

Egypt's New Mental Health Bill: A First Step on the Right Path

**Health and Human Rights Program
Egyptian Initiative for Personal Rights
January 2009**

Title: Egypt's New Mental Health Bill: A First Step on the Right Path

Publisher: Egyptian Initiative for Personal Rights (EIPR)
8 Mohamed Ali Jinnah Street
Garden City – Cairo
Tel/fax: + (202) 27943606 - 27962682

Website: www.eipr.org
Email: eipr@eipr.org

First Edition: January 2009 – Cairo

National Library Registration no.: 22582/2008

Acknowledgements

This study was compiled and written by Dr. Ragia Elgerzawy, Health and Discrimination Project Officer in the Health and Human Rights Program of the Egyptian Initiative for Personal Rights (EIPR). It was reviewed and edited by Dr. Alaa Ghannam, director of the Health and Human Rights Program; Soha Abdelaty, Deputy Director of the EIPR; and Hossam Bahgat, Executive Director of the EIPR. Aida Saif El-Dawla translated the study into English, and Nikki Columbus edited the English version.

Oliver Lewis, Executive Director of the Mental Disability Advocacy Center in Budapest, provided pro bono advice throughout the research.

Contents

Introduction.....	5
I. Historical Background	6
Positive Developments.....	8
II. International Standards for the Protection of the Rights of Individuals with Mental Disorders.....	9
III. Mental Health Status Worldwide: Prevalence and Burden	10
IV. Mental Health Situation and Services in Egypt	13
V. The Role of Legislation in Protecting the Rights of Mental Health Patients.....	15
VI. The Need for a New Mental Health Law in Egypt	16
VII. New Mental Health Law.....	17
1. The drafting process	17
2. Positive aspects of the bill.....	18
3. EIPR recommendations for the new mental health bill.....	19
a. Scope of legal protection for people with mental disorders	20
b. Right to community integration.....	21
c. Safeguards in cases of involuntary admission and treatment.....	23
d. Bill of rights and freedoms.....	31
e. A human rights–based approach and the goals of the legislation	32
f. Promoting equal opportunities and promoting the human rights of people with mental disability	33
Appendix 1: Law for the Institutionalization of Those with Mental Illnesses Law no. 141/1944	35
Appendix 2: Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care	44

Introduction

In 2008, the Ministry of Health and Population in Egypt announced that it would submit to Parliament a draft for a new mental health law to replace the existing one, which has been in force since 1944. This legislative initiative provides an important opportunity to discuss the issue of mental health from a human rights perspective. The moment also calls for a review of the existing law and its compatibility with the Egyptian government's legal obligations under the provisions of the Egyptian Constitution as well as international human rights law to ensure the highest attainable standard of mental health and the protection of persons with mental disorders from discrimination.

The constitution of the World Health Organization (WHO), adopted in 1946, defines health as "a state of complete physical, mental and social well-being." Since then the organization has continued to stress the interrelatedness of physical and mental health.¹ The importance of mental health is also highlighted in the International Covenant on Economic, Social and Cultural Rights, issued in 1966, which affirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Regional human rights conventions, such as the African Charter for Human and People's Rights, the European Convention on Human Rights and the American Convention on Human Rights, have affirmed this understanding.

Parallel to these conventions and charters, the past decades have witnessed a radical shift in the concept of mental health, its importance and the measures for providing care and treatment to individuals with mental disorders. As noted by the General Secretariat for Mental Health (the division in charge of mental health issues at the Ministry of Health and Population), the new bill comes as a response to those developments. The current law in Egypt was written at a time when successful treatments had not yet been discovered; indeed, this is made clear by the title of the 1944 legislation: "Law for the Institutionalization of Those with Mental Illnesses." Therefore, the General Secretariat declared, there is an urgent need to introduce a new law that is compatible with contemporary views, scientific developments and the principles of human rights.² The explanatory memorandum accompanying the bill states that "the concept of treatment for mental disorders has changed to focus essentially on the treatment of the patient and his/her reintegration in society, and to help him/her lead a productive life; and is no longer targeting

¹ World Health Organization, "Investing in Mental Health" (2003), p. 10, available at http://www.who.int/entity/mental_health/en/investing_in_mnh_final.pdf.

² Website of the General Secretariat for Mental Health: http://mentalhealthegypt.com/law_arabic_final.htm.

his/her exclusion and isolation in a mental institution for long periods of time, as is the case in the current law."

This study aims to analyze the proposed mental health law from a rights perspective in order to measure its compatibility with human rights principles and the international standards that guide the practice of the mental health care profession; at the same time, the study considers the status of mental health care in Egypt. The study includes historical background regarding the development of the concept of mental health and mental illnesses and the developments in the fields of care and treatment worldwide. It also addresses the close link between mental health issues and human rights, referring to the most important international standards that protect the rights of persons with mental disorders. The study then addresses in detail the new mental health bill, highlighting its positive aspects in comparison to the present law, and providing concrete recommendations for improvements.

I. Historical Background

Throughout history and across the world, people with mental disorders have been subject to prejudice, rejection, fear and exclusion, not to mention abuse and exploitation. For centuries, mental disorders were considered mysterious phenomena caused by supernatural forces, either evil or divine. The Middle Ages in Europe witnessed extreme cruelty in the treatment of the mentally ill; they were frequently tortured or even murdered, and some were burned alive to expel the demons that were believed to possess them. In the seventeenth century, mental illness came to be seen as the result of an organic impairment. This new theory, however, did not lead to greater sympathy and tolerance, as patients were believed to be responsible for their illnesses and emotional disturbances. Thus, many mental patients were punished and cruelly exploited, especially the poorer ones, who were held in prisons, workhouses or isolation centers, under inhumane conditions.³

With the beginning of humanitarian trends in the middle of the eighteenth century, there was a call to end such treatment of people with mental illnesses. Large institutions were built to accommodate them instead of prisons, and a "moral treatment" was adopted, which provided humane care to patients and encouraged them to discuss their problems and to behave in a "proper" manner. However, conditions inside these institutions soon deteriorated, and they became yet another place to isolate and incarcerate patients in extremely poor conditions. Although the nineteenth century saw the early development of psychology as a branch of medicine, the mentally

³ World Health Organization, "The Mental Health Context" (2003), p. 15, available at www.who.int/mental_health/resources/en/context.PDF.

ill—as well as others whose conduct differed from societal norms—continued to be isolated in huge sanatoriums, built at the peripheries of cities, which had more in common with prisons than with health care facilities.⁴

In the Arab world, mental illness was also subject to religious interpretations and associated with supernatural forces; it was most often believed to be the result of possession by jinns. Although this explanation granted the mentally ill some degree of acceptance, the treatment they received from the public depended on the values of the era; in general, however, they continued to be excluded from society and treated harshly. Yet, as Dr. Ahmed Okasha, a professor of psychiatry and head of the Egyptian Psychiatric Association, has written, the first mental hospitals in the world were built in the Levant and Egypt in the eighth century.⁵ Medical writings by El Razi and Avicenna, in the ninth and tenth century, are considered to be among the first on mental illnesses, identifying "insanity" as a disease of the mind or the brain that affects its functions. Illnesses were classified and their treatment described according to that understanding.

In the fourteenth century, the Qalaoon Hospital in Cairo acquired special fame for its department for mental illness, which operated alongside its other medical departments, thereby serving as an early model for the inclusion of mental health care within the framework of public hospitals, six centuries before our present time. The hospital provided mental health care services to the poor, and the mentally ill were only isolated from the rest of the patients in exceptional cases. The Egyptian historian Al Maqrizi mentions that the sultan himself supported the hospital and would see its mental patients during his visits. However, the following centuries witnessed a major deterioration in the care of the mentally ill. Cairo hospitals lost their status, especially following the confiscation and appropriation by the state of the assets and endowments that had been allocated for the upkeep of these hospitals.⁶ Then, during the British occupation of Egypt, two enormous mental institutions were built, modeled on Western hospitals: Al Abaseyya in 1883, and Al Khanka in 1912; both had a capacity of more than a thousand beds and were constructed on vast areas of land on what was then the periphery of the city.⁷

⁴ World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope" (2001), p. 49, available at <http://www.who.int/whr/2001/en/>.

⁵ Okasha, Ahmed, "Foreign Report: Psychiatry in Egypt," *Psychiatric Bulletin* (1993), p. 17.

⁶ Dols, Michael, "Insanity in Byzantine and Islamic Medicine," *Dumbarton Oaks Papers*, vol. 38, Symposium on Byzantine Medicine (1984), pp. 116–117.

⁷ Okasha, Ahmed, "Psychiatry in Egypt," p. 17.

Positive Developments

With the rise of the human rights movement after World War II, which advocated the rights and basic freedoms of all persons without discrimination and was determined to expose human right violations wherever they occurred, the horrific sufferings of the mentally ill in asylums and shelters began to be revealed. Personal testimonies and reports on conditions behind the walls of institutions were published, in addition to a record of crimes committed inside these institutions.⁸

The release of these reports and testimonies led to the increasing condemnation of the contemporary system of treatment. Research showed that the therapeutic impact of the mental asylums was minimal and that, in fact, the prolonged isolation of patients sometimes exacerbated their illness or led to new problems and disabilities.⁹

The extraordinary discoveries in the fields of neurology and the chemical sciences in the second half of the twentieth century, attended by the development of new medical treatments for mental health and new forms of psychological and behavioral therapies, resulted in a change in attitude toward mental disorders: They came to be considered illnesses akin to other physical ones, the result of a constellation of biological, psychological and social factors—and, importantly, they could be treated and cured like other illnesses.

