and conventions to a minimum. Nonetheless, there are a few concepts that are helpful to understanding how international law frameworks are to be understood.

⁵ See E Rosenthal and C Sundram, 'The Role of International Human Rights in National Mental Health Legislation' (Geneva: WHO, 2004). Copies available at http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf (accessed 15 June 2010); World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: WHO, 2005). Copies in English and French available at http://www.who.int/mental_health/policy/legislation/policy/en/ (accessed 15 June 2010).

International law relating to people with mental disabilities falls into two categories. The first concerns rights and standards that must be met immediately for compliance with international law. These are generally matters relating to fundamental human rights and dignity, such as appropriate legal regulation of psychiatric admission and treatment. While there is some flexibility as to how these standards are met, there is no flexibility as to whether they may be met: they are required. Many (but not necessarily all) of these rights will be mirrored in national constitutions and bills of rights. Such constitutions often contain, for example, rights to access courts, property rights, voting rights and the right to legal process prior to any deprivation of liberty.

Many of the rights contained in the African Charter on Human and Peoples' Rights are of this immediate variety. Of particular relevance in the mental health field are the following articles in that charter:

- Equality before the law, and equal protection of the law (art 3), and the right to have ones cause heard by a court (art 7): this will be relevant to the overall oversight of the courts on matters relating to mental disability. In conjunction with the right to property (art 14) it affects issues surrounding guardianship, and the right of persons with mental disabilities to continue to make decisions about their lives and affairs
- The right to life, and dignity of the person (art 4): case law outside Africa has held that the right to life requires a full and independent investigation when a person with mental disabilities dies in custody. This means a full investigation of the circumstances of the death by an independent official such as a judge or coroner, in a hearing to which the family of the deceased has a right to be present and to be represented by a lawyer. Case law within Africa has held that the use of terms such as 'lunatic' to describe people with mental disabilities is a violation of the right to dignity under this article.⁶
- Prohibition of cruel, inhuman or degrading treatment or punishment (art 5): this requires, among other things, that appropriate standards of care are in place in psychiatric hospitals and other mental health facilities
- Right to liberty, and freedom from arbitrary detention (art 6): in other jurisdictions, such a provision has required the introduction of proper criteria and processes for compulsory psychiatric admissions. The African Commission⁷ shied away from this approach in *Purohit and Moore v the Gambia*, holding that the section did not concern people in need of hospitalisation for medical reasons. This is a surprising result, as the involuntary admission of an individual to a psychiatric facility, and the prevention of that individual leaving, would

⁶ See *Purohit v the Gambia*, Comm. No. 241/2001 (2003), para 59. Available at <http://www1.umn.edu/humanrts/africa/comcases/241-2001.html> (accessed 15 June 2010).

⁷ The African Commission on Human and Peoples' Rights and the African Court of Human and Peoples' Rights are both established by the African Charter on Human and Peoples' Rights. The Commission was created a number of years before the Court, and was for a number of years the only arbiter established by the Charter. It may still entertain complaints under the Charter, and in the event that it finds a complaint has merit, it may send it to the Court for consideration. The decisions of the Court are, however, more authoritative than those of the Commission.

seem to be detention under any usual meaning of the word, and it has been found to be so under other conventions and similar legal documents. It remains to be seen if the Commission's approach will be upheld by the new African Court of Human and Peoples' Rights. The Commission did hold, however, that article 7, above, provides a right to an independent hearing into involuntary psychiatric admissions, and it is difficult to see how such a hearing can be effective without clear criteria.

- The right to participation in government of the country (art 13). This has been held by the African Commission to include the right to vote, with any departure from that right requiring objective and reasonable criteria.⁸ It presumably also includes the right to be a candidate for elections, and to hold government appointments when otherwise qualified to do so.

All the rights in the African Charter are subject to a non-discrimination provision (art 2). While this provision does not expressly mention disability, the categories of discrimination are not closed. The African Commission on Human and Peoples' Rights has already determined that the non-discrimination provision is broad enough to include mental disability,⁹ and it is highly likely that the African Court of Human and Peoples' Rights will do the same. This seems particularly likely, given the express provision of the Charter that the disabled will be given special protection (art 18).

The second category in international law concerns rights and standards that allow for 'progressive realisation'. The right to the best attainable standard of health provides a convenient example. It is a right in international law, and its implementation must be taken seriously by states; but it is acknowledged that what constitutes the 'best attainable standard of health' will change over time, depending on local economic circumstances, developments in health sciences, and changes in social structures and conditions that affect public health. The realisation of these rights may also involve the realignment of service delivery models, which may take time. As such, the rights allowing for progressive realisation may be perceived as an ongoing journey – a journey that it is required for states to take, but one which, it is acknowledged, will be ongoing. A number of rights in the African Charter are within this category, including the right to work, the right to health, and the right to education.

The acknowledgment that progressive realisation may take time, and may be affected by economic and social realities, does not of course mean that governments can put implementation off until some future time. The right exists, and governments are obliged now to do the best they can with the resources they have available. The progressive element in implementation refers to the fact that some changes take time (e.g., training of teachers and nurses), and that economic circumstances may change, resulting in different possibilities for realisation. It is not an argument for governments to do nothing now.

⁸ See *Purohit v the Gambia*, Comm. No. 241/2001 (2003), para 76. Available at <http://www1.umn.edu/humanrts/africa/comcases/241-2001.html> (accessed 15 June 2010).

⁹ See *Purohit v the Gambia*, Comm. No. 241/2001 (2003), para 54. Available at <http://www1.umn.edu/humanrts/africa/comcases/241-2001.html> (accessed 15 June 2010).

A list of particularly significant rights in the current context, drawn from the African Charter and other relevant international law is contained in table 1:

Table 1: Rights relevant to Persons with Mental Disabilities in International and Pan-African Law

Immediate Effect	Progressive Realisation
Appropriate procedural and substantive standards of detention, including right to challenge detention	Right to health, habilitation and rehabilitation
Appropriate procedural and substantive standards for compulsory treatment, including right to challenge such treatment	Right to education
A humane standard of care in hospitals and other institutional environments, including controls on restraint, seclusion and inappropriate medical treatment	Right to community living, including right to reasonable housing and reasonable standard of life, right to work and employment, access to community services
Equal recognition before the law, access to justice and appropriate an guardianship regime	
Right to privacy	

The rights above are to be applied without discrimination – men and women, and people of different ethnic or cultural backgrounds all benefit from them. They also apply to children with mental disabilities and people with mental disabilities in the criminal justice system, although some differentiation is permitted in those cases to take account of the different contexts of those individuals.

