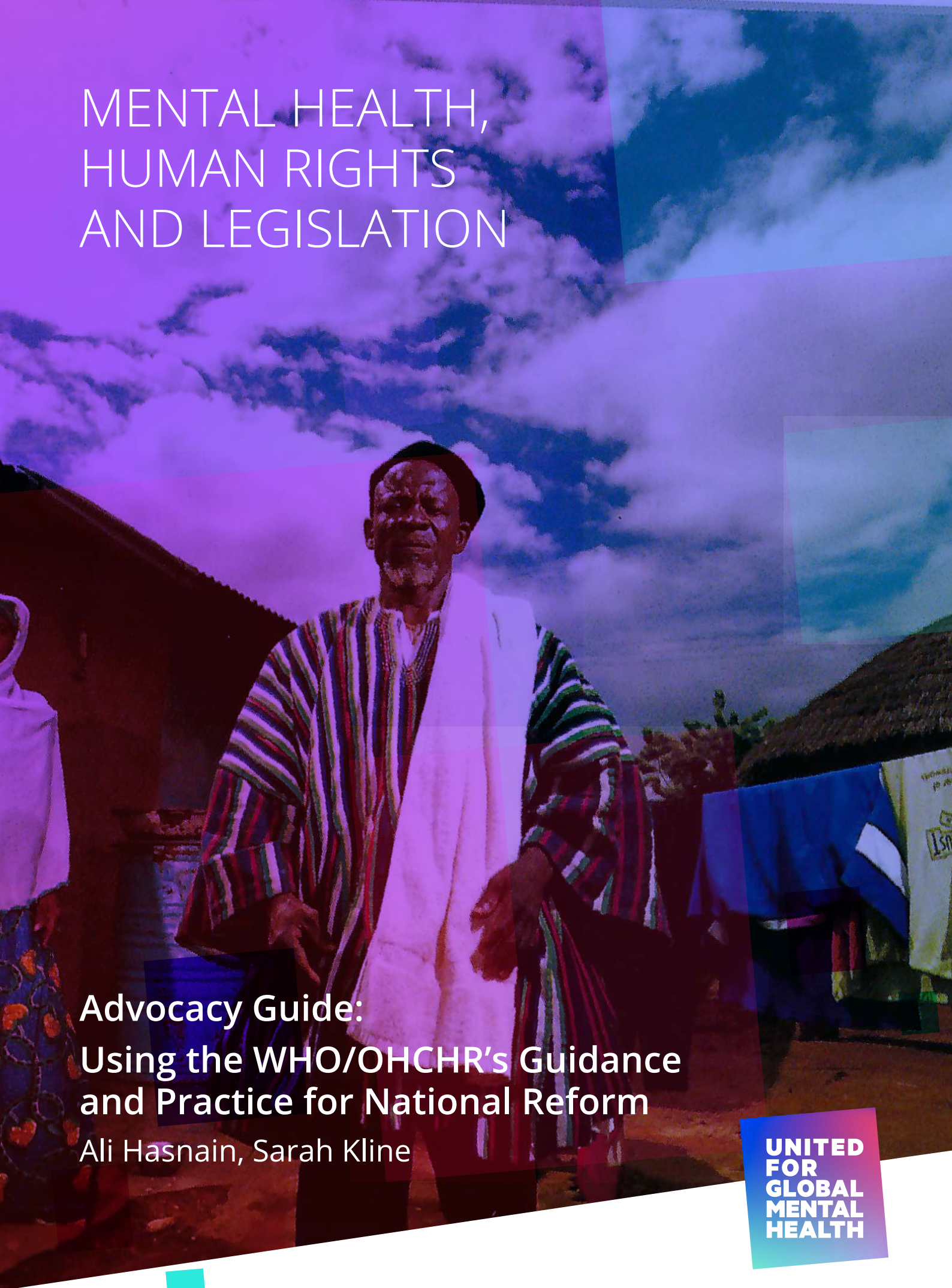
MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION



Advocacy Guide:
Using the WHO/OHCHR's Guidance and Practice for National Reform

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UNITED FOR GLOBAL MENTAL HEALTH

INTRODUCTION

International human rights law requires non-discrimination and respect for all human rights in the implementation of the right to health, including through health policies, programmes, plans and services. Legislative reform is a crucial tool to achieve this and to challenge stigma, discrimination and exclusion. It can foster a human rights-based approach, and enhance access to quality mental health care and support.

