

# A Key, Not a Straitjacket: The Case for Interim Mental Health Legislation Pending Complete Prohibition of Psychiatric Coercion in Accordance with the Convention on the Rights of Persons with Disabilities

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## Abstract

The practice of coercion on the basis of psychosocial disability is plainly discriminatory. This has resulted in a demand from the Committee on the Rights of Persons with Disabilities (the CRPD Committee) for a paradigm shift away from the traditional biomedical model and a global ban on compulsion in the psychiatric context. However, that has not occurred. This paper considers conflicting pronouncements of the CRPD Committee and other United Nations bodies. Assuming the former's interpretations of the Convention on the Rights of Persons with Disability (CRPD) are accurate, involuntary psychiatric detention and enforced treatment on the basis of psychosocial disability are *prima facie* discriminatory and unlawful practices. However, dedicated mental health legislation both permits discrimination and protects and enhances rights. This paper proposes a practical way out of the present impasse: the global introduction of interim “holding” legislation lacking full compliance with the CRPD. While imperfect, such a framework would facilitate a move toward a complete ban on psychiatric coercion. The paper outlines four essential ingredients that any interim legislation ought to contain, including clear timebound targets for full CRPD implementation. It concludes by urging the CRPD Committee to take the unprecedented step of issuing a general comment providing reluctant “permission” for the progressive realization of respect for articles 12 and 14 of the CRPD.

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“[L]iberty and security of the person is one of the most precious rights to which everyone is entitled.”<sup>1</sup> Accordingly, it is enshrined in numerous international treaties, including the Convention on the Rights of Persons with Disabilities (CRPD).<sup>2</sup> It is, however, subject to exceptions, such as punishment for certain criminal offenses and hospitalization for the purpose of treating mental illness. Involuntary hospitalization and enforced treatment for those with severe mental illness have become so normalized globally that few question their lawfulness, much less the likely success of their purpose. Yet they have been held to amount to torture and cruel, inhuman, or degrading treatment or punishment under article 15 of the CRPD.<sup>3</sup> They are also the springboard for further degrees of restriction, such as seclusion and physical, chemical, and mechanical restraint. Legally endorsed hospital coercion can lead to systemic and other human rights violations, including “unlawful or arbitrary institutionalization, over-medicalization and treatment practices that fail to respect ... autonomy, will and preferences.”<sup>4</sup> Psychiatric compulsion reduces trust, breaks down the therapeutic relationship, and often leads to cyclical hospital admissions and the “revolving door” patient.<sup>5</sup> The United Nations (UN) Special Rapporteur on the right to health has observed that it causes “enormous psychosocial pain and hopelessness,” with numerous studies highlighting its extremely traumatizing impact.<sup>6</sup>

This acceptance of coercion stems from a protective and paternalistic biomedical model of mental health that gives insufficient attention to the psychological and social causes of mental illness. Although coercion is “mostly carried out with the noble desire to reduce suffering and improve the human condition,” the fact that it is applicable solely to those with mental disorder makes it wholly discriminatory.<sup>7</sup> By contrast, compulsory hospitalization on the basis of a physical health issue is permissible only in rare circumstances, such as where an unconscious person cannot provide consent to life-saving medical treatment, or to curb a pandemic such as COVID-19, which has required unprecedented quarantines and country-wide lockdowns.<sup>8</sup>

The CRPD, adopted 14 years ago, embraces a social model of disability, viewing mental disorder not as an intrinsic medical issue requiring cure, but as an *extrinsic* inequity caused by structural barriers that prevent the equal societal participation of all. Requiring the full integration of human rights in all laws and health-related policies and services, it seeks a significant alteration of the normative landscape. The Committee on the Rights of Persons with Disabilities (CRPD Committee) has repeatedly labeled non-consensual psychiatric care as discriminatory and hence contrary to the treaty. Peter Bartlett emphasizes that “CRPD ratification means acceptance of the need for a paradigm shift ... [which] does not occur without the challenge to fundamental assumptions about how we have acted in the past.”<sup>9</sup> Yet, to date, no country has attempted to comply fully with the CRPD Committee’s pronouncements, as demonstrated by the fact that all recently amended mental health legislation permits coercion. Further, many low- and middle-income countries (LMICs) that have no such legislation use coercion nonetheless, without legal basis.