Thus, as a result of a cumulative series of occurrences—the acknowledgement of the human rights of people with mental illnesses, the growing evidence of the failure of the mental asylum system and modern scientific discoveries—the model for treating mental disorders changed significantly during the second half of the last century. The number of patients in mental asylums decreased as they were instead placed in more open facilities and reintegrated into society. In Italy, a 1978 act to reform mental health care demanded the closure of mental hospitals, replacing them with a comprehensive network of community care services. A number of developed and developing countries

⁸ Many of the violations that came about as a result of incarceration continued over the years, and were documented by several human rights mechanisms. See for example the report of the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, 2005, paragraph 9, UN Doc E/CN.4/2005/51. Some of the violations documented by the Special Rapporteur include: "rape and sexual abuse by other users or staff; forced sterilizations; being chained to soiled beds for long periods of time, and, in some cases, being held inside cages; violence and torture; the administration of treatment without informed consent; unmodified use (i.e. without anesthesia or muscle relaxants) of electro-convulsive therapy (ECT); grossly inadequate sanitation; and a lack of food."

⁹ World Health Organization, "The Mental Health Context," p.17.

have shifted from dependence on the asylum system of exclusion and isolation to providing treatment within the community and at home, through outpatient clinics, general hospitals, emergency departments, mobile medical services, daycare centers and support for families and caregivers.

This is the kind of care that must be available for individuals with mental disorders: responsive to their needs, effective and encouraging self-help. Community-based care should involve the participation of families and caretakers in all aspects of patient support, and motivate the community itself to play a role as well.

II. International Standards for the Protection of the Rights of Individuals with Mental Disorders

The developments in the understanding of mental health and the associated advances in treatment methods led the international community to acknowledge and support these changes. Conferences and meetings on the topic produced a number of international documents and initiatives targeting the protection and promotion of the rights and basic freedoms of mental patients and detailing regulations for their treatment. Those efforts culminated in the United Nations' 1991 "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care."

The UN Principles of 1991, which were adopted by a General Assembly resolution, is a very important document. The twenty-five principles detail the rights of individuals with mental disorders or disabilities, including their right to health. The document also includes an extensive list of commitments related to treatment and care. It presents a firm stance against the stigma of mental illness and discrimination against those who suffer from it, supporting individuals' integration in society and acknowledging the right of all persons with mental disorders to receive treatment and care within their respective communities; all possible efforts must be made to achieve that end.¹⁰

At the same time, the international community was making similar progress in the promotion of rights of people with disabilities. Recognizing the link between mental disorders and disability, it was agreed that the latter occurs when a long-term mental disorder prevents those affected from full and effective participation in their community, on an equal basis with others, because of social factors. As an outcome of this realization, the umbrella of legal protection for the rights of persons with disabilities was extended to include persons with mental disorders or disabilities as well.

¹⁰ Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, UN General Assembly resolution, 46th meeting, 17 December 1991. The principles are reproduced in Appendix 2 of this study.

In 1975, the UN General Assembly adopted the "Declaration on the Rights of Disabled Persons," and in 1983 it announced the Decade of Disabled Persons and the launch of a universal action plan concerning those with disabilities. In 1993, the UN General Assembly endorsed a resolution titled, "The Standard Rules on the Equalization of Opportunities for Persons with Disabilities," which includes a long list of commitments to provide equal opportunities for disabled persons in all fields, such as health care, rehabilitation, education and employment; the document also stresses the importance of the participation of people with disabilities in policy-making and the drafting of legislation that ensures the provision of equal opportunities.¹¹

Recently, the International Convention on the Rights of Persons with Disabilities was adopted by the UN, and it was ratified by the Egyptian government in April 2008. This comprehensive and legally binding treaty seeks to ensure the respect, protection and promotion of the rights and basic freedoms of all persons with disabilities, including mental disability, and ensures their enjoyment of those rights and freedoms without discrimination. The Convention calls on all member states to undertake all necessary measures to ensure equal opportunities for persons with disabilities, including legal and special measures in all aspects of life, in order to protect and compensate those with disability for any deprivation they might have suffered.¹²

III. Mental Health Status Worldwide: Prevalence and Burden

WHO considers that people's enjoyment of mental health is not limited to the absence of mental illness or disorder but is a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."¹³

Still, it is difficult to reach a precise definition of mental disorder because, according to WHO, it "is not a unitary condition but a group of disorders with some commonalties."¹⁴ For example, mental disorders include short-term problems as well as long-term ones such as schizophrenia, depression and

¹¹ The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, UN General Assembly resolution, 48th meeting, 20 December 1993, available at <http://www.un.org/esa/socdev/enable/dissre00.htm>.

¹² Convention on the Rights of Persons with Disabilities, available at <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>.

¹³ World Health Organization, "What is mental health?," available at <http://www.who.int/features/qa/62/en/index.html>.

¹⁴ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (2005), p. 20, available at http://www.who.int/mental_health/policy/essentialpackage2/en/index.html.

Alzheimer's disease. The Convention on the Rights of Persons with Disabilities recognizes that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participating in society on an equal basis with others."¹⁵ Some examples of mental disabilities that result from mental disorders are an inability to obtain or to keep a job, inability to maintain adequate social relations and inability to carry out daily activities such as maintaining personal hygiene or health.¹⁶

Contrary to general belief, mental disorders are not rare. WHO estimates that about 450 million people in the world suffer some form of mental disorder, that one in every four families has at least one member with a mental or behavioral disorder and that one in every four people is likely to develop a mental disorder at some point in his or her lifetime.¹⁷

The residents of developing countries are especially vulnerable to mental disorders. These regions have a high population growth rate and especially youthful populations, and it is the young who are most at danger of developing mental and behavioral disorders. Other factors include widespread poverty, high unemployment, low level of education and deprivation—indeed, the probability of developing a mental disorder doubles for those living in poverty.¹⁸ Developing countries also experience political, economic and social changes that can lead to increased urban migration, resulting in the expansion of slum areas, homelessness, overcrowding, and greater violence. These are all risk factors for mental disorders because they disrupt the traditional social fabric and lead to the collapse of supportive social and family networks.¹⁹ To make matters worse, developing countries also tend to have a serious shortage of mental health services.

Besides pain and suffering, mental disorders also result in a major economic burden. In 2001 mental and behavioral disorders constituted nearly 12% of the global burden of disease;²⁰ this is expected to increase to 15% by the year

¹⁵ Convention on the Rights of Persons with Disability, preamble.

¹⁶ World Health Organization, "Mental Health and Substance Abuse," available at http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1827_8056.htm.

¹⁷ World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope," p. 20.

¹⁸ World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope," p. 40.

¹⁹ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached" (2006), p. 9, available at www.emro.who.int/dsaf/dsa702.pdf.

²⁰ World Health Organization, "The Mental Health Context," p. 13. Burden of disease measures the gap between the current health status and an ideal condition where a person lives a long life free of illness and disability. World Health Organization, "Global Burden of

2020.²¹ The economic burden is composed of direct costs, such as the patient's expenditure on treatment and the provision of medical services. The indirect costs include the loss of jobs and decreased productivity, not only of the patient but also of his or her family members or caretakers. Estimates show that the indirect economic burden in developed countries is two- to six-fold the amount of the direct one; i.e., the cost of not treating someone is, in the end, far greater than the cost of treating him/her "attributable to the increased duration of untreated illness and associated disability."²² It is likely that this ratio is higher in developing countries where direct treatment costs tend to be lower.²³

Despite the evidence that the treatment of mental disorders is beneficial for society at large, mental health is one of the most neglected areas of public health.²⁴ The mental health allocation in most countries is less than 1% of the total health expenditure; in more than 40% of countries there is no mental health policy, and more than 30% of countries do not have mental health programs.²⁵ With regard to mental health legislations worldwide, more than half were drafted over twenty years ago, while 20% of them date back to the 1960s.²⁶

Moreover, in spite of the increasing number of people with mental disorders in the world, only a minority receives treatment; even those who do receive treatment rarely receive the best available.²⁷ In developing countries there is an alarming mental health treatment gap; i.e. the discrepancy between the number of people who need therapy and those who actually receive it. A 2006 report by WHO found that the treatment gap in the Middle East reaches 95% in the case of depression, 80% in the case of schizophrenia and between 60% and 98% for epilepsy.²⁸

Disease 2000: Version 2 Methods and Results" (2002), available at www.who.int/healthinfo/paper50.pdf.

²¹ World Health Organization, "The Mental Health Context," p. 13.

²² *Ibid.*, p. 14.

²³ *Ibid.*

²⁴ Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, paragraph 6.

²⁵ World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope," p. 3.

²⁶ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 1.

²⁷ Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, paragraph 6.

²⁸ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached," p. 10.