It is in this context that the World Health Organisation (WHO), and the United Nations Office of the High Commissioner for Human Rights (OHCHR) have jointly released new guidance on mental health, human rights and legislation. The guidance will help countries develop or reform national mental health legislation in a way that protects and promotes the mental health of their populations, while upholding their human rights.

UnitedGMH is keen to encourage civil society organisations and people with lived experience of mental ill-health to use the guidance and the accompanying checklist to engage with their governments and ensure their national mental health-related legislation meets international human rights standards. This advocacy guide sets out how to use the WHO/OHCHR guidance and checklist.

THE CASE FOR REFORM

The WHO/OHCHR guidance makes several arguments about why most mental health-related legislation across the globe requires reform to make it human rights based. It also explains why legislation covering other sectors beyond health needs to include mental health in order to promote holistic, person-centred care. Here are some of those arguments:

THERE ARE PERSISTENT HUMAN RIGHTS VIOLATIONS UNDER EXISTING LEGISLATIVE FRAMEWORKS IN COUNTRIES EVERYWHERE

Stigma, discrimination and human rights violations persist in mental health care in low-, middle- and also high-income countries, fuelled by an overreliance on biomedical approaches and a lack of attention to the social determinants that influence mental health and on community-based interventions. Many individuals, particularly those from marginalised groups, face unequal treatment and discrimination when they try to use mental health services. Legislation can often deem people incapable of making decisions about their own mental health care. Involuntary admission and treatment measures, seclusion and the use of restraints, including chemical restraints, are frequently employed to enforce compliance to treatment and medication. Many people are institutionalised, and live in mental health facilities or social care institutions for months, years or even for life. Some remain in the community but are locked at home or shackled.

The absence of adequate mechanisms to prevent, detect, report, address and redress these violations is concerning.

Ensuring the right to free and informed consent, and ending the denial of legal capacity, coercive practices, and institutionalisation is imperative for creating a more equitable and rights-respecting mental health system. The WHO Comprehensive Mental Health Action Plan 2013-2030 recommends moving away from institutional care and focusing on primary and rights- and recovery-based community health care. It is important that the legislative framework that forms the basis of national mental health care reflects this. It should carry with it a plan for transitioning and reallocating finances.

Moreover, as long as there are legislative provisions, such as the criminalisation of suicide, that discriminate against people with mental health conditions or who are experiencing a mental health crisis, it will be difficult to achieve human rights-based mental health for all. There are still at least 23 countries around the world where suicide is criminalised in law. This type of legislation, which is mostly outdated and of colonial origin, not only actively hinders people from seeking help, but perpetuates stigma and discrimination towards people with mental health conditions. It is therefore essential that mental health-related legislation either directly incorporates or goes hand in hand with the repeal of such discriminatory legislation.

EXISTING COMMITMENTS MADE BY NATIONAL GOVERNMENTS TO REFORM LEGISLATION NEED TO BE UPHELD

National governments have already committed to reform their mental health-related legislation: these commitments need to be upheld. The Human Rights Council, through separate resolutions in 2016, 2017 and 2020, has underscored the imperative for UN member states to fulfil their commitment to eliminating discrimination, stigma, violence and abuse in mental health care by adopting, implementing and monitoring relevant laws.