This article assumes the CRPD Committee’s interpretations to be accurate and does not debate their validity. Since the CRPD forms part of international law, involuntary psychiatric detention and enforced medical treatment are unlawful practices, for they are *prima facie* discriminatory. Highlighting some of the reasons for the global community’s tardiness in ending coercion, this paper examines the utility of mental health laws within the contextual framework of the CRPD. I argue that the current impasse is inexcusable and that the option of incremental change would be an inadequate response to the CRPD Committee’s pronouncements. Finally, I propose a practical way out of the deadlock through the use of stop-gap measures.

## The current landscape

The CRPD’s aims are “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.” Importantly, those with “long

term ... mental ... impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” are included in the definition in article 1. In its reports, the CRPD Committee prefers the term “psychosocial disability” for those with a mental health diagnosis, which refers to those who have experienced negative social factors, including stigma, discrimination, and exclusion.

### *Key CRPD provisions for those with psychosocial disabilities*

Article 14 of the CRPD requires states to ensure that persons with disabilities enjoy the right to liberty “on an equal basis with others” and indicates that “the existence of a disability shall in no case justify a deprivation of liberty.” Article 25 clarifies that this applies “[a]t all times, including in crisis situations.”<sup>10</sup> Those subject to detention are “entitled to guarantees in accordance with international human rights law ... including by provision of reasonable accommodation.”<sup>11</sup> Yet, many countries’ mental health legislation permits coercive treatment provided that various criteria exist—usually related to perceived risk or a specific degree of illness severity. Other relevant CRPD principles violated by psychiatric coercion include article 3(a), which demands “[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons,” and article 5(2), which requires the prohibition of “all discrimination on the basis of disability,” guaranteeing to persons with disabilities “equal and effective legal protection against discrimination on all grounds.” The duty not to discriminate *per se* is found in article 28. Article 12 governs the equal right of those with psychosocial disabilities to make decisions about their own treatment and care “on the basis of free and informed consent” with appropriate support and “reasonable accommodation” where needed.<sup>12</sup> Controversially, the CRPD Committee has interpreted article 12 as requiring the complete prohibition of substitute decision-making—a view with some support from other UN bodies, such as the UN Working Group on Arbitrary Detention.<sup>13</sup>

### *CRPD Committee interpretation*

The CRPD Committee has emphasized, in country reports from 2011, that compulsory hospitalization and enforced medical treatment violate the convention.<sup>14</sup> This is reiterated in General Comment 1 on article 12, issued in 2014, and in the committee’s guidelines on article 14 concerning the right to liberty, issued in 2015.<sup>15</sup> The committee’s interpretations have been supported by the Special Rapporteur on the right to health, Dainius Pūras; the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas-Aguilar; and the Special Rapporteur on torture, Juan Méndez, who has called on states to “impose an absolute ban on all forced and non-consensual medical interventions ... including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs [and] the use of restraint.”<sup>16</sup> However, among UN institutions, there is by no means a complete consensus. In its General Comment 35 on liberty and security of person, the Human Rights Committee outlines a set of conditions and safeguards under which both non-consensual *and* coercive treatment might be permissible under the International Covenant on Civil and Political Rights, in part based on disability.<sup>17</sup> In its view, legal procedures permitting coercion must merely “ensure *respect* for the views of the individual and ensure that any representative genuinely *represents and defends* ... [their] wishes and interests.”<sup>18</sup> Such open disagreement between treaty bodies within the UN human rights system has been “remarkably rare,” as W. Martin and S. Gurbai note.<sup>19</sup>

