MENTAL HEALTH LAW PROFILES

Mental health law profiles

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Argentina and Brazil are two countries which have yet to recover fully from the crushing legacy of imperialism, dictatorship and inequality in their history. In this context, the rights of patients with mental illness have suffered, along with those of others. Since the restoration of democracy there has been a clearly expressed intention in law to redress this legacy, as the authors of this issue's Mental Health Law Profiles report. Regrettably, they also highlight that the reality on the ground, in terms of service delivery, lags well behind the intention of the law, which perhaps is not surprising in light of the persistent inequalities in both countries.

MENTAL HEALTH LAW PROFILE

The new mental health law in Argentina

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The Argentinean Congreso de la Nacion (National Congress, or Parliament) approved in November 2010 a new Mental Health Law (MHL) (Law 26657, 'Salud Publica. Derecho a la Proteccion de la Salud Mental' [Public Health. The Right to Protect Mental Health]). Although it is not the first law concerning mental health – as several of the provinces and the autonomous city of Buenos Aires (Argentina's capital) have enacted their own – the MHL establishes principles for human rights and the protection of patients, and aims to develop approaches in mental health that are compatible with the most advanced views and legislation from high-income countries. In this paper we report on the most important aspects of the MHL. We highlight areas that represent a change for Argentina, such as the new arrangements for both informal and compulsory admission to hospital.

We have published in *International Psychiatry* a paper outlining the main aspects of mental healthcare in Argentina, to which we refer the reader who wishes to understand more about the context for the law (Moldavsky *et al*, 2011).

The MHL is divided into 12 sections (or chapters), each section comprising several articles.

Section 1. The rights of people with mental disorders

The MHL is explicitly grounded on principles from the United Nations, the World Health Organization (1996) and the Pan-American Health Organization. It is also based on some existing Argentinean legislation from several provinces for people with mental illnesses, particularly those laws that stress treatment in the community (in Rio Negro, 'Promocion Sanitaria y Social de las Personas que Padecen Sufrimiento Mental' [Health and Social Advance for People with Mental Suffering], 1991; in Buenos Aires, 'Ley de Salud Mental de la Ciudad de Buenos Aires' [Law for Mental Health of the Autonomous City of Buenos Aires], 2000).

Section 2. Definition

The MHL defines mental health as a multifactorial outcome of several processes, in line with a robust social orientation that is developed further in several of its articles.

The Law establishes the presumption of capacity (i.e. a patient has capacity unless this is proven otherwise).

It sets up also diagnostic exclusions (e.g. socio-political affiliation, sexual orientation and other personal and lifestyle matters) and inclusions (particularly the addictions as illnesses that require treatment).

Section 3. Domain of the Law

The MHL applies to all health providers, from the public, private and social security sectors.

Section 4. Human rights

The MHL acknowledges cultural diversity and the protection of personal and collective identity. The latter is particularly relevant for the recognition of the rights of indigenous people in a multicultural country where the rights of the native populations have been historically neglected. The MHL prohibits discrimination on any grounds.

Other principles here include using the least restrictive environment, the need for informed

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consent and the need for monetary compensation if the patient is in protected employment within the mental health system.

Section 5. Professional approaches

In this section the Law promotes the creation of multidisciplinary teams (MDT), which include all the professions involved in delivering mental healthcare. It is remarkable that the MHL encourages the prescription of psychotropic medications as an outcome of the MDT discussion. All these approaches are considered substantial pathways to community-based treatments that promote social inclusion.

Section 6. Equality among mental health professionals

In the spirit of supporting values of equality and democracy, this section explicitly upholds the equality of all mental health professionals and enables non-medical professionals to become programme directors and team leaders.

Section 7. Hospital admissions

This is the longest section of the MHL, containing 16 articles. We shall consider its main points.

- For an admission to be considered as a therapeutic option, it should bring more benefit than a community-based intervention. Equally, it has to be of the shortest possible duration. It should aim at the reintegration of the patient within the family and community. The state bears responsibility for providing social resources (notably housing) that may prolong admissions if they are otherwise nonexistent. The decision to admit should be made by the MDT.
- A new government organisation, the Review and Regulatory Body (RRB), will control both voluntary and compulsory admissions.
- Voluntary admissions should be notified to the justice system if they last more than 60 days. The justice system must respond within 5 days if a problem is encountered and eventually suggest alternatives.
- Compulsory admissions must be reported to the justice system and the RRB within 10 hours. Immediate risk and the impossibility of community-based approaches are necessary conditions to initiate the compulsory admission. This is done by two professionals, who need to be from a different discipline, but one must be either a psychiatrist or a psychologist.
- Once the justice system receives the information, the judge must reply within 3 days. The justice system can authorise the continuation of a compulsory admission, reject it and order a discharge (or convert the admission to informal status), demand further evidence, or ask for an independent evaluation by professionals appointed by the justice system. However, if the justice system authorises the continuation of the admission as compulsory, it will request periodic assessments every 30 days, and if the admission will last longer than 90 days the justice system will appoint an MDT to review the case.
- Patients have a right to appoint a solicitor and in the case of a patient under compulsory admission the state has the duty to provide one.
- A key topic of this section is a prohibition on new psychiatric hospitals (asylums) in either the public or the private sector. The asylums already existing must adapt themselves to the regulations of the MHL. The Law aims to promote the admission of psychiatric patients to psychiatric units within general hospitals.