The WHO's Comprehensive Mental Health Action Plan 2013-2030 requires that all WHO member states develop or update their mental health legislation in line with international and regional human rights instruments. However, as per the WHO's Mental Health Atlas 2020, only 57% of WHO member states currently have stand-alone mental health legislation and only 39% report their laws to be fully compliant with international and regional human rights instruments. Even this low figure overestimates the reality, as reviews of laws around the world reveal that no country has fully implemented the UN Convention on the Rights of Persons with Disabilities (CRPD). Significant efforts are urgently required to develop or update national mental health legislation.

Mental health is relevant to all of the Sustainable Development Goals (SDGs), explicitly SDG3 on good health and well-being, with SDG 3.4.2 specifically talking about reducing suicide mortality. Good mental health legislation is crucial to meeting the SDGs, which have been agreed by all UN member states. People with mental health conditions are more likely to fall into poverty, experience poor physical health, and have less access to job and educational opportunities and resources. This emphasises the need for national legal frameworks to address the socio-economic determinants that influence mental health.

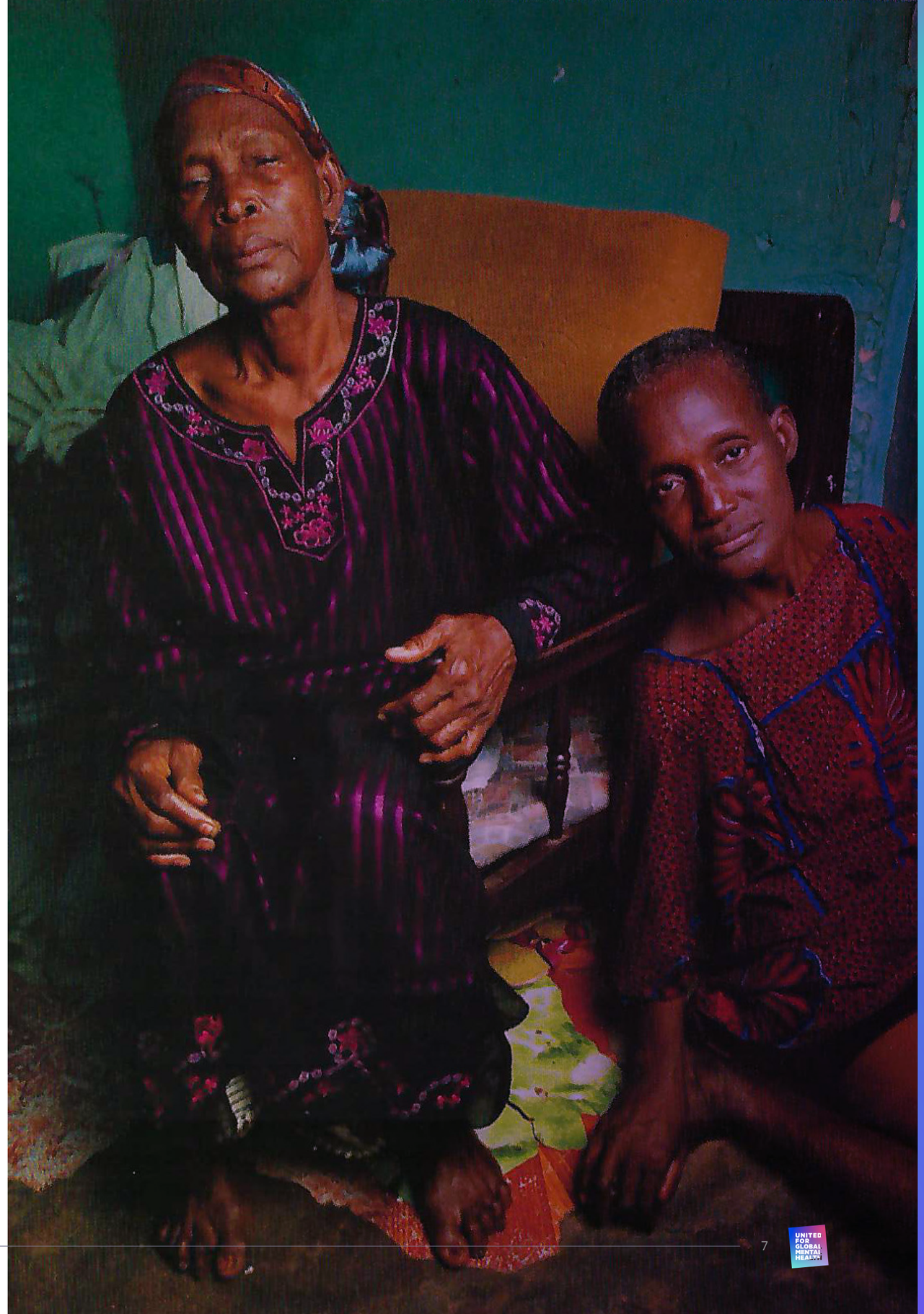
There are a variety of international and regional human rights instruments ratified by member states that oblige them to implement measures, including legal measures, to promote human rights in mental health. Some of these measures include:

