

# Mental health law profiles

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The Caracas Declaration, referred to in both of this issue's mental health law profiles on Bolivia and Colombia, and agreed by all national governments in the Latin American region in 1990, has set clear aspirations and extracted explicit signed commitments. Materialisation of these, however, has been distinctly patchy. On the evidence of the paper by Anne Aboaja and colleagues, Bolivia offers an alarming example of promises failing to materialise. This is particularly disappointing, because rights and service deficits remain largely unchanged despite a stable and popular government and a tripling of the size of the economy in the decade to 2014. Irrespective of future politics and economics, people with mental illness and their families have a right to expect early improvement and to hope that such wider social developments as have occurred in Bolivia will create a favourable climate in which to address mental health issues.

Both Bolivia and Colombia face major problems with substance misuse and domestic violence. In addition, Colombia faces the legacy of violent armed conflict that has repeatedly placed it at the top of relevant international tables. According to

the report by Roberto Chaskel and colleagues, the suffering engendered by such violence, especially against women, seems to have spurred much research-informed progressive legislation tailored to the particular needs of the Colombian population. This is coupled with commitment to service provision in the area of mental health, particularly trauma-related mental health problems.

In their paper the Colombian authors lay emphasis on the importance of service provision (e.g. mandatory provision of 30 individual and 30 group sessions for all patients and unlimited sessions for victims of violence) and report less on the protection of liberty in relation to compulsory detention (e.g. they do not specify whether patients have a right of appeal and under what conditions). In part perhaps this reflects that 'institutionalisation is the rare exception' and lack of resources and services remains the paramount issue in that country. This, however, is cold comfort for the patient who is at risk or who has been detained in violation of fundamental human rights. Such rights are universal and their violation a contravention of the Caracas Declaration.

## Mental health law in Bolivia

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**Bolivia's mental health plan is not currently embedded in mental health legislation or a legal framework, though in 2014 legislative change was proposed that would begin to provide protection and support for the hospital admission, treatment and care of people with mental disorders in Bolivia. Properly resourced, regulated and rights-based mental health practice is still required. Mental healthcare in the primary care setting should be prioritised, and safeguards are needed for the autonomy of all patients, including all those in vulnerable and cared-for groups, including those in prisons.**

Bolivia is a lower-middle-income country in South America surrounded by four middle-income countries (Peru, Brazil, Paraguay, Argentina) and one high-income country (Chile) (World Bank, 2015). Despite the lack of large-scale psychiatric

prevalence studies in Bolivia, there is some evidence to suggest that mental disorders are common. A cross-sectional study showed that nearly one in two women is a victim of violence perpetrated by an intimate partner and that this is associated with symptoms of depression (Meekers *et al*, 2013). According to a review published by Jaen-Varas *et al* (2014), alcohol addiction has a clear impact on psychiatric admissions, domestic violence and road traffic accidents in Bolivia. A study using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) tool examined the reasons for admission to psychiatric centres and showed that just over one-quarter of patients were admitted for psychotic illnesses, a similar proportion for substance misuse problems and a slightly lower proportion for affective or neurotic disorders (Caetano, 2008). There are, though, no data available on the prevalence of mental disorder in the general

**Table 1**

Articles in Bolivia's Constitution relevant to mental health

Article	Provisions
35	I. The state at all levels protects the right to health, promoting political policies oriented to improving quality of life, collective well-being and the population's free access to health services
37	The state has the inescapable obligation to guarantee and uphold the right to health, which constitutes a supreme role and financial responsibility. Health promotion and disease prevention will be prioritised
41	The state shall guarantee the population access to medicines
70	Everyone who has a disability enjoys the right to be protected by his or her family and by the state
71	I. The state shall take affirmative action to promote the effective integration of persons with disability into the productive, economic, political, social and cultural field, without any discrimination II. The state will create conditions for the development of the individual potential of persons with disabilities
72	The state shall guarantee persons with disabilities the integral services of prevention and rehabilitation and other benefits established in law
73	I. Everyone deprived in any way of liberty shall be treated with the respect due to human dignity

population or in prisons which might be used to inform policy and shape legislation.