Sections 8–12

Section 8 stipulates that any treatment must take place where the patient has local connections, to promote the aforementioned approaches based on community integration and social inclusion.

Section 9 establishes several principles for implementation. The MHL states that within a 3-year period there must be an increase in the budget allocations for mental health, to 10% of the total health budget. It also demands from the Ministry of Health a National Plan for Mental Health. A further remarkable feature is the inclusion within the ambit of the MHL of health maintenance organisations (which provide insurance-based and private medical services).

Section 10 governs the composition and goals of the RRB, focusing on the protection of the human rights of service users and families.

Section 11 states the need to promote agreements between federal policies and those of the provincial governments.

Section 12 deals with modifications to the Argentinean Civil Code of Legislation that will need to be done as an outcome of some of the changes proposed by the MHL.

Principal issues in the Mental Health Law

Considering the historical and social contexts in Argentina, we think the present Law has many progressive aspects.

The MHL encourages approaches that are socially oriented and endorses the rehabilitation and recovery model for those with mental disorders. It aims to create MDTs for the present and future mental health system. In this respect, bearing in mind that the medical profession has been traditionally dominant in Argentina, proposals promoting the equality of all mental health professionals and the expansion of a multidisciplinary approach for assessment and treatment are necessary and welcome.

The judicial supervision of admissions to hospital, both informal and formal, is progressive as well. The aim is to consolidate the rule of law and principles of citizenship and good governance. These matters have already been welcomed by organisations of patients and carers.

The MHL ventures also into issues of general policies for mental health. It determines that

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the model for in-patient treatment should be the general hospital, and rules out opening new asylums. Together with the proposed establishment of MDTs this is another enlightened step forward.

Despite these advances, there are some potential conflictive features. The Argentinean health system is fragmented. Different and sometimes contrasting sectors coexist side by side, with poor central regulation. With a historically debilitated public sector, poor regulation and supervision in other sectors within health and social care, and a private sector that has significantly expanded over the past decades, it is challenging to see how the practical principles of the MHL might be enforced (for example, introducing the concept of the MDT as the unit for assessment and treatment). Mental health organisations have welcomed the MHL in general terms, but have been mindful of various areas of tension and dispute.

Other important challenges for future consideration include:

- regulating the private sector
- promoting the teaching of mental health in general hospitals (following recommendations from the World Health Organization and the Pan-American Health Organization at Caracas in 1990)
- the inclusion of public health in the training of psychiatrists and psychologists
- relocating budgets from the psychiatric hospital-based facilities to the community.

The absence of a robust and prolonged democratic tradition is another obstacle to the subordination of conflicting sectors of the health system to the principles of the MHL.

Will the MHL be sufficient as an instrument to change existing realities? What other structures need to be created? These and further questions arise. Nevertheless, the MHL is a very good starting point. The sovereignty of the rule of law, the parliamentary discussions that originated the law, and its focus on the protection of human rights of patients make the MHL a progressive hallmark of a system that aims to improve conditions for patients, families and professionals. It is now the responsibility of the state's executive structures, together with health and social care organisations, to design comprehensive mental health plans and policies that will render the MHL a living reality.

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MENTAL HEALTH LAW PROFILE

Mental health law in Brazil

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Brazil is a Federal Union which comprises 27 member states, one Federal District, and about 5000 municipalities. According to the Federal Constitution (Constituição da República Federativa do Brasil; *Diário Oficial da União*, 05/out/1988), the competence to rule over health issues is shared by all of them. So, in each part of the country three levels of legislation apply: federal, state and local law. However, as an inferior level of law must not conflict with a superior one, there is a relative uniformity throughout the country, at least in theory. Regarding actual mental healthcare delivery, there are many differences across the Brazilian regions, mostly due to socioeconomic variation.

Historical issues

In Brazil, reform of mental healthcare (derogatorily called 'psychiatric reform' by anti-psychiatry activists) has two main themes: changing the model from hospital-based to community-based care; and the regulation of involuntary psychiatric in-patient treatment. Changing the model of psychiatric care had actually begun in some states (the more developed and richer ones) in the 1960s. However, by the end of the 1980s most of the states still had large psychiatric hospitals, whose main functions were to 'feed and shelter' patients with enduring mental health problems, instead of treating acute psychiatric in-patients. The grounds for involuntary in-patient psychiatric treatment have been specified in law since 1934 (Decreto 24.559/34, Dispõe sobre a profilaxia mental, a assistência e proteção à pessoa e aos bens dos psicopatas, a fiscalização dos serviços psiquiátricos e dá outras providências [Provisions for mental prophylaxis, assistance and the protection of the person and property of psychopaths, supervision of psychiatric services and other matters]; *Diário Oficial da União*, 03/jul/1934). However, there was no specification of the due legal process for depriving patients of their freedom: involuntary hospitalisation was simply agreed between the physician and the patient's relatives.

In 1989 a federal bill on mental healthcare, authored by a member of the House of Representatives of the Partido dos Trabalhadores (Labour Party), was proposed to the Brazilian Parliament. In that decade Brazil was emerging from a military regime which had lasted 20 years. The same

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