### *Fallback on the status quo and impossibility of an immediate coercion ban*

Even though the cost of psychiatric inpatient treatment is extremely high, maintenance of the status quo is nearly always cheaper—and easier—than developing new pathways of care. In accordance with the right to health (first articulated in article 25 of the Universal Declaration on Human Rights), ending involuntary hospitalization and treatment will require alternative care and treatment within the community, with levels of support tailored to individual disability.<sup>20</sup> Intensive community health

care, including supportive accommodation with fully qualified staff, is expensive, even for higher-income countries.<sup>21</sup> In many LMICs, staffed residential placements do not exist, and mental health remains embedded in tertiary care. The absence of sufficiently available, accessible, adequate, and affordable alternatives to involuntary hospitalization in the community globally, as the right to health requires, means that fully CRPD-compliant legislation introduced at this juncture would likely be ignored.<sup>22</sup> For example, research by H. Liebling and L. Davidson et al. found that the Ugandan Mental Health Treatment Act of 1964 had never been properly implemented because a lack of infrastructure made adherence impracticable, with some key informants admitting that “they deliberately ignored requirements under the legislation.”<sup>23</sup> Respect for the law is essential for any functioning society, and occasional circumvention might regress to purposeful avoidance, particularly in LMICs with inadequate checks and balances. Furthermore, “[i]t would be an unhappy state of affairs if regard for the CRPD were undermined by the Committee’s interpretation.”<sup>24</sup> Accordingly, setting the standard too high and too soon risks rendering the rights to health, autonomy, and liberty meaningless. Thus, even if the requisite political will existed, immediate and full compliance with the CRPD would be impossible in any country without compromising the right to health or potentially the right to life. For example, in Gauteng province in South Africa, at least a hundred patients discharged from psychiatric detention in 2016 to inadequate and un-monitored community care died within a year.<sup>25</sup>

### *The impasse*

There has been considerable pushback against the CRPD Committee’s pronouncements, with many scholars, clinicians, commentators, and politicians maintaining that a ban on coercion in the psychiatric context would be folly.<sup>26</sup> While the committee’s interpretations are authoritative and hold significant weight, they are not considered legally binding.<sup>27</sup> Additionally, no real consequences flow from non-compliance, other than censure in

a CRPD Committee’s concluding observation or a Special Rapporteur’s country report—both of which are likely to receive scant heed from other equally blameworthy states. Of course, not all states have ratified the CRPD, and some have made reservations to articles 12 and 14 (although the validity of such reservations may be contestable, as article 46 of the CRPD prohibits reservations that are contrary to its object and purpose).<sup>28</sup> There is general agreement, nonetheless, on the need for well-formulated mental health laws to protect the human rights of those with psychosocial disabilities.<sup>29</sup> “All over the world, governments and legislatures are considering whether and how to reform mental health and mental capacity legislation in order to ensure greater respect for human rights.”<sup>30</sup> In 2017, the Special Rapporteur on the rights of persons with disabilities reported that at least 32 countries had either undertaken or were in the process of implementing legal reforms on the right to legal capacity of persons with disabilities. However, it is important to note that these reviews excluded mental health legislation.<sup>31</sup> Furthermore, since legislative amendments can take several years, laws passed within a few years of General Comment 1 would have been drafted prior to the CRPD Committee’s May 2014 interpretation. Nonetheless, there has been some progress, the majority of which relates to the incorporation of supported decision-making—an important and necessary step in CRPD compliance—into legislation. Unfortunately, “most of these laws and bills are not in full compliance with article 12 of the Convention,” as the Special Rapporteur on the rights of persons with disabilities has pointed out.<sup>32</sup> For example, in Northern Ireland, the Mental Capacity Act came into force in 2019 and makes decision-making capacity the trigger for all non-consensual interventions, but the act remains discriminatory because it still has a greater impact on those with psychosocial disabilities. Thus, six years after the publication of General Comment 1, no country has banned involuntary detention and treatment, and some have specifically rejected the CRPD’s interpretation.<sup>33</sup>

