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The Impact of the Caracas Declaration on the Modernization of Mental Health Legislation in Latin America and the English-speaking Caribbean

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Introduction

In November 1990 the Latin American countries signed the Caracas Declaration, aimed – among other objectives-- at promoting the respect for the human and civil rights of the mentally ill, and at the restructuring of psychiatric care on the basis of primary health care under the framework of local health systems. The Declaration calls for the revision and redrafting of mental health legislation that guarantees the fulfillment of the human and civil rights of persons with mental illness.

Many developments have taken place in the countries of the Americas since the Caracas Declaration from the economic and political to the social standpoints, such as health sector reform, stabilization of democratic forms of government, political and social participation, and economic downfalls. These events had important consequences for the formulation of health policies and legislation in general, and mental health in particular.

The objective of this study is to review the status of mental health policies and legislation in Latin America and the English-speaking Caribbean, in order to determine the degree to which mental health legislation has complied with the reform process called forth by the Caracas Declaration. Consideration will be given to the special circumstances that have characterizing the last decade.

The document will cover the following topics: the impact of the Caracas Declaration in psychiatric care and mental health policy and legislation; policy and legislation developments in the last decade in the Latin American and the English-speaking Caribbean countries. A special case study on Brazil view of Federal Law No. 10.216, enacted on April 6, 2001 will follow and a

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segment on conclusions and recommendations. Annex I presents a table on legislation enacted since 1990.

The impact of the Caracas Declaration in psychiatric care and mental health policy and legislation

The purpose of the Caracas Conference was to formulate frames of reference for the restructuring of conventional psychiatric care in Latin America and the promotion of its transformation in compliance with the principles formulated by the World Health Organization (WHO) and the Pan American Health Organization (PAHO/WHO).

Product of the Conference was the Caracas Declaration, which called for the upgrading of mental health legislation to guarantee the human and civil rights of persons with mental illness. Furthermore, calling on the participation of all segments of society in supporting the restructuring of psychiatric care, the Caracas Declaration contributed to a process that enhances the participation of civil society in advocating for the defense of the human and civil rights of persons with mental illness.

By means of the Declaration of Caracas the international and national organizations and participating authorities urged the "Ministers of Health and Justice, Parliaments, social security systems and other service providers, consumer organizations and advocate groups, universities and other training institutions, and the media to support the restructuring of psychiatric care thus ensuring its successful development for the benefit of the populations of the Region."

In the years previous to the II World War, the situation of people with mental illness in Latin America was similar to those living in Europe, since the ideas of the time were introduced by academics trained is that continent. After the 1940s, the influence of the United States began to be felt due to a program implemented by the Rockefeller Foundation in Latin America for the exchange of academics and researchers. With very few exceptions, in the 1970s psychiatric care was structured around custodial care centered in the asylum and far from the urbanized areas. The system was characterized by a marked disproportion between the interned population and the availability of human resources, by poor hygiene, food and clothing and by lack of privacy, conditions contributing to an ill respect of patients' rights. In this context, rehabilitation was not provided (Larrobla and Botega, 2000). A coherent mental health policy was also lacking due to a variety of factors among which was the small share of budgetary allocations to mental health programs (Alarcon and Aguilar, 2000).

As a reflection of the above-mentioned conditions, legislation on psychiatric care was outdated and out of context. A thorough study conducted at the onset of the Caracas Conference identified the following characteristics of mental health legislation in Latin American:

- Although for the drafting of legislation the multiplicity of factors influencing the mental health process were taken into account, the majority of the standards enshrined such legislation were not applied. In practice, the existing care structures did not conform to the provisions that, in some cases, contained the bases that would make it possible to incorporate the variety of factors comprised in the mental health process. Therefore, an empirical framework prone to the protection of the rights of the patients was neither found.

- None of the countries studied had a specific law on mental health regulating all the aspects from a holistic perspective. Mental health issues were usually addressed in health codes or general health laws that only established general principles. Commissions and technical advice committees were created for the administration of some services, or to regulate entities devoted to the mental health care (González Uzcátegui y Levav, 1990).

- In general, the existing legal frameworks favored the perpetuation of already outdated models of mental health care. As a consequence, in most of the countries of Latin America psychiatric care was, a the time of the study, mostly centralized in the psychiatric hospitals, with the consequent damage to the human and civil rights of patients, specially as they refer to privacy (OPS/OMS, 1990).