If we move from the realm of abstract rights into actual regulation, many issues appear in both columns. The institutional standards that apply to psychiatric hospitals will serve as an example. As table 1 notes, there is a threshold below which conditions in these hospitals may not fall. Failure to provide adequate food, physical conditions, staffing, habilitative care and occupation for people detained in psychiatric hospitals can, if the deficiency is sufficiently great, constitute inhuman or degrading treatment under international law, and must be remedied immediately. These matters will also be relevant to the right to health of people in these hospitals, however, a right which is subject to progressive realisation. Even when conditions in a psychiatric hospital are not such as to constitute inhuman or degrading treatment, there is thus still a duty to look to improve them on an ongoing basis over time, as part of the attainment of the best available standard of health.

Alongside these rights in international law are questions of good professional practice. Often, these issues will intersect with rights subject to progressive realisation. Thus good professional practice in the provision of community services for example will, obviously, intersect to a considerable degree with the right to the best attainable standard of health. Sometimes good practice issues are in addition to minimum rights, however. Thus many countries have found it desirable to introduce procedural safeguards prior to hospitalisation that are well in excess of the minimum requirements of international law. Moving beyond human rights minimums is no doubt good. As long as good

practice does not conflict with either domestic constitutional law or international law, it is of course desirable that the health care system adopt it and, where appropriate, introduce it into statute.

The introduction of the CRPD throws something of a wild card into the international law. It came into effect in 2008, and the committee formed to interpret it has only just begun meeting, so it is too early to say with precision what the specific terms of the CRPD mean. A growing number of interpretations are coming forth. It is a firm reaffirmation of the rights of people with disabilities, including mental disabilities, re-enforcing that they have the rights granted to all other citizens in international law. It further requires states to make all reasonable efforts to provide services which will make community life and community integration possible for people with disabilities, although the specifics of what that will mean in the context of people with mental disabilities is not yet clear. It is clear, however, that this convention continues and re-enforces the international trend away from reliance on hospital and domiciliary institutions such as large-scale settings, in favour of normalisation of the lives of people with disabilities through the provision of community-based alternatives.

All of this raises fundamental questions about how to proceed with law reform. Some aspects of what is discussed above and in the remainder of this section will be sensible to include in a statute that is specific to mental disability issues. Issues regarding hospitalisation are perhaps a clear example of this. Other aspects may be better dealt with by amending other legislation. It may well be for example that ensuring appropriate voting rights for people with mental disabilities is best accomplished by amending the elections statute, or provision of social services and housing through amending social services or housing legislation. Other aspects may not be appropriate to a statute at all, and belong in other policy-related documents. Statute law can establish the legal duties of people, but it does not increase the economic resources of a country, and targets for the scale of service provision may therefore be better left outside statute law. Statute law can, however, create monitoring bodies to keep track of progress on policy issues, and to apply appropriate pressures when those policy developments stall. As many of these non-statutory policies may be essential to improving the lives of people with mental disabilities and to implementing the right to health, these bodies should be viewed as an important part of the statute law.

Further, laws are irrelevant unless they are properly implemented. Far too frequently in African countries, mental health laws – some good, some not so good – are simply not put into practice. While the minimum standards of international law and the African Charter must be met, beyond this a realistic assessment must be made as to what can practically be accomplished in the law. To this end, the substantive part of the discussion that follows endeavours to provide an indication both of the minimum that international law requires, as well as good practice beyond this standard. While better practice is obviously preferable, actually implementing the minimum standard, or something between the minimum standard and best practice, is almost certainly better than legislating but failing to implement high standards. A plan for implementation should be commenced concurrently with the legislative drafting process.

All this means that drafting a new law must not be viewed in isolation. It is part of a larger programme of planning, involving consideration of the direction in which the mental health service

in general should move, how the law fits in with that overall direction, and how the whole business can be implemented.

Issues Surrounding Community Services and Community Living

As noted elsewhere in this report, the overwhelming consensus in international practice, now articulated in Article 19 of the CRPD, is towards a move away from a focus on institutions, and towards care in community settings. There are a variety of reasons for this. Some of these are economic: the consensus would appear to be that better health outcomes for more people are possible through the provision of good community services than through large institutions. Some of these are human: institutionalisation drives a wedge between the service user and his or her community, creating problems of re-integration at the end of a hospital admission; and community living appears to be preferred to institutionalisation by the vast majority of service users. When a service user can be cared for in his or her community, therefore, it is almost certainly preferable to institutionalisation, and the object of mental health policy should therefore be to make these community options practically possible for as many service users as possible.

These community-based rights are likely to be particularly important in Africa. Statistically, Africa has a low rate of psychiatric hospitalisation by international standards, and thus presumably a correspondingly high prevalence of people with mental disability in the community. This gives African countries an important set of possibilities for exemplary community-based care, but also makes the provision of community-based services of vital importance.

As noted above, the CRPD approach is not merely to provide clinical services and housing in the community, although that is of course important. The expectation from the CRPD is that legal and social programmes will be put in place to allow people with mental disabilities to become part of the community in which they live. The CRPD includes not merely a right to health care (art 25), but rights to personal mobility (art 20), to privacy (art 22), to the home and to family life, including reproductive rights (art 23), to education (art 24), to work and employment (art 27), to an adequate standard of living and social protection (art 28), to participation in public and political life (art 29), and to participation in culture, recreation, leisure activities and sports (art 30).

In many countries, including many countries in Africa, services for people with mental disability have been synonymous with hospital and other medical care. The CRPD approach will require a significant change of thinking. One result will involve a change in political practice: as mental disability law is no longer only a medical matter, compliance with the CRPD will no longer be the exclusive preserve of health departments. Laws which restrict employment rights of persons with mental disabilities, for example, will need to be changed; that will be the responsibility of Departments of Labour. Meaningful provision must be made to ensure proper education of people with mental disabilities; that will be the responsibility of Departments of Education. And proper procedures will be necessary to ensure that persons with mental disability can vote; that will be the responsibility of the electoral authorities.

There is little in international law that determines standards of community care that must be met with immediate effect. Certainly, care provided in the community must not be cruel, inhuman, or

degrading. This provides something of a floor to community services. The state must, for example, intervene in the event that it becomes aware of people with mental disabilities being subject to physical or emotional abuse, as it would intervene to protect other citizens in these circumstances. Similarly, as discussed in more detail below, appropriate law must be put in place to govern the restriction of any rights based on a lack of mental capacity. Service users living in the community also enjoy the rights of any other citizens under international law, including rights to privacy, to free expression, to marry and found a family, to vote, and the right to dignity of the person. These are classic political rights, and states must ensure compliance with immediate effect. The best advice at this time is that the right to non-discrimination in legislative provision is also, generally, immediately realisable. Thus even if the provision of specific employment programmes may be subject to progressive realisation, a law which precludes people with mental disabilities from working (eg., because they are subject to a restriction imposed by a guardianship regime) must probably be changed with immediate effect.