### A promising but unsuccessful start to mental health legislation

Although Bolivia was one of the first South American countries to have a written mental health plan (Bolis, 2002), in the past two decades fewer changes than expected have been made in the development of psychiatric services. In contrast, many other Latin American countries have made important progress in order to meet their commitments under the 1990 Caracas Declaration, which was agreed by all the health ministers of the Americas (de Almeida & Horvitz-Lennon, 2010). This landmark declaration aimed to ensure mental healthcare legislation will protect the human and civil rights of people with mental illnesses and will lead to the reform of mental health services based on scientific evidence. The main objectives of the latest (2009) Bolivian mental health plan, revised for 2009–15, were to embed mental health services within primary care and to promote and develop community mental health services (World Health Organization, 2011). Compared with other South American countries, however, following the Caracas Declaration Bolivia has seen a minimal reduction in deinstitutionalisation as measured by a reduction in the number of psychiatric beds (Mundt *et al.*, 2015). Moreover, the mental health plan does not address care provision or regulation of patients admitted to hospital involuntarily. Furthermore, the absence of sufficient funds for its implementation has meant that the goals have not been achieved. According to local stakeholders, other reasons for this include the lack of importance given to mental health by society and by health authorities and the stigma associated with mental disorders (CBM, 2010).

### International influences on mental health legislation and human rights

In the 21st century many South American countries have embraced a new era characterised by the integration of international recommendations into national legislation and policy, and the

creation of mechanisms for monitoring human rights in mental health services. While Bolivia has been slower than neighbouring countries to adopt similar changes, new laws have been passed, such as Law 4034, which promotes housing for people with dementia, while the General Law for People with Disability offers benefits to people with intellectual disability and major mental disorders (Ortiz-Antelo *et al.*, 2009; Montaña-Viaña *et al.*, 2012). Furthermore, Bolivia's new (2008) Constitution promises to protect the right to health (Bolivia, 2008; and see Table 1). Civil legislation defines how, on the basis of a medical assessment, a person can be deemed mentally incapacitous and be made subject to power of attorney.

The Bolivian government has signed both the 1969 American Convention on Human Rights and the 2006 United Nations Convention on the Rights of Persons with Disabilities, in which the definition of disabilities includes those associated with mental and intellectual impairment (Gable *et al.*, 2005). Since 2007, the United Nations High Commissioner for Human Rights has played a formal role in monitoring, reporting and advising on the human rights situation in Bolivia (United Nations, 2014). The Office of the High Commissioner has made a number of recommendations for the improvement of human rights to government ministers. However, the current remit of the Office does not extend to monitoring the human rights of patients admitted to psychiatric hospitals, and the 2009 mental health plan fails to address ethical practice and matters concerning the protection of human rights of people with mental disorders.

Constitutionally, people can be admitted to psychiatric hospitals involuntarily (Camisón Yagüe, 2012). However, there are no formal mechanisms for a detained patient to appeal against hospital detention and there is no responsible, independent body which actively monitors unlawful hospital detention and the use of coercive practices of administering treatment to patients in hospitals or in the community or the use of mechanical restraint. Legislation pertaining to mental health in Bolivia remains weak in offering actual protection and equality to these people, who are likely to

encounter stigma, who may not always have insight into their health and social needs, and who may disagree with medical opinion regarding hospital admission and treatment (Gable *et al.*, 2005). In the absence of national mental health legislation and the effective implementation of a national mental health plan, region-specific mental health guidelines have been published (Cocarico *et al.*, 2014).

### Forensic psychiatry and legislation

Forensic psychiatry, which intersects many branches of law, is not a recognised subspecialty in Bolivia at present. Systems for diverting those with mental disorders in the criminal justice system towards mental health services have not been established. There are no legal means by which prisoners in Bolivia with serious mental disorders can be transferred to a psychiatric hospital in order to receive appropriate treatment and care (Caetano, 2008). At a national level, no formal agreement has yet been made between the prison system and mental health services. Although the 2009 national mental health plan set out to meet the needs of vulnerable populations such as women, children and those with addiction problems, prisoners were not identified in the plan as requiring a targeted mental health intervention (Camacho-Rivera, 2009). It is therefore not surprising that prison mental healthcare remains underdeveloped in Bolivia.