## The way forward: The case for interim “holding” legislation

This stasis negatively affects the lives of millions of psychiatric patients worldwide who remain subject to involuntary confinement and enforced treatment. To overcome the stalemate, I propose the following unprecedented step as a proportionate and justifiable response: all states should introduce or amend their mental health legislation in a way that significantly reduces coercion, with a clear intention to comply with the CRPD fully in due course. Signatory states must “refrain from adopting any retrogressive measures that directly or indirectly affects [sic] persons with disabilities,” but legislative amendments that improve on the status quo will not be a backward step.<sup>34</sup> Where no current law exists, mental health legislation should be introduced urgently to provide a legal framework to prevent violations, protect and promote human rights not previously enshrined, and provide a justiciable framework for those with psychosocial disabilities.<sup>35</sup> The use of interim legislation finds support in the Human Rights Committee’s General Comment 35, which recommends the revision of “outdated laws and practices in the field of mental health in order to avoid arbitrary detention.”<sup>36</sup> Admittedly, the repeated amendment of legislation within a short time frame is unlikely to find favor with many governments. Nonetheless, reducing compulsion and increasing individual empowerment to protect and promulgate the rights of those with psychosocial disabilities is at the very least a moral imperative.

### *Progressive realization*

The use of “holding” legislation with the intention of improving safeguards and strengthening rights while alternatives to coercion are scaled up is, in essence, “progressive realization.” This concept permits states to take appropriate (including legislative) steps to introduce rights as quickly and effectively as possible within the confines of their finite resources. “Appropriate” steps “should be deliberate, concrete and targeted.”<sup>37</sup> Such a process appears to be supported by the CRPD Committee itself, given its sometimes ambivalent language.

For example, in its General Comment 5 on living independently and being included in the community, published three years after General Comment 1, the committee urges states to “take steps to the maximum of their available resources” “to ensure the full implementation of article 19.”<sup>38</sup> They are exhorted to “[a]dopt clear and targeted *strategies* for deinstitutionalization, with *specific time frames* and adequate budgets, in order to eliminate all forms of isolation, segregation, and institutionalization of persons with disabilities.”<sup>39</sup> D. Pūras and J. Hannah use comparable language, calling for “the progressive move towards an end to all forced psychiatric treatment and confinement.”<sup>40</sup> Similarly, the terminology in a 2018 report by the Special Rapporteur on the right to health acknowledges the practicality of gradual change.<sup>41</sup>

Yet, progressive realization is permitted only with respect to social, cultural, and economic rights (such as the right to health), rather than civil and political rights (such as the right to liberty); and it does not apply to discrimination.<sup>42</sup> There is no real answer to that conundrum, other than to recognize that improved protection, promotion, and fulfilment of rights is preferable to the status quo. The lawfulness of any new or amended legislation will depend on its amplification of the rights of those with psychosocial disabilities, its restriction of the scope for human rights violations, and a clear aim of an eventual total ban on coercion. Such improvements are unlikely to amount to the kind of “retrogressive measures” that UN bodies preclude.<sup>43</sup>

### *Legislation versus soft law*

It might be argued that updating “soft law”—such as codes of practice, rules, and regulations—would be as equally effective as amending legislation.<sup>44</sup> However, this would be insufficient. First, citizens (and busy clinicians) are more likely to respect and utilize source legislation than the soft law extrapolating it. Second, resort to the law will be the default upon any mismatch, resulting in little reduction in coercion—particularly in LMICs where under-funding may mean that legislative guidance in hospitals is unavailable or difficult to obtain. Third, in 2011 the World Health Organization (WHO)



found that 15% of countries had mental health legislation enacted before 1970.<sup>45</sup> Such laws contain highly stigmatizing language. For example, Gambia's Lunatic Detention Act of 1917 was criticized for its dehumanizing terminology by the African Commission on Human and Peoples' Rights in *Purohit and Moore v. Gambia*.<sup>46</sup> Similarly, in 2017, section 5 of Zambia's Mental Disorders Act of 1951 was held unlawful by the country's Constitutional Court partly due to its discriminatory language.<sup>47</sup> Regrettably, for centuries, those with psychosocial disabilities were considered dangerous or comical, and legislation framed them as nonentities requiring removal from the rest of society. An approach so fundamentally contrary to current human rights standards means that extra-statutory guidance seeking to reduce coercion and enhance autonomy would make little sense; such laws require urgent repeal and replacement. However, since international human rights standards evolve over time with cultural normative change, some quite recent legislation may also require amendment. While an arbitrary cut-off point is not ideal, some guidance is needed. Taking the year of the publication of General Comment 1 as a starting-point (2014), I propose the amendment of laws over five years old, as they are highly likely to be non-compliant with current international human rights standards.