IV. Mental Health Situation and Services in Egypt

While no national statistical studies exist on the prevalence of mental disorders in Egypt, some smaller studies provide useful indications. A 2004 survey estimated that almost 17% of adults in Egypt had mental disorders.²⁹ Another study in 2001 found that 50% of students have symptoms.³⁰ An earlier inquiry revealed that 4.5% of the elderly population in 1988 suffered from dementia and 2.2% from Alzheimer's.³¹

With regard to funding, mental health expenditure in Egypt is no more than 2% of the total government expenditure on health. More than half of that allocation (about 59%) is spent on mental health hospitals,³² most of which are based in big cities and urban areas, and with a total working capacity of 6,000 beds.³³ The occupancy rate of the five major hospitals affiliated with the General Secretariat for Mental Health (Abbaseya, Heliopolis, Helwan, Khanka and Maamoura,) reached about 80% in the month of July 2008.³⁴ The number of patients admitted to all fifteen mental health hospitals in total in 2004 is estimated at about 23,047 patients.³⁵

In addition to those specialized government hospitals, public hospitals in a number of governorates have departments devoted to mental health and hold a total of about 600 beds. In addition, there are psychiatric departments in nine medical schools of public universities, comprising about 200 beds. As for private hospitals, their overall capacity does not exceed a total of 750 beds. Thus, the Ministry of Health is by far the main provider of mental health services in Egypt.³⁶

Egypt has sixty-two mental health outpatient clinics, only two of which specialize in treating children and adolescents. In 2004, 176,133 people visited these clinics.³⁷ There is only a single clinic that provides follow-up services for patients receiving community-based treatment, only one mobile clinic, and

²⁹ Ghanem, et al., quoted in World Health Organization, "The Mental Health Atlas" (2005), p. 176, available at: http://www.who.int/mental_health/evidence/mhatlas05/en/index.html.

³⁰ World Health Organization, "The Mental Health Atlas," p. 176.

³¹ Ibid.

³² World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt" (2006), p. 11, available at http://www.who.int/mental/evidence/who_aims_report_egypt.pdf.

³³ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached," p. 111.

³⁴ Website of the General Secretariat for Mental Health: <http://mentalhealthegypt.com>.

³⁵ World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt," p. 11.

³⁶ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached," p. 111.

³⁷ World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt," p. 10.

two day-care centers.³⁸ According to reports by WHO, there are no residential facilities. As a whole, Egypt suffers a lack of community-based and preventive mental health services.³⁹

As for mental health providers, about 600 psychiatrists practice in Egypt, most of whom work in Cairo, Alexandria and other big cities. These psychiatrists are assisted by approximately 1,500 nurses, 241 social workers and 61 psychiatric social workers.⁴⁰

In the past few decades, mental health policies and programs in Egypt have been drafted with the aim of promoting available services and shifting from institutionalization to community-based treatment. Egypt was one of the countries chosen by WHO in the years 1975–1981 to develop strategies to expand the scope of mental health care services and to develop necessary programs for the integration of mental health care within the primary health care system. In 1986, the national mental health program moved towards implementing these strategies, with the involvement of concerned nongovernmental sectors.

Egypt's mental health policy formulated in 1978 stated as one of its objectives the "improvement of the mental health of individuals through the provision of services to those who need it and through the provision of community care and family support."⁴¹ A 2003 amendment added new objectives: expanding community mental health services, reforming mental hospitals to provide more comprehensive care and developing a mental health component in primary health care.⁴²

Additionally, in 1997, under the auspices of WHO, ministers of health in the Eastern Mediterranean region, including Egypt, announced a work plan to promote mental health. The plan consisted of ten points, the first of which was the provision of comprehensive mental health care services, the integration of mental health into primary care and the development of emergency services within communities.⁴³

³⁸ World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt," p. 10.

³⁹ *Ibid.*, p. 7.

⁴⁰ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached," p. 111.

⁴¹ World Health Organization, "Mental Health Atlas," p. 176.

⁴² World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt," p. 8.

⁴³ World Health Organization, "Mental Health in the Eastern Mediterranean Region: Reaching the Unreached," p. 10.

Despite the continued emphasis on the importance of integrating mental health care within primary care, efforts remained inadequate and results were consequently extremely limited. According to the 2006 WHO report, only 5% of primary care physicians received short refresher training courses on mental health. In addition, fewer than 20% of primary care physicians know the protocols that would help them in the diagnosis and management of mental disorders, and thus only a few of them identify and refer patients to mental health professionals; most physicians have never dealt with mental health professionals at all.⁴⁴

In sum, all studies and reports agree that Egypt is extremely deficient in financial and human resources allocated to mental health, and thus the provision of mental health care services falls far short. Mental health hospitals continue to be the main providers of most mental health care services, which are thereby restricted to big cities. Primary health care services do not include mental health care, and primary care practitioners do not have the knowledge to refer those in need to mental health professionals or to provide essential psychiatric medications. There is also weak collaboration between the official health sector and other community sectors, including civil society organizations.⁴⁵

V. The Role of Legislation in Protecting the Rights of Mental Health Patients

People with mental disorders constitute one of the most vulnerable groups in society and are at great risk of encountering violations of their basic rights. Mental illness can affect individuals' thinking, emotions and behavior in a way that can render them unable to protect themselves and their interests. The stigma associated with their illness, and the attendant discrimination, makes it very possible that their rights will be ignored, even during the process of their treatment. For these reasons, the law is needed to safeguard the rights and interests of individuals with mental disorders. On the other hand, there are exceptional circumstances when an individual's mental illness is so severe that medical intervention is necessary even against the will of the patient, in order to secure his or her safety and the safety of others. Legislation thus must balance the rights and personal freedoms of those who are in such circumstances, including their right to treatment and care, with the requirements for the health and safety of others.

As has been discussed at length above, people with mental disorders are often subject to abuse, even in health care settings and especially in asylums and

⁴⁴ World Health Organization, "WHO-AIMS Report on Mental Health System in Egypt," p. 16.

⁴⁵ *Ibid.*, p. 22.

shelters. A mental health law, then, must set down a number of fundamental principles related to health care, such as treatment in the least restrictive environment, respect for patients' privacy, necessity of informed consent to treatment in cases where the mental capacity of the patient permits it, provision of appropriate safeguards in cases of involuntary treatment (including the right to appeal those decisions and procedures) and the protection of the rights of individuals in mental institutions.⁴⁶

However, it is important to mention that such legislation should not be limited to the field of health or the regulation of treatment but must also ensure the rights of persons with mental disability in all aspects of their lives, such as housing, education, work and social security, as well as provisions to guarantee equal opportunities in those and other fields.

VI. The Need for a New Mental Health Law in Egypt

The current law, as is indicated by its title—Law no. 141/1944, Law for the Institutionalization of Those with Mental Illnesses—is concerned only with regulating the admission of the mentally ill to mental health hospitals. The law reflects the attitude prevalent at the time of its adoption, more than sixty years ago, that there was no cure for mental illness. Thus, the concern was to protect society from mental health patients by locking them up behind the walls of institutions, which were places of incarceration rather than hospitals for treatment. The term *custody* appears throughout the text of the law, and patients are referred to sometimes as *suspects*.

Although its purpose was to govern the institutionalization of mental health patients, the law includes various loopholes that prevent it from achieving this purpose. For example, the stipulations for the involuntary admission of patients are not well specified and permit the admission of persons without medical necessity. Furthermore, the procedures for involuntary admission are complicated and do not take into consideration emergency cases where they would be difficult to follow; this frequently has led both doctors and family members to bypass regulations altogether. Institutionalization orders are reviewed only after a long period, in some cases three months after admittance, and the law does not give patients the right to appeal the decision. On the other hand, families are granted excessive authority, which permits them to keep their relatives in hospitals despite the lack of medical necessity and creates additional risks for the exploitation of patients in the

⁴⁶ World Health Organization, "Mental Health Legislation and Human Rights" (2003), p. 2, available at http://www.who.int/mental_health/policy/essentialpackage1/index1.html.

absence of any protection. The current law also does not include any provisions regulating treatment methods inside the hospitals.⁴⁷

For the most part, however, Law no. 141 is simply not applied in practice. The complexity and inappropriateness of the procedures are the primary obstacles. As a doctor who works in a governmental mental hospital told researchers at the Egyptian Initiative for Personal Rights (EIPR): "If I want to admit a patient according to Article 4, his family must have two medical certificates written on Form 58 and prepared by doctors working outside the hospital. When people come from remote areas with a patient who is out of control, do you think I can tell them, 'Take him to two other doctors and have them write their medical opinions on this form?'"

Another doctor commented on the bureaucratic difficulties that remain even after the admission of a patient: "If I want to change a voluntary admission into an involuntary one, what can I do? Will I get him two medical certificates from doctors outside the hospital?"

A third doctor complained of the inadequacy of the review mechanisms for hospital admissions: "If I admit a patient against his will and report to the Review Board,⁴⁸ it will take them a long time before they actually come. Suppose that the patient improves, the symptoms have changed and he is no longer dangerous—what then would be my legal situation?"

VII. New Mental Health Law

1. The drafting process

The General Secretariat for Mental Health at the Ministry of Health and Population began drafting a new mental health law in 2006, which was inspired by a number of legislations in other countries, in addition to the guiding principles issued by WHO on mental health, human rights and legislation. Mental health experts, legislators, representatives of human rights organizations and the media were invited to comment upon the initial draft, and several amendments were introduced on the basis of those discussions; a second version was then posted on the website of the Secretariat and additional suggestions were solicited.

In August 2007 the General Secretariat for Mental Health formed the Patients' Rights Committee to advise both the Secretariat and hospitals regarding the

⁴⁷ See Appendix 1 of this study for Law no. 141/1944.