- The lack of practical application of the provisions on psychiatric care and mental health was also observed. This phenomenon was caused mainly by the lack of adequate conditions, institutional structures, and real access to the health system (OPS/OMS, 1990).

Policy and legislation developments during the last ten years

In the mid-1980s an important change took place due to the restitution of democratic systems, favored the restructuring of the mental health system and the review of applicable legislation. Social movements transcending the scientific world which inspired this change.

As it refers to civil society participation, for example, it is interesting to note that most of the Constitutions enacted since the second half of the 1980s (Argentina, Brazil, Colombia, Ecuador and Paraguay) provide for the protection of collective rights and interests. These Constitutions specify public health and consumers' rights, as well as others related to the quality of life. By virtue of these provisions, all persons, individually and collectively have the right to bring suit against public authorities or others to ensure the protection of the environment and public health. These provisions constitute channels for health advocacy and therefore foster a consciousness in civil society as to the defense of health related rights.

International organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) had also an important role in fostering change during the

last three decades. PAHO in particular has rendered technical cooperation to the countries of the Americas for the integration of psychiatric care to the *primary health care* strategy, the decentralization of services –day care hospitals, health centers—, continuation of treatments, prevention, and community participation (Larrobla and Botega, 2000).

Based on the Conference held in Caracas, and as a result of requests for technical cooperation for the upgrading of mental health legislation, PAHO conducted, at the request of national authorities, a series of seminars at country level, as well as international workshops in several of the Latin American countries; such as Brazil, Colombia, Chile, Ecuador, Venezuela, and Panama. These activities resulted in the formulation of draft legislation followed, in some cases, to their enactment. This modality of work incorporates not only mental health professionals, but also others interested groups, such as human rights and community leaders, attorney general offices staff, universities, rehabilitation experts, unions, legal advisors of ministers of health, lawmakers, and advocacy groups (Bolis, 1998). Through similar procedures, the principles enshrined in the Declaration were also taken into account when drafting the new health codes and general health law of Guatemala and Dominican Republic, and the health codes and general health drafts currently under discussion at parliamentary level (Nicaragua, Paraguay and Venezuela).

➢ Latin America

♦ *Policy*

In 2000 Larrobla and Botega conducted a study on psychiatric care and de-institutionalization in South America. The countries covered in the study were Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela. The research postal questionnaires utilized were based on studies conducted by WHO and a census also conducted through postal questionnaires. The questionnaires were addressed to ministers of health --mental health commissions or departments of mental health—presidents of boards of psychiatric and relevant informants –distinguished practitioners and academics. The study covered the following areas: mental health policies and programs; existing psychiatric beds, and psychiatric units in general hospitals.

In the area of health policies and programs, the research arrived at the following results (Larrobla and Botega, 2000):

- In all the countries studied two systems of medical attention concurred –public and private. A mental health policy exists in nine countries.

- Only five of the countries, however, have a written mental health plan (Bolivia, Chile, Colombia, Uruguay and Venezuela). In the others (Brazil, Ecuador, Paraguay and Peru), there is only verbal declaration.

- In all the countries service coverage of mental health services is national.

- Eight countries –whit the exception of Bolivia-- have integrated their mental health programs to *primary health care.*

- Multisectoral participation in the formulation of health plans and programs was heterogeneous. The participation of the health sector was identified in all the countries. In Bolivia, Colombia, Paraguay, Peru, Uruguay and Venezuela, there was also participation from other sectors. In Brazil, Paraguay, Uruguay and Venezuela, patients participated as well. Only in Venezuela there was also participation at the level of politicians.

- In Bolivia, Brazil, Colombia, Paraguay, Uruguay and Venezuela some patient participation in mental health programs was identified, while in Chile and Ecuador it was not specified.

- The objectives of the mental health program were stated in an official document in Bolivia, Chile, Colombia, Ecuador, Peru, Uruguay and Venezuela; not so in Brazil.

- According to one relevant informant, mental health is yet low in priority ranking. Health policies are centered mainly in transmissible diseases, maternal and childcare and nutritional problems.

- In the particular case of Argentina, the authors found discrepancies between the public and the private sectors, with the public sector concentrating all of the resources in assisting the chronically ill. The development of mental health policies and the implementation of programs vary according to jurisdictions. The province of Buenos Aires, for example, lacks a mental health plan. On the other hand, in the provinces of Chaco and Río Negro, there are written policies and programs. In the latter province, the mental health program has also a specific policy evaluation process. Policy priories promote activities for patients as well as their psychosocial integration.