- The UN Convention on the Rights of Persons with Disabilities (CRPD), which promotes the rights of persons with disabilities, including persons with psychosocial disabilities. Through Article 3(1), member states have committed to legislation that protects human rights and to remove discriminatory legislation, which would include, for example, laws that allow for substitute decision-making, or criminalise suicide. Articles 12, 13, 14, 19 and 25 cover issues such as exercise of legal capacity, access to justice, the right to liberty and security, the right to be part of the community and healthcare based on free and informed consent.

- The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Article 2 mandates taking legislative measures to prevent torture and Article 16 outlines requirements to prevent acts of cruel, inhumane and degrading treatment, such as shackling.

- The International Covenant on Civil and Political Rights requires all people to be considered equally before the law and entitled to the same legal protections. This goes against current systems that allow for people with mental health conditions to be deprived of their right to exercise their legal capacity and to be subject to involuntary admission and treatment.

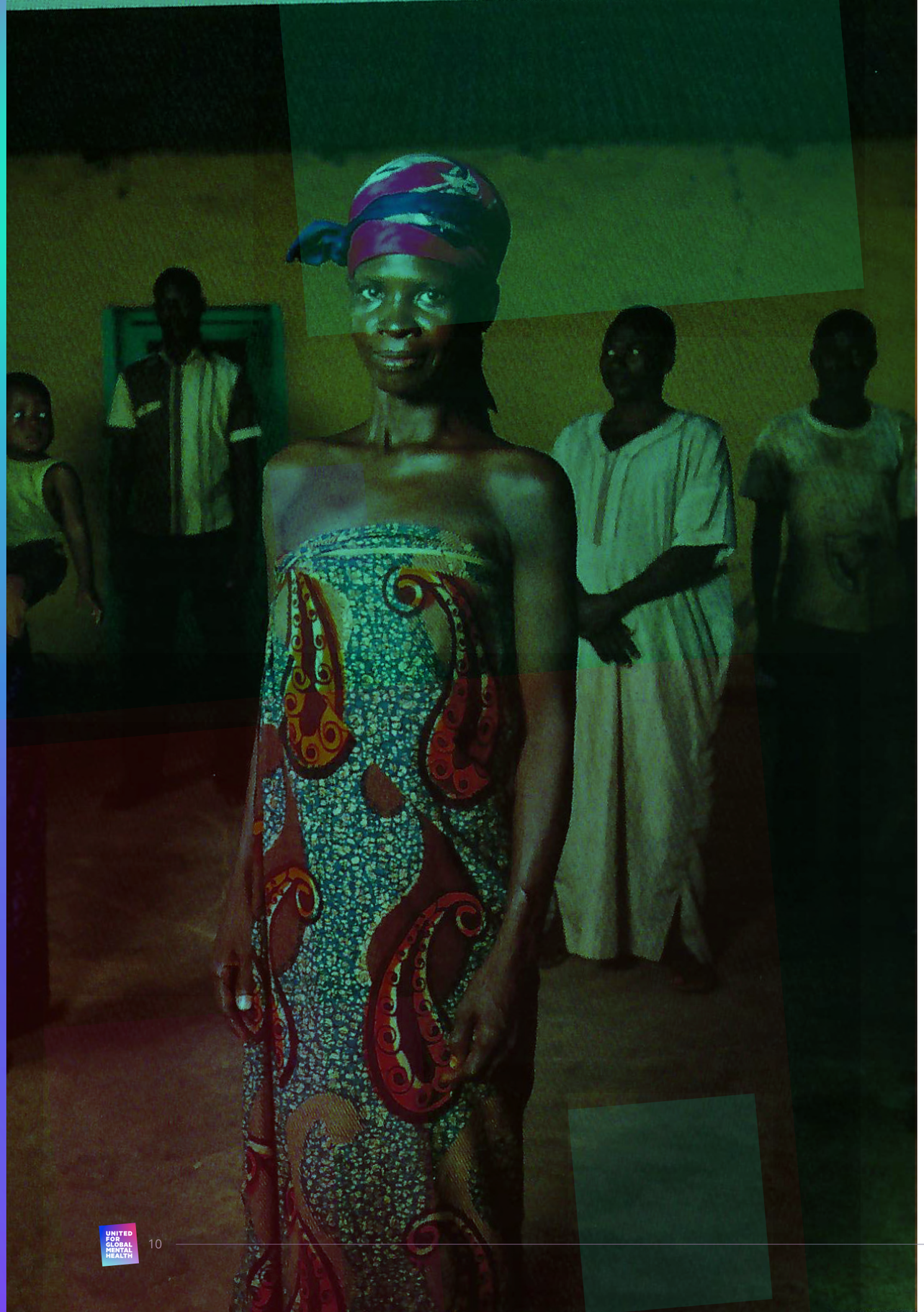
As countries seek guidance on compliance with the CRPD and other human rights instruments, it is crucial for policymakers to reinforce their commitment to these changes in mental health-related legislation.