Many other rights relating to life in the community and rights to community services are subject to progressive realisation: while states must work to implement these rights, it is acknowledged that this is an ongoing process, and is, pivotally for much of Africa, subject to economic realities. Included in this basket of rights, are the right to education, to work and employment, to an adequate standard of living and social protection, and to participation in culture, recreation, leisure activities and sports. In all these cases, what is subject to progressive realisation is the provision of specific services. Laws which discriminate against people with mental disabilities, as noted above, are probably subject to enforcement with immediate effect. By way of example, a law that says people with mental disabilities cannot apply for social housing must be changed immediately; programmes to provide social housing specifically catering to people with mental disabilities are subject to progressive realisation.

A discussion of what constitutes good community services is outside the scope of this report, but by way of illustration, such services may require a variety of public health measures, proper housing, employment programmes, educational opportunities, social assistance and networks of good medical treatment. In essence, what is called for are meaningful programmes that will assist people with mental disabilities in becoming or remaining integrated with their communities. Local culture may well prove of particular importance in designing successful programmes. As such, distinctively African solutions may be appropriate. Programme design may require not merely working with service users, although that will be of pivotal importance, but also their families and carers, and the broader community. Here, it should be recalled the particular emphasis African law places on family relationships. While the service user owes responsibilities to his or her family under the African (Banjul) Charter on Human and Peoples' Rights, so responsibilities also flow from the family to the service user. Such relationships, along with the particular social structures of African communities, should be considered in the development of community-based services; although it will also need to be considered how services are to be provided when these relationships break down.

This is therefore clearly an area where non-statutory policy will play a significant, if not a primary role. Statute law will also have a role, however, in providing legal form to services that are provided. If, for example, the decision is made to provide financial assistance to people who care for people

with mental disabilities, it is likely that this will need to be given legislative form, either in law relating to mental disability or, more probably, relating to social services. Similarly, if there are specific community services that, in the view of the legislature, every citizen in need ought to have a right to, it may well be appropriate to include that right in a statute.

The more interesting question is whether statute law has anything to bring to the process of realisation of these community-based rights. The real issue regarding these rights is how to ensure that governments continue in the process of progressive realisation. How is it to be assured that ongoing pragmatic reforms remain on the political and bureaucratic agenda? One way to address this problem is to establish an independent body whose role is to monitor services of people with mental disabilities. For this to work, the body needs sufficient independence from government to be and to be perceived as objective, and to have the expertise to command the respect of government, service users and health and social care professionals alike. The body should publish periodic reports about progress towards the community services for people with mental disability.

This is a good approach anywhere, but it may have particular importance for Africa. Appropriate services will depend very much on the local culture and circumstances of a country. While Africans are encouraged, of course, to learn lessons from community service provision in the rest of the world, African culture is likely to require African solutions. While we are beginning to see ideas generated as to what these solutions might look like, it is too soon to offer definitive guidance. The use of a national panel to further the right to live in the community and other similar rights subject to progressive realisation offers a good mechanism to encourage momentum towards these local solutions.

Some African countries have panels of this sort in their law, but it does not seem that they have been brought into being in practice. This is unfortunate, and emphasises the requirement for an implementation plan to be developed in tandem with statutory reform. Certainly, such bodies do have some costs attached to them; but they will not be particularly expensive, even given the relatively limited health budgets of many African countries.

Issues Surrounding Hospitalisation and Treatment in Hospital¹⁰

The basic requirements concerning Involuntary Hospitalisation

Not all people who are admitted to hospital for their mental disabilities will require involuntary hospitalisation (also called 'detention' or 'compulsory hospitalisation'). The trend internationally has for many years been away from formal legal detention, towards the right of service users to make their own decisions regarding hospital admission, treatment, and engagement with the health and social services systems in the same way that people admitted to hospital for non-psychiatric conditions do. These voluntary patients have the right to leave the hospital, and to make their own treatment decisions, and a well-drawn mental health statute should make this clear. When such patients wish to leave the hospital, most statutes currently do allow them to be formally detained there, when the relevant criteria are met.

¹⁰ Issues in this section are discussed in greater detail in chapter 2 of the WHO Resource Book.

While it has long been good practice to move as far as possible to a situation where service users make their own decisions regarding hospital admission and treatment, the international norm prior to the CRPD was that compulsion is available in sufficiently severe circumstances, where the service user continues to refuse admission and treatment. While the intentions of the staff members involved in these cases have no doubt generally been benevolent, the detention of a person in a mental health hospital is also very a significant intrusion into the private life and personal integrity of that individual, resulting in the deprivation of the individual's liberty and, often, his or her treatment with very strong medication or electricity. Unsurprisingly, service users often experience these admissions as violative.

As a result, international law established both substantive and procedural requirements for compulsory hospital admission of people with mental disability. A clear diagnosis of mental disorder was required, but that was not of itself enough: the disorder had to be of sufficient severity that compulsory admission was demonstrably necessary. Some flexibility was permitted to countries as to how this was defined – dangerousness to self or others, or suffering from a serious disorder that was amenable to psychiatric treatment, for example. Procedural safeguards were also required, defining who would have the authority to enforce admission and according to what process, and providing the person admitted with a challenge to the admission before an independent judge or similar person. All of these were viewed as classic liberty rights, and therefore subject to introduction with immediate effect.

It is not yet clear what the effect of the CRPD will be regarding compulsory admission. Article 14 states that 'the existence of a disability shall in no case justify a deprivation of liberty' but this does not necessarily mean, as some have claimed, that all laws which allow the forced admission of people to hospital on the basis of psychiatric conditions are now in violation of the CRPD. The same part of article 14 states that deprivations of liberty must be 'in accordance with the law', suggesting that the position may be a good deal more complex than simply 'no detention allowed'. There are a variety of other possible interpretations of the Article:

- It may be arguable that article 14 will be construed to mean that the existence of a disability in and of itself will not be sufficient to justify a deprivation of liberty. If this is the case, it will mean that other factors (such as dangerousness or least restrictive alternative) will need to be shown in addition to mental disability prior to a compulsory admission. This would result in a position very similar to the previously existing international law.
- It is possible that some criteria may be construed as 'disability neutral'. Whether an individual has capacity to make the decision as to whether or not to enter hospital might be such a criterion, and if so, then its use as a gateway to enforced hospitalisation would be defensible under article 14.
- It may also be arguable that the CRPD must be understood as a package of rights, with article 14 rights coming into effect in parallel to the other rights in the CRPD. Certainly, it is difficult to see that large scale de-institutionalisation is a good idea without the provision of community services for the people discharged. These other rights are, often, subject to progressive realisation, however. If the rights are construed as a package, article 14 too becomes a right

subject to progressive realisation, in tandem with these other rights. Mandatory hospitalisation would wane over time, as community services gained strength. In the interim, the traditional international law relating to the right to liberty – law which is immediately realisable – would continue to apply.