⁴⁸ The Mental Illness Review Board is an agency affiliated with the Ministry of Health and Population, and empowered by the current law to investigate the institutionalization and release of people with mental disorders and to authorize and inspect mental health hospitals.

rights of patients, and to organize seminars and training workshops on the issue; the committee also receives reports from subcommittees in governmental hospitals. The Patients' Rights Committee is made up of three psychiatrists at the Al Abaseyya mental hospital, two nurses, a professor of psychiatry at Ain Shams University, a State Council judge, a chief prosecutor, a lawyer and a journalist who focuses on issues of mental health, as well as a representative from the EIPR to provide a human rights perspective and a patient to present the viewpoint and interests of patients. The committee played an important role in further revising the bill.

The draft was next presented to the Fatwa and Legislative Department (*idarat al fatwa wa al tashria'*) of the State Council for an additional legal review, which introduced a number of further changes, and in August 2008, the Minister of Health issued Decree no. 340/2008 ordering the formation of a committee for the final review of the mental health act. The committee included four professors of psychiatry, Ahmed Okasha, Mohamed Fakhr El Islam, Emad Hamdi Ghaz and Alaa El Din Soliman; representatives from the General Secretariat for Mental Health, Dr. Moody Zaki and Dr. Ahmed El Beheiry; a State Council judge; and a member of the EIPR to represent the Patients' Rights Committee. This group made still more changes, bringing the bill to its current form. The bill was presented to the Cabinet, which endorsed it in November 2008, and then referred to Parliament.

2. Positive aspects of the bill

Compared to the existing law, this mental health bill has many advantages. It contains several provisions to ensure that people with mental disorders and mental health issues are addressed with due consideration for the human rights perspective. The bill stipulates the establishment of a National Council for Mental Health, consisting of a multi-disciplinary membership to undertake the thorough supervision and monitoring of mental health institutions. Affiliated with this main body are a number of local councils in the different governorates—an acknowledgement that a single review mechanism, such as under the current law, is not sufficient. The proposed law also stipulates that national and local councils include members of human rights and other civil society organizations as well as representatives of patients and their families.

One area of care that the new law hopes to clarify and improve is that of involuntary admission to mental health facilities. The bill specifies the circumstances that permit the admission of patients with mental disorders to hospitals against their will, in accordance with international professional guidelines, and simplifies procedures for involuntary admission in order to enable urgent intervention in emergency cases. While the supervising

physician is permitted to extend a stay of involuntary admission up to three months, the bill mandates that reevaluation is required after that period; patients and their families have the right to appeal the decisions. The legislation thus abides by the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which state that persons in mental hospitals enjoy the same rights and guarantees as other detainees, such as prisoners. The objective is to protect these individuals from abuse of power, arbitrariness or oppression.

The bill stresses the right of informed consent to treatment for patients whose mental capacity permits, even if they have been involuntarily admitted to a hospital. This provision is crucial to ensure and encourage patients' autonomy, and it corrects the prevalent perception that every person with a mental illness is incapable of making decisions. In cases of voluntary admission, the bill prohibits treating patients against their will except in emergency situations.

The draft also details the circumstances under which involuntarily admitted patients can receive involuntary treatment and obliges doctors to document and periodically review their treatment plan with a view to improve medical performance and ensure proper follow up rather than simply continue the same routine. The current bill also introduces instructions for the involuntary treatment of patients outside hospitals. This system could contribute to a reduction in long-term hospital stays, which can sometimes result in the worsening of a patient's condition. The bill also prohibits the solitary confinement or restriction of patients without abiding by certain regulations; the hope is to reduce the employment of these measures, secure the safety of patients to whom they are applied and bar their use as punishment.

Among the most important aspects of the proposed law is that it includes a bill of rights for mental health patients inside institutions and states punitive measures in case of their violation. Among the rights listed are the right to treatment, to quality health care in a decent setting, to protection from abuse and exploitation of any form, to confidentiality of the patient's private information, to privacy, to consent to treatment, to information regarding the patient's own condition, to communicate with the outside world and to appeal any procedures undertaken. The bill stipulates that patients and hospital workers must be informed of these rights and calls for the creation of a Patients' Rights Committee in each institution.

3. EIPR recommendations for the new mental health bill

The EIPR welcomes the many positive aspects of the mental health bill. However, the proposed legislation still has gaps that prevent it from

completely fulfilling the Egyptian government's legal obligations with respect to mental health. The EIPR recommends that these issues be reviewed during the discussion of the bill in Parliament and, after it becomes law, addressed in the policies, programs and action plans for its implementation.

a. Scope of legal protection for people with mental disorders

Article 1 of the first chapter of the bill specifies that the law is to apply only to patients in mental health institutions, i.e., mental health hospitals and mental health departments inside public and private medical facilities, but not private clinics.

This restriction to patients in mental institutions assumes that they are the ones most likely to have their rights violated. Although this is true to a large degree, people with mental disorders can be subject to stigma, discrimination and exploitation anywhere. A law drafted especially for the protection of the mentally ill should extend its protection to all such individuals, not only those receiving treatment in mental and other institutions.

Excluded from the scope of the bill's protection, then, are individuals attending outpatient clinics or primary health care centers, or receiving treatment outside hospitals. Treatment might in the future be available in rehabilitation or residential centers, but it is not regulated by the proposed legislation. While the Law for the Regulation of Medical Institutions (no. 51/1981) permits private clinics to hold a number of inpatient beds (three maximum), and special treatments such as electroconvulsive therapy are sometimes performed here, patients in private clinics will not be protected by the new law.

When representatives of the EIPR discussed this point with the General Secretariat for Mental Health, officials replied that Egyptian laws normally regulate a delineated scope of application rather than specific groups or communities. They added that other laws already in existence regulate private medical institutions and the new law should not contradict them. Furthermore, the General Secretariat argued that the scarcity of available resources would make it difficult for the government to oversee all private institutions.

However, those rationalizations and difficulties should not prevent the provision of complete legal protection to all persons with mental disorders. A new precedent was set by the amendments to the Child Law that were approved by Parliament in June 2008, extending the scope of application to all children wherever they are, with no specification of location. The same will apply to the new law on protection of the rights of persons with disability that is currently being discussed in the cabinet. In addition, efforts should be made

to resolve conflicts between laws and obstacles to implementation rather than use them to rationalize the exclusion from protection of some people with mental disorders—wherever they may be: at home, at work, at school or in the hospital.

The EIPR therefore recommends amending Article 1 of the bill to read as follows: "This law applies to all persons with mental disorders, including persons being evaluated for admission into mental health facilities."

b. Right to community integration

As mentioned above, since the middle of the previous century, the practice of isolating persons with mental disorders in institutions has been increasingly criticized. Today, community-based treatment and community mental health services are widely considered the most humane and most successful strategy, and the right to community integration has come to be considered one of the fundamental rights of people with mental disorders. This kind of treatment respects the dignity and autonomy of persons with mental disorders and provides them with better health care as well as employment opportunities, a familiar living environment and the chance to contribute to their community. The presence of those with mental disorders within the community and the promotion of community efforts in battling mental illness also help to combat stigma and discrimination.⁴⁹

While WHO emphasizes that the shift away from institutional isolation should be an essential component of the reform of the mental health care sector, the organization warns that this does not happen merely through the discharge of patients from mental institutions. The shift can only occur gradually and simultaneously with the establishment of a solid network of community services. WHO also puts forth three main principles necessary for success: the avoidance of unnecessary hospital admission through the provision of community mental health care services; adequate rehabilitation of chronic inpatients after they reenter the community; and the promotion of the community's role in providing support to patients.⁵⁰

Although the new legislation regulates involuntary admissions in hope of reducing their prevalence and preventing long, unnecessary institutional stays, and even introduces community treatment orders—all necessary measures in and of themselves—the law will not be successful unless sufficient community mental health care services become available.

⁴⁹ Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, paragraph 85.

⁵⁰ World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope," p. 54.

The current situation presents a real crisis for the governmental mental health institutions in Egypt, whose financial and human resources are already inadequate. This issue is repeatedly mentioned by doctors and other health care professionals. As one told the EIPR:

"We have many patients who have improved, but their families do not want them, or they do not have a place to stay or someone to take care of them. If we discharge them, they will suffer and their condition will deteriorate, or they will relapse to an even worse condition . . . but it is unfair that they should spend the rest of their lives here. And so we don't know what to do with them."

As mentioned, the shift to community care has been one of the main objectives of mental health policies and programs in Egypt, but for more than two decades its implementation has failed. The passage of a new law for mental health is a good opportunity to achieve the long-sought-after objective of community integration.

The new mental health act could aid the progression from dependence on institutional care to the desired community care, as follows:

1- Asserting the commitment of the state to provide mental health care services within the network of primary health care. This would improve accessibility to mental health care services and its outreach to deprived sectors in rural and remote areas through the use of already existing resources, as Egypt has a wide network of primary health care units and social care services. In addition, the provision of mental health care services through primary care units will help in the early identification and treatment of mental disorders and will reduce the need for involuntary admissions to hospitals. Global estimates indicate that about 20% of those who visit primary care units have some form of mental disorder⁵¹ that escapes identification because of lack of experience and training available to doctors and staff.

2- Asserting the commitment of the state to provide and make available community care services. The needed services should be described in detail. Mental health legislation in Jamaica, for example, stipulates that:

"The community mental health service shall undertake the provision of:

- a) services to outpatient psychiatric clinics in health centers and general hospitals;

⁵¹World Health Organization, "World Health Report 2001: Mental Health: New Understanding, New Hope," p. 20.