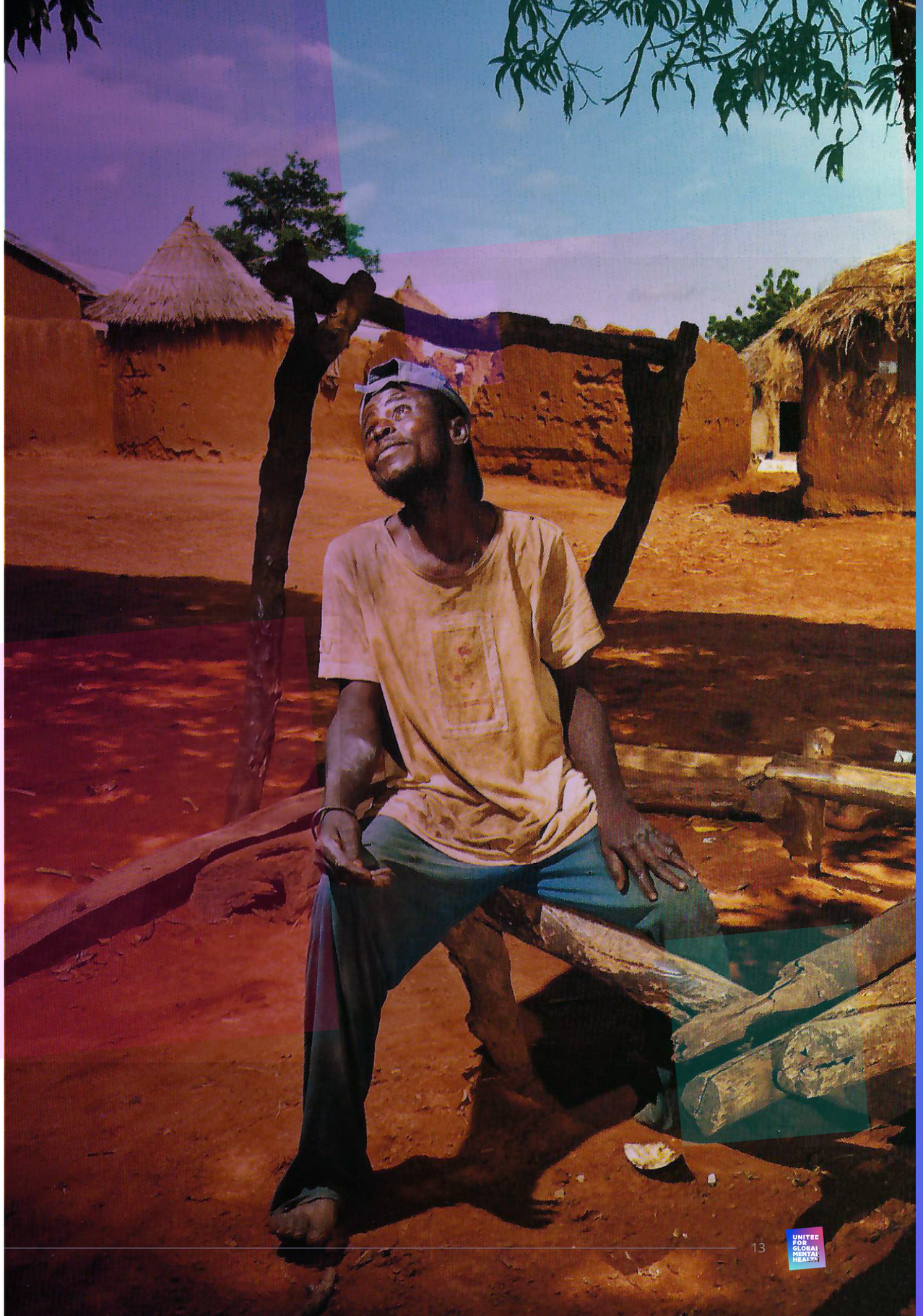
WHO/OHCHR'S RECOMMENDATIONS ON LEGAL PROVISIONS AND WHERE TO FIND THEM

The following table captures the relevant themes that human rights-based legislation safeguarding mental health should cover. It also references the WHO guidance where you can find details on these themes, as well as model provisions that you can adapt and apply to your national legislation:

Theme	What it covers	Page
Ensuring Equality and non-discrimination **This section proposes legislative provisions to uphold the principle of non-discrimination in the mental health system and ensure the equal enjoyment of rights for all people in the provision of mental health services.**	Prohibition of all forms of discrimination	32
	Provision of reasonable accommodation	35
	Discrimination in health insurance	36
	Challenging stigma and discrimination in communities	37
	Equal recognition of rights within mental health services which includes: • Access to information • Confidentiality and personal data protection • Privacy • Communication • Physical and social conditions within services	39
Respecting personhood and legal capacity in mental health services **This section proposes legislative provisions that promote and protect the right to legal capacity of people using mental health services and to provide them with appropriate support if required.**	Respecting legal capacity in mental health services	46
	Prohibiting substitute decision-making in mental health services	48
	Making supported decision-making available for people using mental health	48
	Safeguarding will and preferences	51
	Respecting children's evolving capacities	54
Informed consent and eliminating coercive practices in mental health care **This section proposes legislative provisions which can help to end coercion in mental health services and to uphold the right of all service users to receive mental health-related and other health interventions on the basis of free and informed consent.**	Promoting and protecting the right to free and informed consent, which includes: • Medical emergencies • Prescription of psychotropic drugs • Other specific safeguards • Medical research and experimentation	55
	Advance planning	60
	Crisis support	64
	Prohibiting involuntary hospitalisation and treatment	66
	Eliminating seclusion and restraint	73
	Care process design	74
	Decriminalising suicide	75



