



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.

## References

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# 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

had happened in other Latin American countries. A new Federal Constitution was promulgated in 1988. So, the political atmosphere was intense and a general clamour for freedom had spread all over the country. In the health field, the most obvious target for political struggle was psychiatry and mental healthcare. An anti-psychiatry activist stated that 'The struggle for the insane is part of society's overall strategy of struggle for the woman, the indian, the negro, the homosexual and other minorities' (Amarante, 1998).

Thus, it is not surprising that the bill had a bias against psychiatry and psychiatric care, among them the determination to close all psychiatric hospitals in the country, not taking into consideration the quality of care. This bill was so radical that it provoked a reaction. Finally, 12 years later, in 2001, it was rejected and substituted by a bill without anti-psychiatric tenets. That bill became Federal Law 10.216/01, of 2001 (Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental [Provisions for the protection and rights of people with mental disorders and reform of the mental healthcare model]; *Diário Oficial da União*, 09/abr/2001).

### **Federal Law 10.216/01**

Law 10.216 does not define mental illness but instead relates to 'people with mental disorders'. However, as Brazil has adopted ICD-10 (World Health Organization, 1992) as its official classification of diseases, the psychiatric disorders must fit ICD-10 criteria.

### **Psychiatric hospitalisation**

Law 10.216 recognises three kinds of psychiatric hospitalisation: *voluntary*, *involuntary* and *compulsory*. All require *medical certification* that the patient needs in-patient treatment. Voluntary hospitalisation takes place when a competent patient gives informed consent; involuntary hospitalisation requires consent by proxy; compulsory hospitalisation is effected under a judicial order. The *grounds* for involuntary hospitalisation are not specified in Law 10.216. Thus, the old 1934 Law provides them: risk of aggression against the self, risk of aggression against others, risk of 'moral exposure' (social/moral risk in financial, sexual or behavioural areas) and serious incapacity in terms of self-care. The discharge of the patient is a decision for the treating physician. Under voluntary hospitalisation the patient can apply for discharge at any time; under involuntary hospitalisation the right of application rests with the patient's representative. There is no time limit to involuntary hospitalisation, nor is a need for renewal specified by law.

When a patient is involuntarily hospitalised, the medical director of the hospital must inform the Public Prosecutor within 72 hours. The Public Prosecutor has the power to make an inquiry and must protect the rights of people who are mentally ill. However, in most cases this is limited to a bureaucratic role. Only when a complaint is

received (usually from a patient's relative or friend) does an inquiry take place. This investigation basically consists of sending a psychiatrist from the office of the Public Prosecutor to the hospital. This psychiatrist must contact the treating physician, evaluate the patient, review the medical records and determine whether the patient is receiving appropriate treatment. Finally, this psychiatrist must write a report about the patient's clinical condition and confirm whether or not there is a need for continued hospitalisation for the patient's protection and that of third parties.

### **Changing of the model of psychiatric care**

Law 10.216 rules that it is a right of people with mental disorders 'to be, preferentially, cared for in mental health community services', that 'in-patient treatment will be allowed when the out-patient resources have been exhausted' and that 'psychiatric treatment must target the patient's social reintegration into his/her original environment'. These provisions are general guidelines to direct public policies on mental health. There is no provision forbidding the establishment of psychiatric hospitals or psychiatric units in general hospitals, nor ordering the closure of those already in existence.

### **Involuntary treatment**

Law 10.216 does not rule on involuntary treatment, only on 'involuntary hospitalisation'. The implication is that the latter includes the former and that an involuntary in-patient has no right to refuse treatment. However, for potentially riskier treatments (such as electroconvulsive therapy) consent from the patient's representative is required, except where there is 'imminent risk to life' and there is no time to contact the representative. In Brazil there are no involuntary out-patient or community treatment orders, except for those that apply to offenders with a mental disorder and other forensic patients.

When defendants are found not guilty by reason of insanity, they must receive a criminal commitment called a 'safety measure'. The safety measure could consist of in-patient psychiatric treatment in a forensic mental hospital or of out-patient psychiatric treatment. Regarding the latter, if the patient does not comply with the medical treatment plan the safety measure can be transformed into in-patient treatment.