Current legislation in Bolivia permits children up to the age of 6 to reside in prisons with detained parents, although prisons are ill-equipped for children of any age. Children above this age have been reported living inside adult prisons with detained parents and the Bolivian government has set goals to address this problem. Globally, there is a paucity of literature on the immediate mental health needs of children of detained parents and on the longer-term mental health effects of residence in an adult prison during childhood. It is reported that pre-trial prisoners (who are at higher risk of mental disorder than post-trial prisoners) represent 83% of the total prison population and that prisons can reach 256% occupancy rates – another potential risk factor for mental disorder (International Centre for Prison Studies, 2014). There is scope for legislation and policy to address these two mental health risk factors, which have been reported by the High Commissioner for Human Rights (United Nations, 2014). The development of adequate prison mental healthcare is therefore particularly important in Bolivia but currently, if available at all, it is provided on an *ad hoc* or voluntary basis (Caetano, 2008; Garcia, 2011).

### Future opportunities

Bolivia has shown a commitment to improving mental healthcare through a series of mental health plans revised over the past decade. Although there is no specific mental health legislation, currently the mental health needs of the population are considered to some extent in human rights and disability legislation. New strategic guidelines for

mental health have been developed for 2014–19 (WHO & PAHO, 2014). The move towards de-institutionalisation is likely to contribute to reducing the risk of coercive treatment for patients with mental disorders and the risk of inappropriate deprivation of liberty by patients detained either voluntarily or involuntarily. In August 2014 Bolivian stakeholders and the WHO regional office developed a proposal for mental health legislation which has been presented to the government for consideration (World Health Organization & Pan American Health Organization, 2014).

An increase in the amount of epidemiological data on the mental health needs of the general and prison population is essential in order to inform the development of future mental health policies in Bolivia. Further research and audit are required into the actual practices of hospital admission and treatment. The Office of the High Commissioner for Human Rights in Bolivia could widen its remit to monitor the human rights of hospital patients and prisoners with mental disorders. Lastly, the implementation of any mental health plan and serious discussions about mental health legislation will require greater financial support from the government in order to achieve lasting improvements in the population's mental health.

### Conclusions

The intentions of the current mental health plan and existing general disability legislation are good. They consider global recommendations, promote inclusive healthcare and incorporate modern practices such as community-based care. However, they may prove only partially effective due to the lack of local epidemiological evidence and of sufficient financial and workforce resources. In the absence of specific mental health legislation outlining the conditions and processes for admitting and treating people with mental disorders, it will be necessary to reinterpret existing legislation. Whether Bolivia judiciously opts for new mental health legislation or chooses to operate within existing legal frameworks, there is a need for adequate ring-fencing of mental health funding within the national health budget to support the full implementation of any modern mental health plan which seeks to integrate mental health into primary care, to safeguard patient autonomy, improve access to psychiatric assessment and treatment, and to respect the principles of human rights in mental health and social care practice.

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## Mental health law in Colombia

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**Mental health law in Colombia has evolved over the past 50 years, in concert with worldwide recognition and prioritisation of mental healthcare. Laws and policies have become increasingly sophisticated to accommodate the ongoing transformations throughout Colombia's healthcare system and improvements in mental health screening, treatment and supportive care. Mental health law and policy development have been informed by epidemiological data on patterns of mental disorders in Colombia. Colombia is distinguished by the fact that its mental health laws and policies have been formulated during a 60-year period of continuous armed conflict. The mental health of Colombian citizens has been affected by population-wide exposure to violence and, accordingly, the mental health laws that have been enacted reflect this feature of the Colombian experience.**

### Historical perspective

In Colombia, the latter half of the 20th century was marked by a growing awareness of the importance

of mental health and the need for mental health services based on public education and advocacy from the Colombian Psychiatric Association, the Colombian Psychological Association, a variety of non-governmental organisations and information dissemination via a broad spectrum of media channels.

During the 1960s, the Colombian Ministry of Health established a small section of mental health that, for decades, was staffed by one or two individuals. Only since 2004 has the Ministry expanded mental health to division status, focusing on diagnosis and design of services. However, the Ministry has encountered barriers to the provision and implementation of mental health services due to competing priorities.

During the 1990s, developments in Colombia coincided with hemispheric shifts in healthcare delivery. The 1990 Declaration of Caracas paved the way for adoption of the primary healthcare model promoted by the World Health Organization (WHO). In 1991, the WHO released its 25 Principles for the Protection of Persons with Mental Illness (United Nations General Assembly, 1991). In the same year, Colombia redrafted the