### Guidance on legislative amendment

The first step in eventual adherence to the CRPD is to undertake a "comprehensive legislative review" to identify violations of international human rights law, as advocated by the Special Rapporteur on the rights of persons with disabilities.<sup>48</sup> This should encompass different relevant areas of law, including family, criminal, mental health, tort, and contractual law. Thereafter, mental health policies must be updated and should state a clear intention to ban coercion on the basis of psychosocial disability within a specified period. Until General Comment 1, there was relatively clear agreement on the necessary key components of mental health legislation, with WHO's 2005 *Resource Book on Mental Health, Human Rights and Legislation* widely utilized.<sup>49</sup> With

this resource book now withdrawn for non-compliance with the CRPD, WHO's QualityRights training and guidance materials may instead prove useful for policy rethinks and legal drafting. These materials cover broad topics such as "freedom from coercion, violence and abuse," "strategies to end seclusion and restraint," and "supported decision-making and advance planning."

The reduction and ultimate exclusion of force will require innovative thinking. This paper is not intended as a complete guide to all principles necessary in internationally compliant mental health legislation; rather, it highlights key requirements and the law's role in driving up standards with a view to eventual conformity. I propose that core legislative change focus on four essential aims: (1) building on procedural and substantive protections; (2) reducing coercion and unnecessary interferences with liberty and bodily integrity; (3) non-discrimination and empowerment; and (4) target-setting to reduce and eventually eliminate coercion within a specific and reasonable period.<sup>50</sup>

### (1) Building on procedural and substantive protections

Mental health legislation encapsulates substantive and procedural rights and may cover a broad array of issues. Laws have always specified the circumstances in which the involuntary admission and treatment of those with psychosocial disabilities is permitted, including seclusion and restraint. To such compulsion attach procedural rights—such as the rights to legal representation and to regular and swift independent review of any detention criteria—in accordance with the right to fundamental fairness. Protective negative rights guaranteeing freedom from torture, from cruel, inhuman, and degrading treatment, from abuse, and from discrimination are frequently set out, and offenses specific to hospital and care staff may be described, along with criminal penalties. Positive rights such as the promotion and protection of human rights are often enshrined, as are the legal mechanisms to enforce them. The creation and powers of independent review bodies to oversee hospital admission

and treatment, as well as the establishment of independent monitoring, inspection, and complaints bodies, may be incorporated into either legislation or regulations. Another frequently included positive right is the right to affordable quality mental health care, support, and services. There may be provision for the accreditation of facilities and professionals, including their training, although these may be contained in rules or regulations. More recently drafted legislation often aims at the integration of mental health into primary health care and demands community rehabilitation options for those with psychosocial disabilities. In addition, laws may contain provisions on rights to social protection, such as freedom of association, privacy, citizenship, and marriage. All such provisions enhance disability rights and should continue to be included in mental health legislation.<sup>51</sup>

## (2) Reducing coercion and unnecessary interferences with liberty and bodily integrity

The principles of least restriction and detention as a last resort are so universally accepted that arguably they now form part of customary international law and are binding.<sup>52</sup> However, in many resource-poor countries, institutionalization is the default pathway of care for those with psychosocial disabilities, with Paraguay, for example, recently admonished by the Special Rapporteur on the right to health for investing in tertiary care.<sup>53</sup> Despite WHO's call for reduced institutional care almost 20 years ago, the number of beds available in psychiatric wards in general hospitals increased globally by 60% between 2011 and 2014.<sup>54</sup> In 2017, high-income countries had 52.6 psychiatric hospital beds per 100,000 population, compared to 1.9 beds per 100,000 population in LMICs.<sup>55</sup> Yet, there is a powerful argument that "[e]mpowerment and recovery cannot happen in closed settings."<sup>56</sup>