The possible readings of article 14 therefore range from no change to existing international law, to progressive realisation as formal detention is gradually removed, to an outright ban on compulsory psychiatric admissions. It will be some time before we have clear answers on how Article 14 is to be understood, and in the interim at the very least the previously existing international law continues to apply, and as noted above, this law is not subject to progressive realisation, but must be introduced with immediate effect, and the remainder of this section focuses on those immediate requirements. Consistent with the introductory discussion in this chapter, good practice in this area considerably exceeds the minimum required by this international law. In this subsection, the requirements required as a minimum by traditional international law will be identified; in the next section, additional comments will be made as to what constitutes good practice.

In terms of process, the vital issue is that the service user who objects to his or her involuntary admission can have a prompt review of that admission by court, tribunal, or independent review board. This must be a proper legal hearing, to determine both that the correct administrative processes were used and that the relevant criteria actually apply to the service user. The court or tribunal must be independent of the hospital, and of everyone involved in the admission. The service user must be able to present his or her case personally if he or she wishes to do so, and have a right to legal representation, although not necessarily at the expense of the state. It is of vital importance however that the hearing constitute a proper review of the merits of the case, even when the person with mental disability is not represented and, sometimes, is not (by reason of disability or otherwise) able to present their case well. This, again, is consistent with African judicial practice, where unrepresented litigants frequently appear, and where judges are nonetheless expected to ensure that their rights are properly protected. The fact that the litigants have a mental disability, and the context of the case involves involuntary admission, does not change this fundamental approach.

Many countries internationally choose to fulfil this role using a multi-disciplinary tribunal, typically including a lawyer or judge, a doctor or other medical expert, a lay person, and, sometimes, a service user.¹¹ The advantage of such a review panel is that it can be constituted so that its members understand the somewhat technical nature of the evidence it will hear. Its hearings can also be somewhat less formal than court hearings, and less intimidating for the service user. This is thought to be a good approach, but it is not formally required by international law. The regular court system may be used instead. What will be key to making the system work however is implementation: the decision-makers must treat their role seriously, rather than as a ‘rubber stamping’ exercise; and service users must be told about their right to challenge their admissions, and assisted in having their case heard when their circumstances require such assistance. The people staffing the tribunal must be such as will attract the respect of both service users and professionals.

¹¹ The Mental Health Care Act 2002 (Republic of South Africa) uses this system, for example, albeit without a service user representative.

A review must be available the first time the service user requests it. Because the treatment provided in the hospital should improve the service user's condition, subsequent reviews must be available periodically, to determine whether the service user remains properly detained.

The Act must also be clear as to how the admissions process will be administered. What documents will be required for an admission? What will the qualifications have to be for the people completing those documents? Should people in the community (e.g., a police officer or a tribal chief) be able to start an admission process, and if so, what procedures and criteria will apply to these admissions? Many of these issues are discussed in detail in chapter 8.3.3 of the WHO Resource Book, and that discussion will not be repeated here. Suffice it to say that the statute should consider what the pathways into care will be, who will be responsible for administering those pathways, what legal powers they will possess, what criteria they will use to exercise them, and how it will be ensured that they are using those powers properly and appropriately.

Under the pre-CRPD international law, the criteria for the involuntary admission had to include a requirement that the individual is suffering from a mental disorder. If this approach is followed, a medical assessment will be required as part of the admission process. Ideally, this should be done by a medical doctor (indeed, in a truly ideal world, by a psychiatrist), but in many African countries the shortage of such staff may make that impractical. The Republic of South Africa has avoided this problem by allowing such assessments also to be made by psychologists, nurses, occupational therapists and social workers, following appropriate training. This approach will be successful, of course, only if appropriate training programmes are put in place, as part of the implementation strategy.

In addition to the processes for involuntary admission, the law must be clear as to the criteria to be used for detention: a person applying the law must be able to be reasonably sure whether the law applies or not in a given case. Without such clarity, mandatory admission becomes a lottery, based on who does the relevant assessments. According to international law prior to the CRPD, the individual had to be suffering from a mental disorder or intellectual disability. This must be a 'true' disorder, recognised by medical science: detentions based on spurious conditions for sake of convenience are something the rule of law in this area exists to avoid. It does not follow that all mental disorders must be included in the criteria, however. Some countries choose to exclude personality disorders, for example, or disorders related to alcohol or drug abuse. The advantages and disadvantages of such exclusions are discussed in the WHO Resource Book at chapter 2.3.

However mental disability is defined for purposes of involuntary admission, the mere presence of the disability will not be sufficient on its own to justify involuntary admission. International law requires that in addition, criteria be adopted as to why the admission must occur. The most usual criteria, discussed in the WHO Resource Book at section 2.8.3.2, are dangerousness and the need for treatment. Either of these was acceptable in international law prior to the CRPD, either separately or in some conjoined form. Recently, some countries have moved to a requirement that an individual have impaired decision-making capacity as part of their criteria for involuntary admission. This has the advantage of bringing psychiatric care more closely to the same footing as other forms of medical care - a desirable outcome.

Good Practice Issues Relating to Involuntary Hospitalisation

While the above discussion indicates the minimum requirements of pre-CRPD international law, there are many more factors that may be considered by way of good practice, if they can be successfully implemented.

As noted above, the traditional approach is that the admission process must include a medical assessment by a suitably qualified person. Frequently, states require two such assessments. In situations where the existence of a mental disorder is legitimately disputable or where the degree of the disorder is such that it is disputable whether it warrants confinement, this makes it more likely that the dispute will be identified and dealt with, and ensure that only those people who really need detention are in fact detained. Sometimes statutes require the involvement of an individual other than a medical practitioner, such as a social worker. This is also desirable, in that psychiatric detention is not just a medical issue, but a social and community one as well. Particularly if the medical expert has not had prior acquaintance with the service user, or does not know the details of the cultural or community dynamics surrounding the service user, the involvement of someone from the local community in the process may make considerable sense to ensure that the admission is objectively justified, rather than an inappropriate community or family response to the individual.

In practice, it will almost certainly be a good idea to limit the period of detention under the statute, allowing the detention to continue only after a re-assessment as to whether the detention criteria remain met. It is good practice for health practitioners to keep the detention criteria in mind in any event, and to release the service user as soon as he or she no longer meets these criteria, but time-limiting the detention certificates means that such re-assessment must in any event happen as a matter of routine, reducing the risk that people will through inadvertence remain in hospital longer than necessary. Frequently, these re-assessments are co-ordinated with the right of the service user to require a new court/tribunal hearing into their detention, so that a service user may request one hearing in each of these periods. Assuming the periods are reasonably short – say, a month for the first period and every six months thereafter – this is consistent with international law.