In the case of the Central American countries, a study conducted in 1998 at PAHO/WHO by the Mental Health Program, Division of Health Promotion, concluded on a series of aspects related to the human rights of persons with mental illness. As such, the study might be useful to asses the current status of mental health policy development. The study, which was supported by the WHO Collaborating Center at Umea University in Sweden and WHO, made a diagnosis of the current status of human rights of persons with mental illness in the Central American countries. Countries included in the study were Belize, Costa Rica, El Salvador, Honduras, Guatemala, Nicaragua and Panama.

The study was based on two protocols, one for the public sector and the other for the private sectors. To give more validity to the protocol, it was agreed that in each country the

mental health authorities would select at least one mental health professional, preferably independent from the government, and a lawyer who would be an expert on human rights issues. The field operations consisted of site visits to psychiatric institutions, mostly but not exclusively, to mental hospitals (Levav and González Uzcátegui, 1998).

The study arrived, among others, to the following conclusions:

- All the countries studied have endorsed the Caracas Declaration and have committed to restructuring the psychiatric care they provide.

- The Central American countries --El Salvador, Honduras, Guatemala and Nicaragua— had faced, until recent to the preparation of the study, either civil war in their territory or were indirectly involved in war across the border.

- All the countries have psychiatric services in both the public and private sectors. The public system varies from a developed one such as Costa Rica, with high coverage, to more limited forms such as El Salvador, Honduras, Nicaragua and Guatemala.

- Access to specialized psychiatric care is limited for those in rural areas, and for children and the elderly in rural and urban areas.

- Psychological rehabilitation is almost non-existent through the sub-region.

- Consumer associations currently existing in Costa Rica and Panama have not dealt with the subject of advocacy. At the time of the study, a committee was established in Honduras to monitor the safeguard of the human rights of persons with mental illness.

♦ *Legislation*

The *Caracas Declaration* prompted several countries in Latin America to review their legislation regarding psychiatric care, with a view to adapting it to its principles. Even though only two legal instruments have incorporated specifically the principles of the Declaration, progress has been steady. The following advances may be reported since 1990:

- In Costa Rica *Decree No. 20,665 of 25 July 1991* expressly refers to the Declaration and establishes that the National Mental Health Plan will be developed in accordance with the Declaration. The Decree also states that psychiatric and mental health programs will be incorporated to the basic programs of mental health and at the psychiatric services level.

In reference to hospitals, Decree No. 20,665 establishes that the National Plan of Mental Health will include the humanization of the therapeutic environment and the creation of a network of decentralized psychiatric services incorporated to primary care and to the local health systems.

- In Venezuela. *Resolution No. 1,223 of 15 October 1992* emphasized the responsibility of the Ministry of Health and Social Welfare (MSAS) in seeking comprehensive medical care for the mentally ill, with a view to achieving his or her rehabilitation and adaptation to the social environment. The Resolution also refers to the principles contained in the Caracas Declaration, and estates that the general hospitals assigned to the MSAS will study and adopt measures related to the hospitalization of acute psychiatric patients, guaranteeing them a minimum of ten percent of its beds.
  According to the Resolution the physician ambulatory services, assigned to the Regional Office of the Directors of the National Health System, must incorporate progressively into its primary health care programs the necessary resources so that the patients discharged by the respective hospital or institution, may be assured periodic controls until total recovery. Finally, the regulation recommends that the Division of Mental Health jointly with each Regional Office of the Director of the Health System, before opening new establishments of long stay, confer priority to the design and execution of alternative care programs. These establishments will also contribute to the protection og the chronic mentally ill and their families, through day, night and weekend hospitals, transit units, intermediate homes, and others services as deemed necessary.

- Also in 1992, Venezuela enacted the *Regulation for Psychiatric Establishments of Long Stay*. The regulation refers to the humanitarian treatment of patients, their individual freedom and safety; patient admission to institutions; professional and technical assistance; specialized health care; records and responsibilities for injuries and harm caused to the patients.

  The Regulation also contains provisions applicable to the isolation and physical contention of the patient; their hygiene and self-care; drugs; nutrition; community participation; permissions, re-entries, and runaways; evaluation and supervision; death of patients; ambulatory care and day-hospitals regulation, and the requirements for the building of establishments of long stay.

- In Colombia *Ministerial Resolution No. 2417 of 2 April 1992* guarantees the following rights to persons with mental illness:

    - The right to be treated with due dignity and respect.
    - The right not to be diagnosed nor treated as mental patient for political, social, racial or religious reasons, nor for another reason alien to his/her mental condition.