Theme	What it covers	Page
Ensuring full and effective participation in public decisions **This section proposes key legislative provisions to recognise and support the right of people with lived experience to participate in all decision-making and service-development processes concerning mental health systems.**	Recognising the right to actively participate in decision-making Implementing accessible and fair consultations	97 98
Ensuring accountability **This section proposes legislative provisions that ensure and enforce accountability within mental health systems.**	Information systems Independent monitoring bodies Implementing effective remedies and redress Professional responsibility and liability	100 101 102 105
Cross-sectoral reform for holistic service provision **This section proposes important legislative provisions to ensure coordination and collaboration between mental health and other sectors to guarantee the provision of holistic, integrated care and support services in the community.**	Promoting community inclusion, including: • Recognition of the right to live independently and be included in the community • Multisectoral coordination and action for mental health • Supporting organisations of people with lived experience • Supporting families Access to justice, including: • Recognising and supporting legal capacity to access justice • Police involvement • Diversion from the criminal justice system • Criminal responsibility • Prisoners with mental health conditions and psychosocial disabilities • Training for the administration of justice	107 111



EXAMPLES OF BREAKTHROUGHS ON MENTAL HEALTH AND HUMAN RIGHTS THROUGH LEGISLATION

The following are examples of countries that have enacted mental health and related legislation that has proved effective in safeguarding the rights of people with mental health conditions. While none of these examples completely satisfy the requirements of the WHO/OHCHR's checklist, countries can learn from each of them as they strive to develop mental health-related legislation that better aligns with the obligations and requirements set by international human rights standards.

PERU AND THE PROVISION OF LEGAL CAPACITY TO PERSONS WITH DISABILITIES

The Peruvian government ratified the Convention on the Rights of Persons with Disabilities in 2007 and published its legislative decree no.1384 in 2018 which removed all restrictions on the legal capacity of persons with disabilities, including people with mental health conditions. This complements the new national mental health legislation passed in 2019, which prioritises community-based healthcare in an attempt to shift the locus of care away from institutions and bans seclusion and solitary confinement in mental health care.

While there are still provisions where legal capacity may be restricted, such as in medical emergencies, the legislation recognises the capacity of individuals with mental health conditions to make decisions for themselves. It also acknowledges the need for health professionals to respect this capacity. This is not only a crucial stepping stone toward ending coercive practices and involuntary treatment but also safeguards several other legal rights of people with mental ill-health, such as to make wills, enter into contracts and decide their own affairs.

The 2018 law also makes provisions for supported decision-making where required, replacing substituted decision-making entirely, and putting the cost and responsibility for this on the state. Although Peru needs to do more to move away from institutional care and safeguard the rights of people with mental health conditions, these are positive steps that other countries are encouraged to replicate.

INDIA AND THE RECOGNITION OF THE RIGHT TO MENTAL HEALTH AND REPEALING DISCRIMINATORY LEGISLATION

India ratified the Convention on the Rights of Persons with Disabilities in 2007, and passed its new national mental health legislation in 2017. While the act does not fully meet the requirements of the CRPD and the WHO/OHCHR checklist for assessing rights-based legislation, there are still several significant advances worth highlighting.

One of these is the recognition of a variety of human rights of people with mental health conditions, including the right to access mental health care. Coupled with other provisions requiring community-level mental health care provision, and the integration of mental health across the health sector (primary, secondary and tertiary care), this right paves the way for greater access to mental health services. Moreover, other important rights stemming from the CRPD – such as the right to community living, equality and non-discrimination, legal aid, and protection from cruel, inhuman and degrading treatment – are all big steps forward in safeguarding people with mental health conditions from human rights abuses.