As noted in the previous section, traditional international law requires only that a full hearing into the detention be available when the service user requests it. Often, statutes will make provision for mandatory hearings on a periodic basis. The WHO considers it best practice that such a hearing ought to occur as a matter of routine after the initial assessment and after each re-assessment. This again is meant to be a way of ensuring that people are not left detained through inadvertence, but only when their condition actually requires it. Other countries require the routine scrutiny of admissions certificates by an independent person, to ensure that they sufficiently make out the case for detention. The advantage of these routine systems is that all cases of compulsion receive some scrutiny, a system that not only may identify problematic cases but will also put pressure on the admitting personnel to ensure that the criteria are followed properly. The disadvantage is that the evidence would suggest that many of these hearings are highly routine, to the point where no meaningful enquiry is undertaken.

Until very recently, the right to a hearing extended only to situations where a service user was legally detained under a mental health statute. More recently, we have started to see concerns raised about people admitted to psychiatric facilities in theory on a voluntary basis, but where they lack the ability to choose to be admitted. Usually, these people will not be allowed out of the hospital unescorted, and they are in effect detained, but because they do not actively object to their hospitalisation, they are not formally detained. As they lack the ability to decide about their hospitalisation, they are extremely unlikely to request any sort of enquiry or court assessment of their situation. Some statutes introduce particular safeguards such as routine reviews of admission for these service users, to ensure that hospitalisation really is necessary and appropriate for them.

Once again, it is appropriate to recall that the CRPD remains the unknown factor in all this discussion. It is not yet clear precisely what it will require by way of criteria or processes.

Procedural safeguards on Treatment of Service Users in Hospital

The 'hard line' of international law, as distinct from good international practice, requires that psychiatric treatment is neither cruel nor inhuman nor degrading. These are themselves somewhat indistinct concepts, but a few indicators may be helpful. Most medical treatments have adverse effects as well as good effects, so the fact that a treatment may be unpleasant does not of itself render it cruel, inhuman or degrading. At some point, however, when the benefits of treatment are outweighed by adverse effects – particularly when those effects involve pain, ongoing or permanent harm, or disability – questions of whether the treatment is cruel, inhuman or degrading will arise. Consistent with this, treatment in psychiatric hospitals must have a therapeutic purpose; if it does not, it is very likely to be found to be inhuman or degrading. A possible exception to this rule is when the treatment is for restraint of the patient, in circumstances where that restraint is demonstrably necessary and the provision of the medication is the least intrusive way of affecting the restraint. As noted elsewhere, the general move internationally is to favour the rights of patients to make choices, and it may well be the case that treatments to which a patient with decision-making capacity does not consent will be more likely to be scrutinised by international courts with particular care. While there are strong movements that treatment in psychiatric facilities ought to be closely monitored and governed, particularly for detained patients, it cannot – or at least could not prior to the CRPD - be said that there is a right in international law of a capable detained patient to refuse psychiatric treatment that is considered by his or her clinical team to be therapeutically necessary. This may, however, be an early challenge under the CRPD, which provides that treatment may not be provided to individuals except 'on the basis of free and informed consent'.¹² If such a challenge were successful (and the case seems strong), treatment without consent would become illegal in international law, even for people detained in psychiatric hospitals.

There are, in practice, a number of specific treatments that have been considered internationally to be sufficiently intrusive to constitute inhuman or degrading treatment.¹³ Examples include electro-convulsive therapy without the use of muscle relaxants and anaesthesia, sterilisation, and

¹² Article 25(d).

¹³ These are discussed in the resource book at section 2.10.

operations directly on the brain to affect psychiatric behaviour, such as psychosurgery and lobotomy.

International law also provides people in hospitals, like the rest of the population, with the right to the best attainable standard of health, including both physical and mental health care. This will be discussed at more length above regarding the provision of health services in the community; suffice it here to say that those remarks apply equally to the provision of services in institutional settings such as hospitals, and equally to physical and psychiatric treatments in those settings. Too frequently, standards of health care inside these facilities are markedly worse than those in communities; this raises the possibility of a challenge under the right to health.

As noted, the emphasis internationally is on community alternatives to hospitalisation, and for all hospital inpatients, the overarching objective should be to place them as expeditiously as possible into a position where they can be discharged back into the community. To this end, an individualised treatment plan should be developed in consultation with the service user. Discharge planning should commence well in advance of the actual discharge, and should involve not merely the service user but also, with the service user's consent, key people such as family in the community where the service user will live following discharge.

It is further good practice to provide procedural safeguards prior to the treatment of inpatients, and involuntary inpatients in particular. The Resource Book provides a range of possibilities in this regard. It quite rightly emphasises that treatment should be overseen by a qualified medical practitioner. As was the case regarding hospital detentions, there is an issue in an African context as to which professionals should be authorised to do what in a treatment context. It may be appropriate to insist that treatment plans be reviewed by a tribunal or an independent expert prior to the enforcement of long-term treatment. Formal periodic reviews of involuntary treatment can (and where possible should) be required, to ensure that such treatments do not last longer than is necessary.

Frequently, statutes have provided additional criteria that must be fulfilled if a detained patient is to be treated without consent. Sometimes, whether or not the service user has decision-making capacity will be relevant to determining whether such treatment can occur, and make it much more difficult (or occasionally impossible) if a capable service user declines proposed treatment. Whether such options remain possible will of course depend on how Article 25 of the CRPD is read. If this article is found to preclude the involuntary treatment of a capable patient, the statute would need to reflect that. In that event, however, the additional safeguards might still make sense for the treatment of people who were unable to consent because of a lack of decision-making capacity.¹⁴ It might for example be required that treatment for such persons can only be given if it is likely to improve the service user's condition to the point where he or she will be able to be released, or will no longer be dangerous as a result of his or her mental disorder. Alternatively, it might be thought sufficient that the treatment would be likely to result in a marked reduction in the manifestations of the mental disorder.

¹⁴ Decision-making capacity is discussed further below.

Many countries introduce particular safeguards for particular treatments when those treatments are thought to be particularly intrusive. Thus when psychosurgery is not completely banned, it is often subject to particular restrictions. Electro-convulsive therapy, even when performed with anaesthesia and muscle relaxants, is also often subject to particular restrictions. Sometimes treatments that affect the sex drive, or treatments lasting longer than a specific period, are subject to particular scrutiny. Often the provisions related to these specific treatments are based substantively on one or more of the criteria in the last paragraph. Often they also require an order by an independent authority who is removed from the immediate situation, such as a judge or review tribunal.

Treatment of informal inpatients

There is an international consensus that inpatients not subject to involuntary psychiatric admission retain their right to consent to or refuse treatment, often subject to a capacity test relating to the service user's ability to make the treatment decision. As noted elsewhere in this report, however, such apparently 'voluntary' decisions are often experienced by the service user as having a considerable degree of compulsion attached. As a particularly clear example, it is sometimes the case that the threat of involuntary admission is used to induce 'voluntary' consent to psychiatric treatment from previously non-detained patients who would not consent otherwise. There is concern that this may often constitute an abuse: if service users have consented to be in the institution, they presumably understand the problems their mental disorder poses. In that event, the view would be that it should be possible to work with these people co-operatively, rather than resort to legal force for purposes of compelling the medication.