- The right to receive the best possible treatment and attention according to the higher standards of technology and ethics.
- The right to be informed of his/her diagnosis as well as to the safest applicable treatment, and to accept or reject treatment.
- The right not to be submitted without his/her consent to clinical trials nor experimental treatments.
- The right to confidential treatment of his/her clinical history, and to have access to it.
- The right to accept or reject religious assistance.
- The right not to be discriminated against on the basis of his/her mental disorder.

- In Nicaragua *Ministerial Agreement No. 31-93* addressed the issue from the mental health promotion perspective, stressing the need for education, recreation and the prevention of mental health disorders. To this end, the norm establishes that the treatment of mental health disorders encompass the prevention of the disease, as well as the care and rehabilitation of mental patients, the rehabilitation of chronic patients, persons with mental disabilities, alcoholics and drug abusers. Admission of patients must take place at community level --Sistemas Locales de Atención Integral de la Salud (SILAIS)--, and as a last resort and in exceptional situations, in mental health institutions. In any case, hospitalization must comply with ethical, social and scientific principles.

- In Mexico, Norm *NOM-25-SSA2-1994* regulates mental health care in integral psychiatric units (unidades que prestan servicios de atención integral hospitalaria médico-psyquiátrica). The Norm abides by the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, adopted by the United Nations General Assembly -- Resolution 46/119, December 17, 1991. The objective of this provision is to make uniform the operational criteria, actions and attitudes of human resources at units providing mental health services. These services will be permanent, integral, and provided with quality and warmth. The Norm applies to all public, social and private units in the National Health System rendering mental health care to chronically ill patients and patients needing long term admission.

  According to the Norm, admission to mental health care units may be voluntary, involuntary or compulsory. Voluntary admission may be requested by the person with mental illness and prescribed by the physician in charge of the unit. Involuntary admission should be prescribed by a psychiatrist at the request of a relative in-charge of the patient, his or her tutor or legal representative; both requests should be in writing. In case of emergency, the physician in-charge of the hospital unit may request the involuntary admission, also in writing. The patient should be informed of the conditions of his or her involuntary admission. The Public Minister and the judicial authorities must be informed of any involuntary admission and of the patient's evolution. The legal competent authority should request compulsory admissions when the patient needs it according to psychiatric evaluation.

The Norm also contains a catalogue of human rights of patients and provides for the respect of his or her dignity. Among those rights there are: the right to non-discrimination, safe and healthy environment, safe and nutritious food, clothing; privacy; to reject being subject to clinical trials; to have his or her case reviewed, and to receive a treatment that will permit his or her integration to family and social life, and work. Isolation should only proceed with the purpose of protecting the safety and integrity of the patient and others close to him or her, and according to the criteria of the responsible physician. When isolation proceeds, the patient should receive medical attention and supervision at all time.

Accord A/02/95 creates the Agency of the Public Ministry Specialized in the Care of Persons with Mental Disability. The Agency is responsible of all the issues referring to persons with mental disabilities. Therefore, it is mandatory for any agent of the Federal Public Ministry to inform the Agency within 24 hours, of any measure taken concerning a person with mental disability. When a person with disability is involved in a Federal enquiry proceeding, the health authority should be called upon to recommend placement, treatment and the applicable safety measures.

- In Guatemala, the *Health Code, Decree No. 90-97* establishes that the Ministry of Health and other sectoral institutions in their respective sphere of actions foster the promotion, prevention, recuperation and rehabilitation of health at the individual, the family and the community levels, under the framework of community services and primary health care. Ambulatory care will prioritized.

- In Chile, Supreme Decree No. 570 of 14 July 2000, enacts the regulation for the internment of persons with mental disease. The objective is to guarantee the highest quality of services under a framework of dignity and respect for human rights, to all those persons who may need psychiatric care in health institutions.

- In the Dominican Republic, the new *General Health Law* enacted in 2001mandates that the treatment of mental disorders be delivered with an integral and equitable approach and safeguarding the rights and dignity of patients. Actions providing for the social rehabilitation of patients should be strengthened.

- In some countries *state or provincial legislation* have surpassed the development of national legislation. In 1991, for example, the legislature of the Province of Rio Negro in the Argentine Republic, enacted *Law No. 2,440* aimed not only at the improvement of health conditions, but also at the social promotion of the patients with mental disorders. The Act expressly prohibits the establishment and operation of asylums for the insane, psychiatric hospitals or similar institutions, public and private, which do not adhere at its principles.