- b) rehabilitation services for persons after their discharge from a psychiatric facility;
- c) supervised home care and support for persons with mental disorders; and
- d) services for the promotion of mental health."⁵²

3- Asserting the commitment to the principle of using the "least restrictive environment" in the treatment of the mental health patients as well as giving priority to community care and resorting to involuntary admission only after trying all other options. Argentine law states, "Hospitalization shall be a last resort, all other treatment options having been exhausted. . . . In all cases, length of stay shall be as short as possible."⁵³ Portuguese law also avers, "The provision of mental health care is undertaken primarily at community level, so as to avoid the displacement of patients from their familiar environment and to facilitate their rehabilitation and social integration."⁵⁴

It is important that the regulation of hospital admissions be based on the principle of "least restrictive environment." For example, Article 9 of the bill before Parliament, which concerns voluntary admission and permits mental patients above the age of eighteen to request hospital admission, can be amended as follows: "Upon hospital admission the doctor in charge should examine the patients and approve his/her admission after ensuring that less restrictive forms of treatment proved unsuccessful or inappropriate for the condition of the patient."

c. Safeguards in cases of involuntary admission and treatment

Involuntary admission and treatment are significant issues; they represent a limitation to personal freedom and the right to choose, and they can be abused. For these reasons, international standards have specified the necessary conditions that permit involuntary admission and treatment as well as certain measures to ensure the protection of rights and the prohibition of violations.

The provisions of the new law clearly reveal that its authors sought to respect those conditions and measures. Some aspects, however, need further development:

⁵² World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 30.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

Criteria for involuntary admission

Article 12 of the bill specifies the conditions that permit the involuntary admission of patients to any mental health institution: clear signs of a severe mental disorder, the treatment of which calls for admission into a mental health institution in view of a possible and pending deterioration of the mental state or because the patient's symptoms constitute a serious and pending threat to the safety, health or life of the patient or others. This provision is generally in accordance with international recommendations.⁵⁵

Still, when deciding on the diagnosis of a mental disorder, it is important to abide by the full content of Principle 4 of the UN Principles. That principle states that a diagnosis shall be made in accordance with internationally accepted medical standards; that it should never be based on political, economic or social status, or membership in a cultural, racial, political or religious group, or for any other reason that is not directly linked to the mental health of that individual; that family or professional conflicts, or non-conformity to moral, social, cultural, or political values or religious beliefs, should never be a determining factor; that past treatment or hospitalization should not be seen to determine future mental illness; and that no person or authority shall classify the person or indicate that he or she has a mental illness except for purposes relating to the mental illness or its consequences.

To ensure the principle of treatment in the least restrictive environment and to achieve the objective of reducing cases of involuntary admission, it is useful to add to Article 12 the need to confirm that the desired treatment outcome from involuntary admission cannot be achieved outside the hospital. The law should also prohibit hospital admission for purposes other than treatment. We also suggest the inclusion of the basic guidelines mentioned in Principle 4 when defining a "mental patient" in Article 3 of the first chapter of the bill.

Treatment of persons with mental disorders

As mentioned above, the proposed law differentiates between procedures of involuntary admission and those of involuntary treatment and holds the doctor responsible for determining the mental capacity of the patient (Article 31). The law also protects the right of voluntary patients in mental institutions to consent or reject the prescribed treatment (Article 31); doctors are obligated to obtain free informed consent from the patient before starting treatment, and to record the treatment plan and the patient's consent in the medical file. At the same time, the law seeks a balance between the provision of that right

⁵⁵ See Principle no. 16 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, Appendix 2.

and the need to intervene in emergency cases, and thus emergency treatment is permitted for twenty-four hours (Article 34).

Doctors must review a decision of involuntary treatment within a one-month period at the latest and order an independent evaluation if that treatment extends for more than three months (Article 32).

The procedures described in the current bill are, to a great extent, in accordance with human rights and professional principles. However, many details that should be enshrined in the law are left to the Implementing Regulations, which are issued by ministerial decree and carry less legal authority. For example:

- The definition and necessary conditions for an informed consent to the treatment offered to the patient, which are: "consent obtained freely, without threat, or incentives, and after appropriate disclosure to the patient of sufficient information in a manner and language understood by the patient on diagnosis, purpose, method, duration, expected benefits, and side effects of prescribed treatment as well as alternative treatment methods."⁵⁶
- The definition of the criteria by which to assess whether a particular case requires emergency measures and when treatment can be given without the consent of the patient. The law must state explicitly that the doctor has to provide evidence that regular procedures are likely to result in a delay that might cause harm to the patient or others. The same patient should not be subjected to a second round of emergency treatment immediately following the end of the first round. It is also necessary to specify the types of treatment permitted during this exceptional period: Emergency treatment should not include the use of electroconvulsive therapy, long-acting medications or any other treatments that are irreversible, such as psychosurgery.⁵⁷
- The detailed definition of the procedures for involuntary treatment, and how such procedures should be separate from those concerning involuntary admission as stipulated by international medical guidelines.⁵⁸ Those guidelines require that the treatment plan be

⁵⁶ Principle no. 11 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

⁵⁷ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 60.

⁵⁸ Paragraph 6 of Principle 11 of the UN Principles specifies the conditions for involuntary treatment "(a) The patient is, at the relevant time, held as an involuntary patient; (b) An independent authority, having in its possession all relevant information, including the

approved by an independent review, and that the patient and his or her representatives have the right to appeal the decision of involuntary treatment.

Special and intrusive treatment

Article 32 of the proposed law prohibits subjecting a patient to any of the treatments used in psychiatry before informing him or her and obtaining his or her consent, while allowing the doctor to use involuntary treatment in some cases provided the procedures for involuntary treatment are followed.

However, the law does not differentiate in that respect between regular and special or intrusive forms of treatment such as psychosurgery, hormonal treatment or any other form of treatment that is irreversible; such a distinction is recommended by international medical standards.⁵⁹ Furthermore, the law does not distinguish between the procedures for obtaining consent to such treatment from voluntary patients and from involuntary ones.

The UN Principles strictly prohibit the use of psychosurgery or any other form of irreversible treatments on an involuntary patient. It permits the use of such treatments only on voluntary patients, after the informed consent of the patient is obtained and after the satisfaction of an independent review body that the consent of the patient is sound and that this treatment will best meet his or her needs.⁶⁰ The UN Principles proscribe the use of sterilization as a treatment for mental illness.⁶¹ Although some of these intrusive treatments are not used in Egypt currently, guidelines must still be put in place in case they are practiced in the future.

To summarize, the law must explicitly prohibit the performance of psychosurgeries or any other forms of intrusive, irreversible treatment on involuntary patients in mental institutions or on any other patient unable to give informed consent. The law must specify the standard procedure to be undertaken to protect patients capable of giving an informed consent who undergo any of those treatments. Approval must be obtained from the local

information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs."

⁵⁹ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 62.

⁶⁰ UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health, Principle 11, paragraph 14.

⁶¹ *Ibid.*, Principle 11, paragraph 12.

council for mental health after it has examined the patient to ensure his or her capacity to consent, to verify the patient's awareness of possible consequences and side effects, and to confirm that the prescribed treatment is the best for the condition of the patient. The law also should declare the absolute prohibition of sterilization as a treatment for any mental disorder. Such a prohibition is absent in the bill's present form.

Mechanisms of review and supervision

International standards call for an independent review committee to examine all decisions of involuntary admission; if approved, the decision must still be periodically reviewed. This committee—which may be judicial, semi-judicial or otherwise—must be independent, established by law and function according to its provisions. Patients are entitled to submit complaints to the committee, and they, their personal representatives or any other person concerned have the right to appeal its decisions to a higher court, with all procedural guarantees provided.⁶² A multidisciplinary committee or agency should undertake supervision and administrative matters, such as regular inspection of institutions, monitoring of patients' conditions, recording of statistics, updating of records, providing guidance, making recommendations and so on.⁶³

The proposed legislation calls for the formation of a National Council for Mental Health at the Ministry of Health and a number of subsidiary local mental health councils in the health directorates at the level of governorates (Article 4) to monitor and supervise; this corrects the problem in the current law, which asked a single body to undertake this task for the entire country. The formation and mandate of these new councils are outlined in the new bill. Another positive change is that the bill dictates that these mental health councils be composed of a wide spectrum of members: specialized doctors, members of the judiciary and social workers as well as representatives from the National Council for Human Rights and civil society organizations that work with patients and their families. Mental health institutions are instructed to form their own offices affiliated with the mental health councils. These offices will have autonomy from the management of the institution and serve to facilitate the work of the councils and help them be more effective (Article 8, paragraph 5).

As outlined earlier in this report, the mental health councils will review involuntary admission and treatment decisions as well as review hospital

⁶² UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health, Principles 17 and 18.

⁶³ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 71.

licenses, and are responsible for the supervision and inspection of those institutions. The composition described in the draft law for those councils weighs heavily towards officials from or affiliated to the government: most of the members are government employees, chosen on ground of their positions or by their seniors or their respective administrative bodies. Moreover, the National Council for Mental Health is chaired by the Minister himself, who should, in fact, be monitored by the Council. This structure thus permits the government to act as its own watchdog and is contrary to the required independence of the councils, weakening their ability to properly monitor services.