### **Civil competence**

Law 10.216 does not rule on civil competence. This is an issue governed by the civil law. According to the 2002 Brazilian Civil Code (Código Civil, Law 10.406/02; *Diário Oficial da União*, 11/jan/2002), people can be declared incompetent and be put under guardianship if, in addition to a mental disorder, they manifest impaired judgement due to that mental disorder. So, mental disorder itself is not sufficient grounds for guardianship. Unless a judicial decision explicitly declares incompetence, a person with a mental disorder is presumed competent.

## Final remarks

Brazilian healthcare reform has not been a success. 'Minor legislation' (such as decrees) enacted at the national level by the Ministry of Health, or at the state or local-government level, has been used to subvert Law 10.216, by closing psychiatric beds and psychiatric hospitals before sufficient community services have been established, while the opening of psychiatric beds in general hospitals is discouraged by the legislation. Sadly, those with

mental disorder who do not have access to adequate mental health services remain at home in an impoverished state, wander the streets, are locked in prisons or present at general emergency rooms.

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# School-based survey of psychiatric disorders among Pakistani children: a feasibility study

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**A cross-sectional survey of children aged 5–11 years attending 22 primary schools was carried out in Karachi, Pakistan. In the first (screening) phase, broad morbidity rates were measured using the Strengths and Difficulties Questionnaire (SDQ). A total of 968 parents and 793 teachers participated. In the second phase, 100 children were selected for a diagnostic interview using the Kiddie Schedule of Affective Disorders & Schizophrenia for School-Age Children. A weighted rate of 17% (95% CI 6.2–28.3%) was found for common child psychiatric disorders, with a preponderance of behavioural disorders, followed by anxiety and mood disorders. The feasibility study established methods and preliminary rates of child psychiatric disorders, which appear higher than in other countries. School surveys could be an important source of data in low-income countries and form the basis for interventions in the absence of specialist services.**

A review of non-clinic-based epidemiological studies from 51 Asian countries found that the prevalence of child psychiatric disorders ranged from 10% to 20% (Srinath *et al.*, 2010). Most such studies from low-income countries have reported higher prevalence rates than studies conducted in high-income countries, which have, overall, estimated the prevalence at approximately 10% (Green *et al.*, 2005).

In Pakistan, the scarcity of child mental health services mirrors the limitation of evidence-based studies on children's needs and how these should be met (Jawaid & Rehman, 2007). A survey conducted two decades ago produced an estimate of 9% for the prevalence of behavioural and emotional problems among children (Javad *et al.*, 1992).

The increasing public concern over child mental health in Pakistan has highlighted the need for more accurate and up-to-date knowledge on prevalence rates (Syed *et al.*, 2007). This was the rationale for the present two-stage preliminary study, which aimed to develop and test methods, and to establish the rates of common psychiatric disorders among children at primary school in Karachi. The long-term objective is to apply these methods in a later definitive epidemiological study.

## Method

### Setting and sampling strategy

The study was conducted in Karachi primary schools (for children aged 5–11 years). The educational system in Pakistan comprises public or government schools, community schools (typically run by non-governmental organisations) and private schools. In order to maximise the representativeness of the sample, schools of all three types were invited to participate. Table 1 provides the demographic profile of the study sample. Central Karachi has a total of 1380 primary schools. Twenty-seven schools were randomly selected and 22 agreed to participate – seven private, seven government and eight community schools. The five schools (two private and three community schools) that declined to take part in the study asserted that the topic might upset parents or was irrelevant to their pupils. After schools had consented to participate, the researcher (SAH) identified the sample of children using a pseudo-random technique, based on alternating odd–even serial numbers on the attendance register; school authorities selected this technique for pragmatic reasons. A sample of 2188 children aged 5–11 years was selected. The parents of 1003 of these children agreed to participate, and in the first screening stage data were collected from 968 parents and 793 teachers.