  The norm also establishes that institutionalization of the mental patient proceed only as a last resource, to be utilized after all the other therapeutic possibilities have been exhausted. The ultimate objective of institutionalization should be the patient's recovery and social rehabilitation

in the least time possible. The duration of the institutionalization should be minimized in all the cases. The recovery of the patient's identity, dignity, and the respect of the patient with mental disorders, expressed in terms of his or her reintegration to the community is the ultimate aim of the Act and of all the actions prescribed by it.

➢ The English-speaking Caribbean

♦ *Policy*

Governments in the English-speaking Caribbean have long recognized the importance of issues related to mental health and have reached regional agreements about the basic principles of delivery of mental health services. Even though there are not comprehensive polices on mental health, certain trends in mental health care show that ministries of health are aware of the importance of mental health and are taking measures to address them (Mahy, G. and Barnett, B., 1997).

In consistency with the above mentioned, a study conducted by Moss in 1999 mentions that, although the majority of the English-speaking Caribbean countries did not make specific provisions for curative care, rehabilitation, and aftercare and preventive care in their mental health legislation, it is possible to observe the following policy trends:

- The existence in all the territories of a number of community-based services, which are organized and administered by the chief psychiatrist and other mental health personnel from the psychiatric hospital. These services aim at the rehabilitation and health care of patients.

- The above mentioned services are conducted at regional clinics that are an integral part of the primary care system and are located through the respective territories.

- A team organized by the psychiatrist in-charge of the mental hospital –or senior medical practitioner—is attached to the hospital and conducts community health care. This team is composed of the psychiatrist, psychiatric nurses, social workers and other relevant personnel as may be, at time, available.

- The team makes periodically scheduled visits to the primary health care centers.

- Drug detoxification and rehabilitation units, half-way houses, crisis centers for abused women, schools for mentally handicapped children, and the manpower needed to service them, are modalities of curative care, rehabilitation, aftercare and preventive care. The rationale of these services may more accurately be characterized as *promotion of mental health and prevention of mental illness*.

- In the above mentioned services, manpower is composed of psychologists, occupational therapists, psychotherapists, psychiatric nurses, psychiatric social workers, counselors, and teachers with specialized training to work with children with mental disabilities.

- Within the context of those services there are many community-based organizations supported by government subventions, financial and other assistance from the private sector. These services receive technical assistance from international organizations as well as direct funding from international funding agencies.

♦ *Legislation*

According to Moss's study, legislation in the English-speaking Caribbean falls into two categories, which take the year 1960 as the great divide. Category One contains the legislation of Grenada (1895), St. Lucia (1895), Guyana (1930), Belize (1953), Anguila (1956), Montserrat (1956), St. Kitts-Nevis (1956), Antigua and Barbuda (1957), and Turks and Caicos (1959). Category Two refers to Bahamas (1969), Trinidad and Tobago (1975), The Cayman Islands (1979), British Virgin Islands (1985), Dominica (1987), St. Vincent and the Grenadines (1989), Barbados (1989) and Jamaica (1997).

Citing Herwood (1991), the study mentions that mental health legislation of the English-speaking Caribbean is characterized by the following:

1. *It is chronologically old, some dating back to the 1800s or the 1930s or 40s.*
2. *It is anachronistic, having no resemblance to modern principles of legal psychiatry.*
3. *It is based on a service delivery system dominated by a central institution.*
4. *It concerns itself primarily with the adjudication, not the treatment of mental patients.*
5. *Its language is archaic and terminology reflects disrespect for those it supposedly protects.*
6. *It does not concern itself with the rights of patients.*
7. *It does not make provisions for or even mention alternative or community-based modes of services.*
8. *It is not guarantee with economic resources.*
9. *It does not make clear whether it reflects all existing mental health care or services in the country.*
10. *It presently is not compatible with the principles expressed by the Caracas conference – deinstitutionalization, integration with primary care, local health systems implementation, and community participation.*

In spite of this general assessment, Moss's study reveals that several countries have revised their mental health legislation in the area of involuntary admissions (Bahamas, Trinidad and Tobago, Cayman Islands, British Virgin Islands, Dominica, St. Vincent and the Grenadines, Barbados and Jamaica).

According to the new legislation, the admission procedures are in the hands of doctors without the involvement of the court system, except in certain emergencies or in cases involving the involuntary admission of accused prisoners. Other important development was the inclusion of community-based mental health services in both Jamaican and Dominican legislation.