A slightly different area of concern involves service users who lack capacity to consent to treatment in systems where such people may be treated without consent. Here the concern is not merely that there is no choice by the service user; it is also that there may be no mechanism to ensure the ongoing appropriateness of the treatment.

For these reasons, some countries have chosen to extend administrative protections relating to treatment provision to include non-detained patients, analogous to those for detained patients. Such an approach is really a way to ensure appropriate service provision in the hospital – it is a quality check. As such, it could be done for all patients, but it may also be sufficiently effective if it is done for a random sample of patients, with much more comprehensive evaluations performed if the sample shows up problems.

Issues surrounding standards of care in Psychiatric Hospitals and Residential Institutions

Once again, international law imposes a firm minimum standard, that care provided in hospitals and residential institutions not be cruel, inhuman or degrading. As was the case when the same concepts were raised in the context of treatment, the scope of the phrase 'cruel, inhuman or degrading' is not entirely rigid, and much will depend on the facts of a given case upon which the

international court is called upon to adjudicate. Nonetheless, some baseline requirements and guidance may be helpful.

Certainly, the basic conditions of life must be satisfied. This means that adequate food, clothing and shelter must be provided. Where the winter gets cold, adequate heat must be provided to ensure reasonable comfort in the day rooms and bedrooms of the institution. Systems must be in place to ensure that people are safe from violence from other service users, and violence from staff is of course unacceptable. Adequate space must be provided within the facility, both in day rooms and bedrooms, and there must be opportunity for exercise, and at reasonable access to the outdoors. Reasonable things to do must be provided for service users to relieve the tedium of institutional life. Appropriate healthcare must be provided for both physical and psychiatric complaints. International law does not prohibit seclusion or restraint, including the use of tranquillising medications, but it does require that these be closely controlled, used only in cases of clear necessity and for the briefest time possible, and where they are the least restrictive response possible.

The service users must also be able to maintain reasonable contact with the world outside the institution. This is clearest in terms of ensuring contact with their children, spouse, and other family members.

It is the obligation of the state to ensure that these standards of care are enforced. In practice, this is likely to mean that the state must organise periodic independent inspections of its hospitals and residential care institutions to ensure that these standards are being met.¹⁵ Quite how this is done will be a matter largely for the individual state. It is to be recognised that in most African countries, there are relatively few hospitals or residential homes to which people with mental disabilities are admitted, and it may seem excessive to establish an inspection panel for such few institutions. In that event, it may be possible to conjoin the role of these inspectors with a similar inspection mechanism for other hospitals or for prisons, if those inspectorates already exist. In that event, however, it should be noted that particular issues arise regarding institutions for people with mental disabilities, and the composition and expertise of those inspectorates would have to be amended accordingly. Alternatively, if (as will be discussed below) an independent national body is established to foster the improvement of mental health service provision generally, inspection could be included within its mandate.

It is fair to ask how much of the material in this subsection belongs in a statute, and how much in policy or other guidance. For the substantive material, inclusion or not in a statute will not affect whether the care provided constitutes cruel, inhuman or degrading treatment: either the care meets the international requirements or it does not, and pointing to statutory provisions will not change that. Procedures regarding restraint and seclusion will almost certainly need to be written down, but it is not obvious that this needs to be in a statute, rather than in a procedure within the institution itself.

¹⁵ A useful guide to inspection services is Mental Disability Advocacy Center (MDAC), *Inspect!* (Budapest: MDAC, 2006). Copies are available online at <http://www.mdac.info/en/reports>.

There are some things that will probably need to be contained in a statute, however. The mechanism for inspection will need to be created by statute, for example. Further, it should be remembered that law has a symbolic as well as a practical role, and inclusion of standards of service provision in a statute can give them a primacy that they would not otherwise have, in turn increasing the likelihood that they will be realised. If this would be the case regarding standards of care, it may well be worth referring to them in the statute.

Once again, the material identified above is a minimum, and it is to be hoped that certainly over time, services in African countries will be of a significantly higher standard. This is in part about service provision in the institution itself. It is to be hoped for example that the occupation provided for service users will include practical training in skills that will be useful for community living, not merely diversions to limit the tedium of institutional life. How specific services develop will be determined in individual countries and subject to local conditions, as well as subject to ongoing developments in health science and the community services into which institutional services should increasingly integrate. Certainly, such higher provision is a good thing, and indeed, must be taken seriously by national governments as part of their obligation to provide the best attainable standard of health. At this point the discussion merges with the discussion below on that topic.

Issues surrounding the Right to Make Decisions and Mental Capacity

International law is replete with provisions of various sorts, providing all people with access to courts, the right to own property, and the right to personal integrity (which, by extension, must include the right to make basic decisions about oneself and one's life). These can be coupled and to a significant degree limited however with legal provisions to determine decision-making capacity. In many African countries, the legal provisions in the existing statutes are inflexible: decision-making capacity is an 'all or nothing' matter that may deprive people of decision-making powers even in areas where they still have capacity; and capacity is re-assessed rarely if at all. In these systems, the person found to be lacking capacity is subjected to vastly reduced legal rights, and often deprived of any meaningful involvement in the management of their lives and property. These restrictions are often imposed on the basis of minimal evidence, and minimal process. Indeed, it would seem that frequently within Africa, these deprivations of rights occur based on social convention or other informal mechanisms rather than on formal legal process.

Increasingly, these antiquated systems of guardianship are being subject to challenge under international law. It is still too early to provide a definitive statement about what will be required as a matter of 'hard' international law, and what will be merely international good practice, but Article 12 of the CRPD make it clear that a new approach will be required. It is based on a view that society has failed adequately to provide sufficient practical supports to allow people with disabilities to make the decisions those which they are in fact competent to make. Old 'all or nothing' schemes of guardianship are therefore virtually certain to fall afoul of the CRPD; much more sensitive legal mechanisms, coupled with systems to support people with mental disabilities in their decision-making, will be required.