The act still does not cover the deinstitutionalisation of mental health care or sufficiently address the issue of involuntary treatment and decision-making capacity. However, a key legacy of the 2017 mental health care act is its decriminalisation of suicide attempts. Section 115 of the act creates a presumption of severe stress for people attempting suicide, therefore mandating that they can no longer be tried under section 309 of the Indian Penal Code which criminalised suicide attempts. This means that people who attempt suicide will no longer be punished for it, and can seek the help they need. This is an excellent example of how mental health legislation can directly address laws that discriminate against people with mental health conditions.

ITALY AND THE DEINSTITUTIONALISATION OF MENTAL HEALTH CARE

Italy's antiquated 1904 law on mental health had a radical overhaul when, in 1978, a comprehensive new mental health act, often referred to as the Basaglia law, was passed. The law mandated the closing of all forms of institutional care, blocking all new admissions to institutions and regulating involuntary treatment during the transition.

It moved the country away from institutional care and towards providing mental health care through primary and community-based settings.

An excellent example of this is Trieste, where institutional care was replaced by an approach centred on working with the wider community to develop a fully integrated human rights-based system of support. The new approach resulted in the elimination of waiting times, high accessibility of services, continuity and comprehensiveness of care, and rapid response times.

The change in Italy's law came about after social movements called for the human rights violations rampant in institutional care to end. While Italy has struggled with problems such as the lack of financing needed to support its community-based care model and a shortage of primary health workers, the shift has ensured a drastic decrease in the number of involuntary admissions compared to other countries.

Italy's model shows that institutional care is not necessary for the provision of mental health care and offers great lessons on why investment in community-based care and the health workforce is essential. It has already inspired legislative reforms in countries such as Brazil, Argentina, Peru and Mexico, and other national governments are encouraged to follow suit, improving upon the foundations that have been laid.

SYSTEMATIC MENTAL HEALTH REFORMS IN BRAZIL

In the 1970s, Brazil's psychiatric system relied heavily on numerous low-quality hospitals, often the scene of human rights violations. Brazil's mental health law, which was approved in 2001, sought to address this. It led to the successful implementation of a national mental health policy.

Drawing inspiration from psychiatric reforms in Italy, the policy initially prioritised the gradual substitution of psychiatric hospitals with a network of community-based services. Centers for Psychosocial Care (CAPS in Portuguese) – which take a human rights-based approach – were to be the cornerstone. These centres can address complex and crisis situations, have an open-door policy, do not take involuntary admissions, don't allow seclusion or restraint, and focus on community engagement. As of 2022, Brazil had 2,836 CAPS units distributed across the country.

The policy later expanded its scope to include preventing mental health disorders, providing mental health care for children and adolescents, and implementing strategies to address issues related to alcohol, drugs and other forms of substance abuse.

In 2011, a Regulatory Act established the Psychosocial Care Network aimed at integrating all mental health-related services in Brazil's healthcare system 'SUS', including primary health care, CAPS, emergencies, ambulatory care, deinstitutionalisation initiatives, psychosocial rehabilitation programmes, and hospitals. Between 2002 and 2014, there was a notable reduction of 25,405 beds in psychiatric hospitals, with patients moved into general hospitals and into community-based services like CAPS. The progress achieved is indisputable, especially within the context of a middle-income country with an extensive territory.

WHAT COMES NEXT: USE CHECKLIST PROVIDED

The WHO/OHCHR guidance on mental health human rights and legislation concludes with an excellent checklist (starting on page 161). It can be used by national stakeholders as a first step to assess their existing mental health-related legislation or draft bill, how well it captures the themes outlined above and how effectively it protects and promotes human rights in the area of mental health.

It is essential that countries conduct this evaluation of their existing legislation and bring it in line with international human rights standards that promote and protect mental health. Civil society organisations and people with lived experience of mental health conditions must be included, working together with policymakers and government ministries at every step of this process. The collective goal should be to ensure everyone's right to the highest attainable level of person-centred mental health care.

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