The EIPR recommends that the councils primarily be made up of independent figures, and that its composition expand to include members of unions and professional associations, public figures, additional representatives from human rights organizations and more representatives of patients and their families. There should also be no conflict of interest between their posts inside the councils and any other professional commitments they have, especially with regard to the members from the medical community who, in addition to their membership in the councils, may be responsible for one of the hospitals whose inspection the council undertakes. In addition, an appropriate mechanism should be developed to ensure the periodic renewal of membership at reasonable intervals.

It is equally important that the law specify the time frame during which local councils should review all cases of involuntary admission and treatment, that this review be undertaken between short time intervals and be documented in records. Cases of voluntary admission should also be reviewed to ensure the soundness of the medical evaluation and the fulfillment of criteria for voluntary admission, especially free informed consent.

Right to submit complaints and appeal

Article 20 of the mental health bill entitles the patient and his or her relatives or lawyer to submit complaints and appeals regarding decisions of involuntary admission and treatment to the National Council for Mental Health, and calls for the Council to respond in a timely fashion. One of the advantages of this article is that it extends the right of appeal to include the Patients' Rights Committees, permitting them to contest the decisions of involuntary admission or treatment on behalf of patients, thereby protecting those who lack the support of family or other caretakers. The same article permits complainants to contest all administrative decisions in court and provides them with all procedural guarantees in that regard.

Yet the proposed law does not actually specify what these "procedural guarantees" are. The Implementing Regulations of the law will have to clarify

those guarantees, which should be compatible with international standards: the patient has the right to choose his or her lawyer; the state must provide a lawyer free of charge if the patient cannot afford to pay; the patient is entitled to copies of all records and independent reports regarding his or her mental condition; and the patient has the right to participate in the Council's sessions on his or her appeal and to call witnesses.

Children and minors

Article 11 of the bill is the only article that addresses children with mental disorders. This article permits the admission of children under the age of eighteen into hospitals, and allows their discharge, upon the request of parents or guardians. However, the article does not make it obligatory for the mental health council to be informed of the admission of the child into the mental institution.

International guidelines indicate that mental health legislations should reduce the admission of children to institutions, in view of their vulnerability and the negative impact of isolation on their natural development. It is therefore imperative that the law encourage their treatment within the community through primary care or community care facilities.⁶⁴

Reducing mental hospital admission for children is particularly important in Egypt, given the scarcity of specialized institutions for children that take into consideration the requirements for their physical and psychological development (e.g., education, interaction with peers and age-appropriate activities). Accordingly, the article on children and minors should be amended to say, "Children should only be admitted to hospitals as a last resort and after exploring all less restrictive treatment alternatives." Further to this, the relative maturity of minors, especially those capable of making sound decisions related to their admission or treatment in institutions, has to be taken into consideration. This would be stipulated as follows: "The opinions of minors have to be taken into consideration regarding consent to admission and treatment depending on their age and their degree of maturity."⁶⁵

The Convention on the Rights of the Child, ratified by the Egyptian government in 1990, calls for the consideration of the rights of children in institutions to have their cases periodically reviewed.⁶⁶ Therefore, the new law must state that the mental health council is to be informed of all cases of

⁶⁴ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 84.

⁶⁵ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p.84.

⁶⁶ Convention on the Rights of the Child, 1989, Article 25.

children admitted to hospitals and that the council is obliged to review their condition periodically, over specified time intervals, to confirm the continued need for the hospital stay and to ensure their rapid discharge as soon as their condition permits.

The law must also firmly prohibit the use of electroconvulsive therapy on children as well as all forms of special treatment, psychosurgery and sterilization.⁶⁷

An additional provision of the law should address the insufficient services for children and require the state to provide and make accessible specialized care for them. Children should also be prohibited from being admitted to adult facilities.

Admission by court order

Chapter three of the bill under consideration is concerned with cases where a person charged with a crime is referred to a mental health institution for evaluation of his or her mental condition.

The issue of institutional admission by court order constitutes a serious concern. Some individuals have spent more than double the maximum years of their sentence inside mental hospitals; some have committed only minor violations but remain in institutions for several years.⁶⁸ Although medical reasons might have been cited for their admission, the deficiency of the system as a whole and exaggerated security concerns might keep these people incarcerated indefinitely, resulting in the relapse of their original disorders, repeated attempts of escape and occasionally suicide.⁶⁹

The first draft of the proposed law had included a provision calling for the reevaluation, at least once every three months, of the mental state of patients committed to institutions by court decision; these evaluations were to be submitted to the local council for mental health to review and decide whether continued inpatient treatment was necessary. This early draft also stated that the patient or his or her custodian is entitled to receive a copy of this evaluation. However, this paragraph was deleted from the final draft of the bill, without explanation from the General Secretariat.

The chapter of concern in the Criminal Procedure Code, which carries the shameful title "Insane Patients", regulates the treatment of those admitted by

⁶⁷ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 84.

⁶⁸ EIPR Field visit to involuntary admission wards in Khanka mental hospital, 19 April 2008.

⁶⁹ See for example news stories published in Egyptian newspapers *Al Masry Al Youm*, 20 July 2008, p. 3; *Al Osbou'*, 14 June 2008, p. 23; and *Al Fagr*, 15 June 2008, p. 24.

court order. The title of the chapter itself indicates the need to develop an effective way of dealing with these individuals, taking into consideration their human rights as well as the safety of others. This includes not only periodic mental evaluation and procedures for the termination of admission but also, crucially, special programs to prepare inpatients for discharge and reentry into society.⁷⁰

d. Bill of rights and freedoms

Article 45 of the proposed law includes a bill of rights for mental patients receiving treatment in institutions. The law states that these rights must be respected and that their violators will be punished. However, it is necessary that this list be extended to include all fundamental freedoms and rights granted by international conventions to those with mental disorders, and expanded to include all such persons, whether inside or outside mental institutions.

The bill of rights neglects numerous important rights, in violation of the first UN Principle, possibly because of the law's restriction to patients inside mental institutions. Missing, for example, is the right to protection from all forms of discrimination, exclusion or segregation. The law should guarantee that mental patients enjoy all civil, political, economic, social and cultural rights as well as all the rights and freedoms included in the international conventions ratified by the Egyptian government.

As mentioned above, individuals in mental institutions must be given the same rights as others in confinement.⁷¹ Involuntary hospital admission, isolation and certain treatments—not to mention serious mental illness itself— all greatly reduce patients' ability to defend themselves, and thus their rights have to be fully respected. It has to be stated that the patient must be informed, in a language that is understandable to him or her, of the reason for confinement; the patient must be told when and where the session will be held if he or she wants to appeal that decision; the patient must be provided with a lawyer free of charge to represent his or her interests and be permitted enough time to prepare a defense and provide evidence, including the presentation of witnesses. Patients should be informed as soon as possible of the court decision, which must be reasoned and subject to appeal.

⁷⁰ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 79.

⁷¹ UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health, Principle 1, paragraph 5.

e. A human rights–based approach and the goals of the legislation

The law must declare its commitment to human rights, something that is missing from the current draft. As WHO has stated, "A fundamental basis for mental health legislation is human rights."⁷² The new law must declare the government's commitment to the human rights of persons with mental disorders as well as the commitment to the right of all individuals to physical and mental health; its dedication to combating stigma and discrimination against mental disorders; and its responsibility to protect the right of individuals to mental health care as well as physical health care.

A number of nations have sought to include such basic human rights concepts in the preamble and text of their legislations. For example, the preamble of the mental health act of Poland states that the law has been issued "acknowledging that mental health is a fundamental human value and acknowledging that the protection of the rights of people with mental disorders is an obligation of the State."⁷³

Yet Egypt's bill lacks a clear statement of the goals of the law or its principles. Such an explanation would help to ensure that the law's provisions follow its overall objectives. As the language of laws tends to be rather general, a list of principles provides guidelines for its implementation and interpretation when Implementing Regulations are drafted or administrative orders issued; it also provides a framework for policy-makers establishing programs to implement the law. These objectives must, of course, be in harmony with human rights standards. WHO generally recommends that the objectives targeted by mental health legislations should include "non-discrimination against people with mental disorders, promotion and protection of the rights of people with mental disorders, improved access to mental health services and a community-based approach."⁷⁴

Some countries include a detailed and comprehensive list of legislative objectives, such as the primary health care law in South Africa, issued in 2002, which states:

"Objectives of this Act are to—

- a) Regulate the mental health care environment in a manner which—
 - (i) enables the provision of the best possible mental health care, treatment and

⁷² World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 3.

⁷³ *Ibid.*, p. 19.

⁷⁴ *Ibid.*, p. 122.

- rehabilitation that available resources can afford;
- (ii) makes effective mental health care, treatment and rehabilitation services available to the population equitably, effectively and in the best interests of the mental health care user;
- (iii) co-ordinates access to and the provision of mental health care, treatment, and rehabilitation services; and
- (iv) integrates access to and the provision of mental health care services within the general health services environment.
- b) Set out the rights and obligations of mental health care users and the obligations of mental health care providers;
- c) Regulate access to and the provision of mental health care and treatment to:
 - (i) voluntary, assisted and involuntary mental health care users;
 - (ii) state patients (unfit to stand trial or of comprehending their criminal actions); and
 - (iii) mentally ill prisoners.
- d) Regulate the manner in which the property of those with a mental illness may be dealt with by courts of law; and
- e) Provide for related matters."⁷⁵

As noted immediately below in this report, an explanatory memo to the initial version of this legislation presented its basic principles, but these must be included in either the preamble or the core text of the law.

f. Promoting equal opportunities and promoting the human rights of people with mental disability

The explanatory memo accompanying the first draft of the law, signed by the Minister of Health and Population, states that the goal is the development of a comprehensive mental health law.⁷⁶ However, the majority of the provisions of the law as it now stands focus—as mentioned above—on issues of admission to and treatment in mental institutions. This restriction prevents the law from protecting all persons with mental disorders and promoting mental health in general.