As an example of the above mentioned improvements, the Mental Health Act of Jamaica 1997 states that compulsory admission to, and detention in, a psychiatric facility, may be requested by the patient's nearest relative, or by a mental officer, public health nurse or approved social worker. When two certificates are submitted, one of them must be given by the medical practitioner approved by the Chief Medical Officer as having special experience in the diagnosis or treatment of mental disorders. Unless the practitioner has previous acquaintance with the patient, the other certificate needs to be issued by a medical practitioner who has such previous acquaintance.

As a further protective measure, the new Act forbids certain people from issuing the above-mentioned certificate. Among them: a person employed by the applicant; a person that receives or has interest in receiving payment on account of the maintenance of the patient. Finally, a medical practitioner who is related by blood or marriage to the patient, or who has given another medical certificate for the purposes of the same application is also excluded

The case of Brazil

Following the recommendations of the Caracas Declaration, Brazil has undertaken a fertile legislation reform at both the national and state levels. At the national level the Ministry of Health has enacted since 1991 a series of regulations. The most relevant ones, may be summarized as follows (Health Minister of Brazil, 2000):

- *Ministerial Decree No. 189, November 19, 1991*: The Decree was aimed at improving quality in the attention to persons with mental illness by means of the financing of mental health services and actions. According to this norm, the *Sistema Unico de Saúde* (Unified Health System) as the main financing instance, will make it possible for mental health institutions to incorporate modern and ethical principles in the treatment of people with mental illness. The Norm approves procedures and therapeutic workshops.

- *Ministerial Decree No. 224, January 29, 1992*: Establishes that all mental health services will function under the principles of universality, hierarchy and regionalization of actions. The Norm requires the utilization of diverse methods and therapeutic techniques of different levels of complexity, while guaranteeing the continuity of services at all levels. Psychiatric care should be structured around multi-professional teams; social participation is encouraged during all phases –from policy formulation to control.

- *Ministerial Decree No. 1077, August 24, 1999*: Establishes Access to Basic Drugs for Mental Health. This Decree guarantees access to basic drugs by users of public

ambulatory services. State and municipal levels may obtain, with their own resources, other drugs deemed necessary. This measure aims at making effective and regular contributions to states and at the municipal level to maintain a permanent program for basic mental health drugs.

- *Ministerial Decree No. 106, February 11, 2000*: Establishes the Residential Therapeutic Services for Mental Health under the National Health System, for the care of the persons with mental illness. The Residential Therapeutic Services are defined as houses, preferably in the community, for the care of persons with mental illness including those persons released from long term hospitalization who do not have relatives. The Decree, which aims at permitting the reinsertion of the above-mentioned persons into society, had a fundamental role in the transformation of mental health care from the traditional one.

- *Ministerial Decree No. 799, July 19, 2000*: Establishes the mechanisms for auditing mental health services –means for the continued supervision of hospital and ambulatory care.

Developments at state level have also been intense. Since 1992 eight stadual laws have been enacted, all of them establish the progressive substitution of the mental health hospital for other medical services. *Law No. 9,716 of 7 August 1992 of Rio Grande do Sul*, for example, prescribes the progressive substitution of the beds in the psychiatric hospitals for comprehensive care networks of health services. In addition, the norm states principles for the protection of the mental patients, especially in voluntary hospitalization situations. In such case, medical arbitration is required to fundament the procedure, as well as the provision to the patient of the information necessary to understand his or her decision. In the case of involuntary admissions, hospitalization must be communicated to the Public Ministry in a period not to exceed 24 hours.

Article 2 of the Act expressly forbids the construction of new psychiatric hospitals, private and public, as well as the purchase by the public sector of new beds in psychiatric hospitals. Furthermore, existing psychiatric hospitals are to be evaluated every five years, and their licensing would depend on the institution's compliance to the provisions of the Act (Bolis, 1993).

Similar provisions have been established in the states of Ceara, Espiritu Santo, Minas Gerais, Parana, Pernambuco, Rio Grande do Norte, and Rio Grande do Sul, and the Federal District.

Law No. 10.216, April 6, 2001

Recently enacted Law No. 10.216 applies to the protection of the rights of persons with mental illness and the reorientation of the mental health care system. The new norm covers the following areas:

- *Non discrimination:* The new Law applies without discrimination of any kind—race, color, sex, sexual orientation, religion, political views, nationality, age, family, economic condition, degree and stage of development of the condition, or any other cause (article 1).