It might be helpful to present the following pointers and principles guiding mental capacity law:

- The mere presence of a mental health problem does not in itself imply incapacity to make decisions and is therefore *not* the sole basis upon which decisions about incapacity should be made. Sometimes the nature and severity of a mental disability will be relevant to the determination of capacity to make a decision, but many people, even with severe mental disabilities, remain able to make some or all decisions relevant to their lives.
- Capacity instead refers to the ability of the individual to understand and process information regarding to the specific decision or decisions which is/are at issue in the capacity determination.
- Capacity or incapacity should be determined according to the specific decisions an individual is called upon to make, and intervention should affect only those decisions the individual is unable to make. ‘Partial guardianship’ is to be preferred to ‘plenary guardianship’ unless the latter is demonstrably necessary. An individual’s right to make all decisions should thus only be removed if it can be demonstrated that he or she lacks capacity to make all decisions.
- In law, there is a presumption of capacity. As a question of onus of proof, it is on the person alleging incapacity to be able to demonstrate incapacity. That said, wilful blindness to incapacity is not acceptable: capacity should not be assumed in law in the face of manifest evidence to the contrary.
- All reasonable steps should be taken to assist people to make capable decisions. These may include using simple language, using language understood by the individual, and repeating information as required. This right to supported decision-making is expressly provided in Article 12(3) of the CRPD.
- Incapacity is not synonymous with making a bad decision, or making an eccentric decision. It certainly does not result merely because a vulnerable person disagrees with his or her doctor or other carer. It is about whether the individual has sufficient understanding and ability to reach a decision warranting respect (see further discussion below).
- Incapacity is not the same as a loss of trust between an individual and his or her carers. The fact that an individual declines to follow medical or other advice does not mean that the person is unable to understand and make decisions based on that advice.
- Stereotyping is not permitted in assessing capacity. Just because a person is old, or intellectually disabled, or has a mental illness, it does not follow that he or she lacks capacity.
- The finding that an individual lacks capacity to make a decision, any appointment of a substitute decision-maker, and how any substitute decision-making power is exercised should all be reviewed on a regular basis. The initial finding of incapacity should not mean that the individual disappears into the system, unsupervised, for long periods of time.

Essentially, the objective is to leave the person with mental disabilities with as much control over his or her own life as is consistent with his or her actual abilities. Article 12(4) of the CRPD requires that

any restriction of rights in this regard must be tailored to the needs of each individual service user. The CRPD thus precludes the removal of any decision-making authority without evidence of incapacity related to that specific decision or set of decisions. Wholesale removal of decision-making authority such as has existed in many countries in the past will almost certainly be found to be in violation of this article. Similarly, aspects of law which remove rights as the result of being placed under a guardianship order will almost certainly be found in contravention of the article. Thus some countries automatically preclude people who are under guardianship from voting or being employed, for example; such automatic provisions are almost certainly in violation of the CRPD.

The system of capacity determination will be relevant for some decisions relating to people in psychiatric hospitals. For example, while mental health laws often allow treatment of detained patients for mental disorders without their consent, they do not allow for treatment of physical disorders on similar terms: treatment for a broken leg may only be given to a competent detained patient if that patient consents to the treatment. People in hospitals may also own property, and while measures may need to be put in place to ensure that the property is properly cared for during hospitalisation, hospitalisation itself does not mean the service user should lose his or her rights and control over it. Nonetheless, and different to the issues discussed so far in this chapter, issues relating to capacity are also of relevance (perhaps, indeed, greater relevance?) to service users living in the community.

This in turn means that the process to instigate and implement capacity determinations must be available throughout the state. It seems likely that international law will require that these determinations must be time-limited (with the possibility of renewal following relevant process in the event that incapacity continues), based on cogent evidence of incapacity to make the decisions in question, and made by a judge or similar figure who is independent of the parties. Once again, there will be the question of who should be considered qualified to give medical evidence relating to any mental condition that affects capacity. In most African countries, it is unlikely to be practical that this be a psychiatrist or, often, even a medical doctor. That said, it is important that any medical evidence relating to incapacity be of a reasonable standard, suggesting some training in diagnostics will be necessary for this purpose. This is a similar problem as that discussed above as to whom should make the medical assessments prior to hospital detentions, and it may, perhaps, be appropriate to use the same medical experts for both purposes.

The existing African systems of guardianship and capacity determination tend to involve an application to the High Court, which often means travelling to the national capital or another major urban centre, sometimes far removed from the service user's community. Usually, such applications require the services of a lawyer. Thus for reasons both of geography and expense, the existing processes will be out of reach of all but a small minority of society. This is a matter that must be considered in the design of a new system. If it is to be practical for cases to be re-considered on, say, a six-monthly or even annual basis, the hearings must happen near to the service user's home; and they must be designed to ensure that determination of capacity does not require a lawyer. At the same time, the judges making the orders must be sufficiently experienced in the law as it is passed that good decisions will result. Quite how this will work will depend on the geography and the court structure of the relevant country.

Persons with Mental Disabilities in the Criminal Justice System

Issues relating to people with mental disabilities in the criminal justice system are considered in the WHO Resource Book at chapter 2.15, and that discussion will not be repeated here. At the same time, the subject is of sufficient importance both in general and as a specific issue for statutory governance that it cannot be ignored.

There are four points at which issues of mental disorder may become relevant in the criminal process. The first is before trial, where the issue is likely to be whether the individual ought to be dealt with under the criminal process, or instead under the non-criminal law discussed earlier in this paper. The second is at trial, where the issues are likely to be whether the individual is 'fit to plead' (that is, able to participate in the trial at all), and if so, whether the individual's mental illness or mental disability at the time of the offence was such that he (or she) should not be held criminally responsible for the act. The third is following trial, where the issue will be whether, even if convicted of a criminal offence, an individual with a mental disability should be sent to a psychiatric institution rather than a prison. The fourth occurs during the serving of a sentence in prison: in the event that the inmate develops mental health problems, should the inmate be moved to a psychiatric facility.

A number of the issues discussed in previous sections regarding the detention of people with mental disabilities outside the criminal law and the standards of care provided in psychiatric hospitals remain relevant for people detained under the criminal process. In particular, some aspects of the system (e.g., fitness to plead and criminal responsibility at the time of the offence) can be understood as specific applications of capacity law. The issues in that discussion above should therefore be recalled.

The fundamental point in terms of international law concerning people with mental disabilities in the criminal system is that the issues closely mirror those in the non-criminal system. Thus the discussion of standards of care in psychiatric facilities earlier in this chapter will continue to apply: people admitted through the criminal system must not be subject to inhuman or degrading treatment, and continue to be entitled to the right to health for both their physical and their psychiatric problems. Service users in the criminal system do not, under international law, need to be kept in the same institutions as people in the civil system; but the buildings in which they are kept must meet humane standards of care.

Routine re-assessments of service users detained in the criminal psychiatric system must occur, to ensure that the service user's mental health condition still warrants detention in the psychiatric criminal institution. Hearings before a court or independent tribunal to challenge findings of those assessments if requested by the service user. This appears to be a particular problem in some African countries, where people considered unfit to plead are kept in psychiatric institutions well after their fitness is restored. The African Convention on Human and Peoples' Rights includes the right to have one's cause heard by a court; if an individual is no longer unfit to plead, he or she must be returned to the criminal court for a disposition of the charges at issue.

It is further highly likely that continued detention of people in the criminal psychiatric system when they are no longer in need of treatment will also be in violation of international law. While such people may be returned to prison to serve out the remaining portion of their sentence, they should not be kept in a psychiatric environment unless such an environment is demonstrably necessary.