WHO recommends still further that legislations for the protection of persons with mental disorders should not be limited to issues of mental health or public health alone but should also extend to housing, education,

⁷⁵ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, p. 20.

⁷⁶ First draft of proposed mental health act, Egyptian Ministry of Health and Population, General Secretariat for Mental Health, states that: "The proposed law seeks to address mental health in a comprehensive and general manner and not merely the admission of persons with mental disorders."

employment and more. All of these are, in fact, not only necessary for the improvement of the living standards of persons with mental disorders but also contribute to the improvement of mental health.⁷⁷

The government recently announced that it had finished drafting a law for the protection of persons with disabilities. This is excellent news in and of itself, and it also provides an opportunity to address some of the gaps in the mental health bill. This law for the rights of people with disabilities primarily targets the integration of the provisions of the Convention on the Rights of People with Disability into the Egyptian legal framework, to ensure the protection and promotion of the rights and dignity of all persons with disabilities, including those with mental disabilities.

The Convention, ratified by Egypt in April 2008, obliges state parties to undertake necessary measures to the maximum of their available resources to progressively achieve the full realization of the economic, social and cultural rights of persons with disabilities. Among the measures required are new laws,⁷⁸ including laws to accelerate the de facto equality of persons with disabilities.⁷⁹

Finally, it is important to stress that no law, no matter how perfect, can alone achieve the objective of promoting the rights of persons with mental disorders and put an end to discrimination and stigmatization. Even after its adoption, the mental health law, like other laws, is only a single step on the right path. This step cannot realize its purpose if not accompanied and followed by similar steps in training, education, media, allocating the necessary resources and other efforts to reduce mental disorders and maintain the dignity and rights of those who have them.

⁷⁷ Mental Health Legislation and Human Rights, p. 21.

⁷⁸ Convention on the Rights of Persons with Disability, Article 4, paragraph a.

⁷⁹ Ibid., Article 5, paragraph 4.

Appendix 1: Law for the Institutionalization of Those with Mental Illnesses

Law no. 141/1944⁸⁰

I Farouk I, King of Egypt

The Senate and the House of Representatives have adopted the following act, which I have in turn ratified and promulgated:

Part I The Review Board

Article 1- A Review Board for mental illnesses shall be established within the Ministry of Public Health. Such a Board shall be authorized to decide on the institutionalization and discharge of those with mental illnesses, and the approval of licenses for and the inspection of the hospitals where they are held, in accordance with provisions of the law.

Article 2- The Board shall be formed as follows:

Undersecretary of the Ministry of Public Health for Medical Affairs or his representative—as Chairman.

Head of the Mental Illnesses Department in the Ministry of Public Health or his representative.

Attorney General of National Courts or Chief Prosecutor of Appeals—Senior Advocate General of Mixed Courts or one of the chief prosecutors (during the transitional period).

Chief Forensic Doctor or a senior representative mandated by the Minister of the Interior.

Senior official mandated by the Minister of Social Affairs.

Professor of Neurology at Fouad I University.

Representative from the Juridical Department of the Ministry of Public Health, at the level of deputy or more senior.

A senior doctor from the Ministry of Public Health, appointed by the Minister.

Chief Medical Officer of the Prisons Authority or his representative.

The Minister of Public Health shall choose a civil servant to act as Secretary of the Board.

Article 3- The Board shall meet on the specified dates or when convened by the Chairman, if required. The meeting shall not be valid unless attended by

⁸⁰ Unofficial translation. *Qanun hagz al mosabeen bi amraad 'aqliyya*, Official Gazette on 11 September 1944 – Volume 108.

half the members, including one of the public prosecution representatives. The Board shall make its decisions according to majority vote; in case of a tie, the Chairman's vote will determine the outcome.

The Board shall, in order to carry out the assigned duties, demand from hospitals and other competent authorities all statistics and data deemed necessary.

Part II

Institutionalization and Discharge of Those with Mental Illnesses

Article 4- A person with a mental illness may not be institutionalized unless his illness endangers public order or security or adversely affects the safety of the patient or of others, in accordance with the provisions of this law.

Institutionalization may not take place except in hospitals designed for such cases, either governmental or licensed private hospitals.

Institutionalization may take place within the home, with special permission from the Minister of Public Health, after the approval of the Review Board. The permission shall specify the conditions and duration of institutionalization.

Article 5- If a Ministry doctor determines that a patient falls in the category mentioned in the previous article, the doctor shall order the patient's institutionalization by seeking the assistance of the police. Prosecutors and officials with judicial authorizations who receive knowledge of such cases may also order the detention of suspects and their referral to a Ministry doctor for examination within 24 hours of the time of arrest. If the doctor finds that the suspected person is free from the mental condition described in the former article, the person shall be discharged immediately.

If the doctor is uncertain after examination whether the person is suffering from the condition mentioned in the previous article, the doctor shall decide to place the suspected person under observation, for a period not exceeding 8 days, in one of the governmental hospitals and not one of the specialized mental hospitals provided. A doctor shall examine said person on daily basis. At the end of the observation period, the doctor shall decide whether to discharge or institutionalize said person. In all cases, the doctor shall write a report on the examination results.

Institutionalization shall be in one of the specialized governmental hospitals, unless the patient's family or caretaker wishes to commit the patient to a private mental hospital.

Article 6- The doctor may temporarily halt execution of the institutionalization order if the patient's health prevents transferral. If the

injunction exceeds 20 days, the doctor shall notify the Review Board immediately to decide what it deems necessary.

Article 7- In cases other than that stipulated in article 5, the patient shall not be approved for institutionalization in one of the mental hospitals except in accordance with a written request submitted by one of the patient's relatives or in-laws looking after the patient's affairs. This should be submitted along with certificates from two doctors other than the hospital doctors, one of them to be a governmental employee, indicating that said person is suffering from a mental illness of the type described in article 4. The doctor certificate shall not be valid if it is submitted to the hospital director more than 10 days after signed by the doctor, or if it is issued by a doctor who is related to the hospital owner or director, to the third degree.

Article 8- The Minister of Public Health shall decide, via a ministerial decree, what information is to be included in the request and the two certificates. If a request does not fulfill these requirements, the hospital director may temporarily admit the patient, waiting not more than a two-week period for the information to be provided.

Article 9- The hospital director shall notify the Review Board, in writing, of every institutionalization, within three days of the patient's admission to the hospital, and shall submit a report on the patient's condition in the following four days. After examining the patient, the Review Board shall decide, not more than 30 days after the institutionalization date, whether to approve the institutionalization or discharge the patient.

Article 10- The approval decision shall be valid for one year from the date of issuance. The Review Board may, before the end of this period, decide to extend the institutionalization period for another year, then two years, three years, five years and so on.

The extension decision shall be made following a report, to be submitted to the Board by the hospital director, on the patient's condition, the progress of the illness and the necessity of continued institutionalization and treatment.

The Board may decide to end the institutionalization if, at any time, the institutionalized person is found to be in good mental condition and, thus, does not require continued institutionalization.

The Review Board may also examine the patient at any time, assigning one or more Board members to do so or ask specialists, if deemed necessary.

Article 11- If the Review Board does not issue a decision approving the institutionalization or the institutionalization extension during the timeline

described in the above two articles, institutionalization shall automatically be ended.

Article 12- If the institutionalized patient escapes, the patient may be arrested and re-institutionalized without recourse to the Review Board. If the period of escape exceeds three months, the patient's condition shall be re-submitted to the Review Board, within 15 days from the date of arrest. If the period of escape exceeds six months, the institutionalization procedures shall be repeated from the beginning.

Article 13- The hospital director can, from time to time, allow the calm patients to spend all or part of the day outside the hospital, under sufficient observation, as long as this does not conflict with the patients' treatment.

Article 14- If the institutionalized patient is cured, the hospital director shall immediately send a registered letter to the person who admitted the patient to the hospital, the patient's caretakers or any other party assigned by the patient, asking this person to collect the patient within seven days. If any of the aforementioned refuse to collect the patient, the patient shall be discharged immediately. In such cases, the government shall bear the expense of transferring the discharged, poor patient from the governmental hospital to anywhere within Egypt.

In all cases, the hospital shall notify the administrative authority with which the discharged person is affiliated.

If the patient is no longer in the condition stipulated in article 4, the hospital director shall end institutionalization. In such a case, the patient or any of the patient's guardians or caretakers may ask for the patient to stay until fully treated.

Article 15- If the discharge request for the institutionalized patient is submitted by the patient's relative, in-law or caretaker, the hospital director shall decide on the request within a three-day period. If the request is refused or if the submitter insists, the hospital director shall raise the issue directly with the Review Board, attaching a report on the patient's conditions and the reasons for denying discharge. The Board shall decide on the discharge request within a period not exceeding twenty days from the date that the case is brought to them. Other discharge requests shall not be approved prior to three months from the time the Board issues its decision.

Article 16- The Review Board may decide to temporarily discharge an institutionalized person for a specified period under certain conditions. The Board may reverse such a decision at any time, and order re-admission of the

patient by administrative decree to the previous hospital of institutionalization or any other mental hospital.