- *Rights granted to persons with mental illness and their families:* Persons receiving any type of mental care –and their families or persons in charge of them— should be granted the following rights (article 2):

    - Access to the best possible treatment in the Unified Health System, according to the condition of her or his illness.
    - To receive humane treatment and respect to her or his rights, aiming at his or her total recovery in a family and community environment.
    - To be protected against any kind of abuse.
    - To the confidentiality of the information regarding her or his condition.
    - To receive medical assistance at any time to determine the need of involuntary hospitalization.
    - To free access to all available means of communication.
    - To receive as much information as possible about his or her condition, and about the treatments available.
    - To be treated in a therapeutic environment that assures the less invasive methods.
    - To receive priority treatment at community level.

- *Role of the State:* The State is responsible for developing the mental health policy, for delivery of health care and for the promotion of health actions for persons with mental illness, with the necessary social and family participation. This assistance should be provided in mental health establishments, which are those institutions or units offering medical assistance to persons with mental illness (article 3).

- *Involuntary admissions:* Involuntary admissions of any kind will be provided only when other resources are not sufficient (article 4). In such cases:
    - Treatment should aim at the reinsertion of the patient to his or her natural environment.
    - Admission should be based on an integral approach, offering medical services, as well as social, psychological and occupational assistance.
    - Hospitalization in installations not offering the above-mentioned conditions is forbidden.

- *Long term hospitalization/rehabilitation:* Patients hospitalized for a long time or under a situation of institutional dependency, will be subject to a special policy of rehabilitation and psychosocial assistance. Hospitalization will proceed only under the responsibility of

- the competent health authority and the supervision of the instance designed by the Executive Power, assuring him or her the continuation of treatment, when needed (article 5).

- *Psychiatric hospitalization:* Psychiatric hospitalization should proceed only after well-founded medical decision. The following types of admissions are recognized (article 6):
  - Voluntary admission: with the patient's consent.
  - Involuntary admission: without the patient's consent and by the request of a third party.
  - Compulsory admission (adjudication): by judicial order.

- *Voluntary admission:* A patient requesting voluntary admission must sign at the time of admission a declaration stating that she or he has selected this option. Termination of voluntary admission should be requested in writing by the patient or by the physician (article 7).

- *Termination of admission*: Both voluntary and involuntary admissions should be authorized by a physician legally registered in the Regional Council of Medicine of the state where the mental establishment is localized. Involuntary admission should not extend 72 hours and must be communicated to the State Public Health Ministry by the responsible officer of the establishment. The same procedure should apply for the release of the patient. Voluntary admission ends by written request of a family member, legal representative or specialist responsible of treatment (article 8).

- *Compulsory admission:* A competent judge in application of legal norms should declare compulsory admission. The judge should take into consideration the security conditions offered by the establishment, as they regard to the safeguard of the patient's rights and the rights of other patients and human resources (article 9).

- *Special situations:* The director of the medical establishment should communicate to the patient's relatives or legal representatives, and to the responsible health authority, no later than 24 hours if the patient escapes, is transferred to other institution, his or her condition deteriorates drastically, or if he or she dies (article 10).

- *Research:* Scientific research with diagnostic and therapeutic purposes should only take place with the express consent of the patient or his or her legal representative. Due communication should be given to the competent professional councils and the National Health Council (article 11).

- *National Commission*: The National Health Council will create a National Commission to see to the implementation of this law (article 12).

Conclusions and recommendations

The Caracas Conference took place at a propitious time for Latin America. By 1990, the majority of countries in the subregion had returned to constitutional rule. This fact created a new environment that favored the participation of civil society in many spheres of life beyond the political one. Previous times, in which efforts were concentrated in the defense of civil and political rights, gave place to new concerns such as the defense of the social, cultural and economic rights.

As it refers to policies, the aftermath of the Caracas Declaration seems to be a more organized mental health sector, with mental health plans operating –even without a written statement. There has also been an improvement on multisectoral participation in the development of health plans and programs and, somehow timidly, patient's participation. Primary health care was also incorporated in the majority of countries. However, a number of long-standing problems still persist, such as the low priority given to mental health and the consequent lack of resources.

Future policy strategies should include considerations to demographic changes and their correlative impact on mental health services. In some countries, for example, mental health demands from increasingly elderly and migrant populations, and an uncovered informal sector. Other challenge to deal with is the ever-increasing financial crisis of the public health sector coupled with the reliance on private insurance schemes, with the associated coverage restrictions.