In some countries, even when an individual is found unfit to plead, a hearing is held to test the strength of the prosecutor's case. The argument here is that if the accused would clearly have been acquitted, he or she should not be in the criminal mental health system, notwithstanding his or her mental illness. Thus only if the prosecutor's case has sufficient strength is the unfit to plead verdict entered; otherwise, the person may still be dealt with under the civil system in appropriate circumstances, but not under the criminal mental health system. It should be noted that this process is not the same as a trial; if the person becomes fit to plead, he or she then proceeds to trial as anyone else would. It is instead a mechanism to ensure that people who would not have been convicted if they had capacity do not spend potentially long periods of time in the criminal mental health system.

Sources and Drafting Procedures

Chapter 3 of the WHO Resource Book concerns helpful advice about the processes of mental health law reform, and the purpose of this section is not to repeat that discussion. Instead, the intent is to consider some of the issues that may arise in a specifically African context.

As noted in the introductory chapter of this report, issues surrounding mental health law may often be new to the political, social and legal discussions in African countries. Often, the relevant statute remains the one inherited from colonial administrations, and often even that law is not implemented. Certainly, medical professionals have been providing care to service users, but they have generally not viewed this care as having much to do with law. Legislative drafters and government lawyers have not been called upon to be involved in issues relating to mental disability. For all, many of the issues discussed in this report and in the WHO Resource Book will be new. As the discussion in this report shows, those issues are complicated, requiring considerable background to reach good decisions about the direction of law and policy.

This will have an effect on law reform and drafting procedures. The WHO Resource Book divides the process of law reform into four categories: preliminary activities, legislative drafting, adoption of legislation, and implementation of legislation. While this makes analytic sense, it contains the risk that these stages will be seen as separate. This may be reflected in the fact that, while a number of African nations have successfully developed draft legislation, notably fewer have seen that legislation passed (or passed in the form it was originally drafted), and fewer still have seen proper implementation. There are no doubt many reasons for this, but one may well be that a number of the people in charge of seeing the draft legislation through the legislature or costing the implementation have not necessarily been involved in the discussions during the drafting process. The risk in this situation is that they respond by giving the draft legislation low priority, and nothing ever really happens.

It may therefore be helpful to think of the processes of law reform as integrated or at least closely related, rather than focussing on the four steps noted above. It will almost certainly be helpful to include people who will be involved in all four steps of the reform process in the discussions as draft legislation develops, so they will understand how the decisions related to that legislation were reached. Without this knowledge and involvement, when a statute comes to implementation, the treasury official asked to approve the relevant budget is unlikely to understand the significance of the various expenses requested. Involvement of these people in the ongoing process also means a better sense of what is attainable can be incorporated into the statute. If it is clear that an aspect will not be implemented, e.g. for financial reasons, a different approach may be able to be adopted at the drafting stage following a reasoned discussion of what the best result will be for the money available.

It will also be of importance to involve the person who will be drafting the legislation in the substantive discussions relating to the law reform. The drafter may have considerable experience, but as will be clear from the preceding discussion, this is a technical area of law, and the drafter is unlikely to have had any experience in this area. The drafter should remember that (unlike the situation for some commercial law, for example) the people who will be administering mental disability law will not be experts in law, nor will they have routine access to lawyers. It is therefore important that the key sections of the law – things like the detention criteria and processes – are in language that intelligent non-lawyers can understand. Failure to do this will mean that the people applying the law will not understand its terms; in those circumstances the law will not be properly applied, and the whole reform process becomes of doubtful value.

Certainly, the discussions that form the basis of mental health law reform should extend well beyond service providers (although they should, of course, also be included). As the reform process will involve statutory drafting, the establishment of administrative structures, and restrictions on the rights of people with mental disabilities, lawyers with knowledge of the national constitution and legal system should be included. They may have different sense from service providers as to what may systems may be effective and appropriate in a given country.

Service users must also be involved in the discussion as full participants. While this group is sometimes overlooked, experience elsewhere has proven that they provide a different and important view of how services work, and what services are wanted. What was once merely good practice is now a matter of international law: article 4(3) of the CRPD requires that countries ‘closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations’ in the development of law and policy related to disability. It is thus not merely individuals with mental disability that must be involved, but also the civil society organisations formed by people with mental disability.

The people involved in the reform project will thus have different backgrounds and experience to bring to the table; no one will have a good sense of all the issues. The law reform process will thus inevitably involve developments in understanding of all parties, as they are exposed to the areas of knowledge of others. This itself is significant, as it builds a firmer human foundation for mental disability law and policy to build upon.

As a basis for the discussions themselves, in addition to the notes above, reformers will want to consider the relevant international treaties, conventions, principles and good practice guides, including of course the CRPD. A number of these are discussed in chapters 1.6, 1.7 and 1.8 of the WHO resource book. Most of these focus on human rights standards, both requiring that incursions into liberty must be justified, and encouraging legislation to promote the best available standard of health. That said, a number of the instruments are specific to mental health/mental disability legislation. These include :

- UN Mental Illness Principles (contained as Annexe 3 to the WHO Resource Book)
- The Declaration of Caracas (contained as Annexe 4 to the WHO Resource Book)
- The Declaration of Madrid (contained as Annexe 5 to the WHO Resource Book)
- The WHO Ten Basic Principles (contained on p 15 of the WHO Resource Book)
- The Salamanca Statement and Framework For Action on Special Needs Education (referred to on p 16 of the WHO Resource Book)

While these instruments may be helpful in providing an indication of the sorts of language and detail that statutes in this area should include, they must also be approached with some care. They all pre-date the CRPD, which, as noted throughout this report, has considerably changed the legislative landscape, and the effects of the CRPD on them should be considered with care when they are used.

The real risk is that the discussions will become swamped with detail, and lose track of the overall picture. While the detail must be settled in the reform process, that detail must be built on a consistent and firm understanding of the overarching principles and approaches to mental disability law. This report is in part intended to assist with that difficulty, by focussing with limited detail on key themes that legislation must address. Particularly as those involved in the reform discussions become more acclimatised to the issues, a few other tips and sources may help:

- The WHO 10 Basic Principles (see WHO Resource Book, p. 15) encapsulate a good deal of wisdom in a short space. Return to them often.
- As discussed above, the amendments to the law should be part of an overall revision of mental health policy. Keep the policy in mind, as a guide to the directions the law should take.
- Try not to get too complicated. Remember that the statute will be implemented by people who are not legally trained. They need to be able to understand what you write.
- As discussed above, not everything needs to be in one statute (and some things may well be much more effective if placed in other statutes). That said, keep a list as you go of things outside the main statute that you also want changed.



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HUMAN RIGHTS LAW CENTRE
UNIVERSITY PARK
NOTTINGHAM
NG7 2RD
UK
Telephone: +44 (0) 115 846 6309
Fax: +44 (0) 115 951 846 6579
Email: HRLC@nottingham.ac.uk
Website: <http://www.nottingham.ac.uk/hrlc>