Article 17- The hospital director may discharge the patient with the approval of one of the patient's relatives or caretakers if the patient has a fatal physical illness.

Article 18- Whenever an institutionalized patient is discharged or dies, the hospital director shall notify the Review Board, within two days of discharge or death.

Article 19- An institutionalized patient may not be transferred from one hospital to another except with prior permission from the Review Board.

Article 20- The hospital director shall inform the prosecution of every patient institutionalization, within two days of the patient's admission, to take required procedures to protect the patient's property.

Article 21- Specialized mental hospitals may receive any patient suffering from a mental illness, other than the type provided for in article 4, by virtue of a written request from the patient. The patient's guardian or caretaker may also submit a written request asking for the patient's admission into the hospital. In case, the information previously mentioned in article 8 shall be included. The hospital director shall submit a report to the Review Board on the patient's condition within two days of admission.

The patient shall have the right to leave the hospital pursuant to a written request submitted by him or by the person who requested his admission.

However, if the hospital considers the patient's mental condition to fall within the stipulations of article 4, the hospital shall keep the patient and inform the patient's guardians and the police immediately, in order to begin the institutionalization procedures required by this law.

Part III

Housing and Treatment of Those with Mental Illnesses

Article 22- A private hospital for the housing and treatment of those with mental illnesses may not be established and administered except with a license obtained from the Ministry of Public Health, after approval by the Review Board. The license is strictly limited to the licensee and shall only be given to a licensed doctor practicing medicine in Egypt, an accredited charity organization or a social institution recognized by law, without prejudice to provisions and conditions laid down by any other law.

Article 23- The hospital must always meet the following conditions:

- a) The hospital shall be managed and patients shall be treated by doctor(s) with qualifications specified by the Minister of Public Health's decree.
- b) The hospital rooms shall be hygienic, well-ventilated, sufficiently spaced and suitably distributed.
- c) The hospital shall have separate wards for men and women. Patients of both sexes shall be organized according to age and condition.
- d) The hospital shall possess sufficient medical means and equipment. In addition, the hospital shall have a staff that suits patients' needs and conditions, including, inter alia, a sufficient number of doctors, nurses and servants.

If the practicing doctor leaves his position in one of the private hospitals, the licensee shall immediately notify the Minister of Public Health, by registered letter. Further to this, the licensee shall search, for no longer than one month, for a doctor with the aforementioned qualifications to occupy the free position. After the one-month period elapses, the Ministry may appoint a doctor to the position, to be paid for by the licensee, without prejudice to penalties stipulated by this law.

In all cases, hospitals shall not lack a practicing doctor.

If a private hospital is found not to meet any of the above conditions, the Minister of Public Health may, with Review Board approval, decide to cancel the license and close the hospital administratively.

Article 24- General hospitals may allocate a special place for those with mental illnesses. In such a case, the provisions herein shall be applied to the referred patient.

Article 25- The hospital director shall put a complaint box in each department, for patients to make complaints to the Review Board.

Article 26- The directors of mental hospitals shall keep two copies of records, including: patient name, title, age, nationality, distinguishing features, place of residence and date of entry and exit; and, with regard to the person admitting the patient: name, title, employment, place of residence, country and any further information specified by the Minister of Public Health. The hospital shall also maintain, for the period determined by the Minister of Public Health, the treatment papers and documents and a photo of every patient, to be placed at the disposal of the Review Board.

The inspection and removal of records or documents or copies thereof may not occur except with the prior permission of the Review Board.

Article 27- The Review Board shall inspect all mental hospitals, whether governmental or private, in addition to residences where patients are permitted to be institutionalized (by virtue of paragraph 3 of article 4), at least once a year. Inspection shall include checking patients' conditions and means of treatment and care, and reviewing hospital papers and records and complaint-box contents.

Inspection shall be carried out by the Board members, either as a whole or by specific assigned members. A report shall be written for each inspection.

Article 28- If the Review Board decides that the licensing conditions of the private hospital or the permission stipulated in paragraph 3 of article 4 is not sufficient or that treatment in the hospital or home exposes patients or others to danger or disturbs neighbors, the Board may deem additional requirements necessary, and shall specify the length of time the licensee has to implement them. The Minister of Public Health shall be informed of this, and if approved, the Minister shall issue a decision requiring the application of the new rules.

If such conditions are not met, the Minister of Public Health has the right to revoke the permission, as is provided for in paragraph 3 of article 4, or revoke the license, if it is a private hospital, and close the hospital by administrative decree.

Article 29- If the hospital licensee dies or the licensed organization or board to administer the hospital is dissolved, the Minister of Public Health may, after Review Board approval, allow the inheritors of the organization or the association's dissolution officials to continue the management of the hospital, for a period not exceeding one year, under the conditions deemed necessary.

Part IV Penalties

Article 30- The following people shall be punished with imprisonment for a maximum of two years and/or a fine of 100 LE (one hundred Egyptian pounds):

- 1) Any doctor proven to have intentionally manipulated the truth in his certificate concerning a person's mental status, with the aim of institutionalizing or releasing of that person.
- 2) Anyone who arrests, institutionalizes or intentionally causes the institutionalization of a person as a patient with mental illness in places and conditions other than those discussed in this law.

Article 31- The following people shall be punished with imprisonment for a maximum of two months and/or a fine of 30 LE (thirty Egyptian pounds):

- 1) Anyone who enables, helps or cooperates with a person institutionalized according to this law to escape, or hides such a person, either himself or via others.
- 2) Anyone who prevents the inspection process of the Review Board or its delegates, in conformity with the provisions herein.
- 3) Anyone who refuses to provide the Board or its delegates with required information to carry out its duties or intentionally gives incorrect information.
- 4) Anyone who informs the concerned authorities, wrongly and with mal-intent, that a person has the type of mental illness specified in article 4.

Article 32- The following people shall be punished with imprisonment for a maximum of one year and/or a fine of 50 LE (fifty Egyptian pounds): Anyone who is assigned to guard, nurse or treat a patient with mental illness and abuses or ignores these duties, thus, causing pain and harm to the patient. If the abuse results in physical illness or injury to the patient, the punishment shall be imprisonment for a maximum of three years.

Article 33- For any other violation to the provisions herein, the offender shall be punished with imprisonment for a maximum of 7 days and/or a fine of 100 pst (one hundred piasters). The judge shall decide to close the hospital if article 22 is violated, and may close private hospitals if the provisions of articles 7, 9, 23 and 28 are violated.

Article 34- The provisions of articles 30, 31, 32 and 33 shall not infringe upon the Penal Code articles or any other laws with more severe penalties. Further to this, the provisions shall not prevent the resort to disciplinary trials.

Part V General Provisions

Article 35- The inspectors of the Department of Mental Illness and the employees mandated by the Minister of Public Health's decree shall be granted judicial authorization in the investigation of crimes violating the provisions of the law and the decisions issued in implementing it. Therefore, in this capacity the abovementioned officials shall have the right to inspect all hospitals, enter residences where those with mental illnesses have been confined and inspect records and papers stipulated in article 26.

Article 36- The provisions of such a law shall not violate the applicable laws and regulations concerning suspects, criminals and the insane.

Part XI
Temporary Provisions

Article 37- The owners of specialized private mental hospitals established prior to this law shall be given three months, starting from the date of enactment, to submit a license request, according to the provisions of article 22.

Article 38- For patients in state mental hospitals who were institutionalized before the enactment of this law, their institutionalization shall be considered valid, and the rest of the provisions herein shall be applied.

For those patients institutionalized in private hospitals, their conditions shall be presented to the Review Board within fifteen days of the enactment of this law.

Article 39- The Ministers of Public Health, the Interior, Justice and Social Affairs shall execute and apply this law, each in his field, thirty days after it is published in the Official Gazette.

The Minister of Public Health shall decide what decrees are required for the implementation of the law.

We order this law to be sealed by the Seal of State, published in the Official Gazette and applied as one of the state laws.

Issued in Abdeen Palace on 12th of Ramadan 1363 (Islamic Calendar), equivalent to 31 August 1944

Appendix 2: Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

Adopted by General Assembly resolution 46/119 of 17 December 1991

Application

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions

In these Principles:

"Counsel" means a legal or other qualified representative;

"Independent authority" means a competent and independent authority prescribed by domestic law;

"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

"Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

"Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

"The review body" means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

General limitation clause

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Principle 1

Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.

Principle 2

Protection of minors

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3

Life in the community

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Principle 4

Determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.
3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.
4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

Principle 5

Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

Principle 6

Confidentiality

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

Principle 7

Role of community and culture

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background.

Principle 8

Standards of care

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

Principle 9

Treatment

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 10

Medication

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

Principle 11

Consent to treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, Likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive; and

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

Principle 12

Notice of rights

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.
2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.
3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

Principle 13

Rights and conditions in mental health facilities

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
 - (a) Recognition everywhere as a person before the law;
 - (b) Privacy;
 - (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
 - (d) Freedom of religion or belief.
2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

- (a) Facilities for recreational and leisure activities;
 - (b) Facilities for education;
 - (c) Facilities to purchase or receive items for daily living, recreation and communication;
 - (d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.
3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.
4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

Principle 14

Resources for mental health facilities

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
- (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
 - (b) Diagnostic and therapeutic equipment for the patient;
 - (c) Appropriate professional care; and

(d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

Principle 15

Admission principles

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.