The Caracas Declaration has initiated a process of revision of mental health legislation, as well as contributed to the creation of a new framework for advocacy in the defense of the human and civil rights of mental patients. The principles of the Caracas Declaration, which emanated from the Conference, inspired a movement to the revision of the mental health regulatory framework of several Latin American and English-speaking Caribbean countries. Many improvements may be noticed, particularly regarding the procedures for admission into mental health institutions – voluntary, involuntary and compulsory. These improvements show the need for physician participation, the creation of mechanisms for the permanent review of the case, and the guaranteeing of conditions that respect the human and civil rights of the patients, as well as their dignity.

Therefore, it is possible to conclude that, since Caracas, a system of law characterized by ambiguity, is slowly been superseded by one which emphasizes multidisciplinary cooperation, establishes guarantees for the protection of the human and civil rights of mental patients, and creates mechanisms that permit advocacy strategies to be exercised.

However, the process of creating enticing legal frameworks and making them effective is by far over. Future strategies to such ends should include the up grading-of legal frameworks in those countries –such as most of the Central American and the English-speaking Caribbean. The issue of health sector financing should also play an important role. Therefore, beyond safeguarding the human and civil rights of patients, new regulatory frameworks should incorporate guaranties to access care in a privatization setting.

The strategies should also include as well two important elements: civil society advocacy and a responsible judicial system. To the first aim, mechanisms for the participation of civil society, patient are relatives, and patients themselves.

References

Alarcon, R.D., Aguilar Gaxiola, S.A. *Mental health policy developments in Latin America*. Bulletin of the World Health Organization, 2000, 78.

Bolis, M. "The Restructuration of Psychiatric Care in Latin America: Changes in Legislation." *Conference on Human Rights, Mental Health and Therapy in a Changing World*. Calgary, Alberta, Canada, January 26-30, 1993.

Bolis, M. "Comparative Study on Mental Health Legislation in Latin America and the English-speaking Caribbean". Presentation made at the XXV Congress of the International Academy of Law and Mental Health, Paris, France, 1998.

González Uzcátegui, R., Levav, I., eds. "Legislación vigente en América Latina que rige la organización de servicios psiquiátricos". *Reestructuración de la atención psiquiátrica: bases conceptuales y guías para su implementación.*

Lezertua, M. "Estudio comparado sobre legislación en materia psiquiátrica". *Legislación psiquiátrica: crítica y alternativas*. Victoria-Gasteis, 1984.

Mahy, G., Barnett, B. Mental health. *Health Conditions in the Caribbean*. Scientific Publication No. 561, PAHO/WHO, 1997.

Ministério da Saúde. Legislação em Saúde Mental. Serie Legislação em Saúde, n. 4, Brasília, D.F., Brazil, 2001.

Moss, S. Psychiatric Care and Mental Health Legislation in the English-speaking Caribbean Countries. Technical Report Series. Public Policy and Health Program, Health and Human Development Division, 1999.

PAHO/WHO. "Situación actual de la asistencia psiquiátrica en América Latina". *Documento Básico de Trabajo. Conferencia Regional para la Reestructuración de la Atención Psiquiátrica*.

PAHO/WHO. *Memorias de la Conferencia Regional para la Reestructuración de la Atención Psiquiátrica, Caracas, Venezuela, 11-14 de noviembre, 1990*. PAHO/WHO-Mario Negri Institute, 1991, pp. 79-90.

PAHO/WHO. "Questionnaire on the Advances of Mental Health Legislation since the Caracas Declaration". Washington, D.C., 1996.

Annex I

Legislation enacted in Latin America and the English-speaking Caribbean since 1990

Country	National Specific	National General	State
Argentina			Rio Negro Province
Brazil	Ministerial Decree No. 189/91 Ministerial Decree No. 224/92 Ministerial Decree No. 1077/99 Ministerial Decree No. 106/00 Ministerial Decree No. 799/00 Law No. 10216/01		Ceara Espiritu Santo Minas Gerais Parana Pernambuco Rio Grande do Norte Rio Grande do Sul Federal District
Chile	Supreme Decree No. 570/2000		
Colombia	Ministerial Resolution 2417/92		
Costa Rica	Decree No. 20665/91		
Dom. Republic		General Health Law/01	
Guatemala		Health Code/97	
Jamica	Mental Health Act/97		
Mexico	NOM-25-SSA2/94 Accord A/02/95		
Nicaragua	Ministerial Agreement No. 31/93		
Venezuela	Resolution No. 1223/92 Regulation for Psychiatric Establishments of Long Stay/92		