### *Increasing community options*

Less restrictive alternatives to confinement are vital, as General Comment 35 states.<sup>57</sup> The embedding of strong community mental health services in law

is an indispensable aspect of any deinstitutionalization program.<sup>58</sup> Article 19 of the CRPD provides for the right to live independently and to be included in the community, and article 26 requires signatory states to "organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes" to ensure that those with disabilities enjoy "full inclusion and participation in all aspects of life." However, care in the community should not be coercive. The Special Rapporteur on the rights of persons with disabilities has complained about an expansion of "mandatory outpatient treatment, which not only increases involuntary interventions, but also allows for other forms of abuse such as illegal curfews" and similarly discriminatory practices such as tagging.<sup>59</sup> There is increasing evidence that non-coercive models of care within the community are more efficacious than traditional biomedical notions of compulsive support and treatment.<sup>60</sup> They better protect human rights, are easier to access (particularly for those from rural communities), and reduce stigma. There is no interruption to family relationships, friendships, or employment during treatment, with studies reporting better continuity of care, increased adherence to treatment, and greater user satisfaction.<sup>61</sup>

Where community-based alternatives to hospitalization are not already available, states must be obligated to create them. This will require strategic change to mental health priorities, with policies focused on building the necessary structures. Planning should emphasize the mainstreaming of mental health into primary care and community rehabilitation to enable local access, as Rwanda, for example, has done to good effect.<sup>62</sup> Plainly this cannot happen overnight. Presently, no country has sufficient community-based options to meet the collective need, and there is vast variability worldwide.<sup>63</sup> Indeed, high-income countries have approximately 200 times more financial resources for their mental health services than low-income countries.<sup>64</sup> Accordingly, no single model of care is replicable globally. However, the principle of least restriction requires all mental health legislation to include initial consideration of community-based alternatives to involuntary hospitalization, in-

cluding available support from family members or friends.

The precise mechanics of a country's preferred community care structures need not necessarily be incorporated into law, but should be embedded in both policy and strategy to ensure implementation. WHO is currently compiling human rights-based guidance to help community-based mental health services (including acute services) promote autonomy, community inclusion, and the involvement of people with lived experience of psychosocial disability at all levels of decision-making. Peer and circle-of-support methods, which foster the recovery approach through needs-based, people-centered services, are growing, with the open dialogue model of Finland and the personal ombudsman introduced by Sweden both reaping rewards.<sup>65</sup> The "Soteria paradigm" enhances the autonomy of those with schizophrenic spectrum disorders through small, community-based therapeutic environments with significant lay support, social networks, and communal responsibilities.<sup>66</sup> The UK's crisis resolution and home treatment teams have proved effective even for those in crisis.<sup>67</sup> Trieste in Italy has had considerable success in its "shift from hospitalization to hospitality," which was initiated in the 1970s through a "whole life vision" and participatory health care at community mental health centers with limited beds for "guests" rather than inpatients.<sup>68</sup> Every country must develop its own accessible and culturally adapted community-based psychosocial interventions that best meet people's needs.<sup>69</sup>

#### *Ringfencing community care budgets*

Without proper planning and budgeting, the prohibition of coercion could herald a reduction in the quality of life and morbidity of some patients and trigger a rise in the mortality rate.<sup>70</sup> However, "where bed reduction is done responsibly ... the overall costs of community-based care are similar to those of hospital-based services for long-term patients, while the quality of life and satisfaction among individuals receiving residential care in the community are higher."<sup>71</sup> Globally, median spending on mental health is approximately 2%

of total government health spending, with expenditure per capita only US\$2.50 in 80 countries.<sup>72</sup> Small mental health budgets in LMICs are spent mainly on inpatient care, with "significant financial and human resources pouring into mental health services that are, by design, constructed to violate human rights," as decried by D. Pūras and J. Hannah.<sup>73</sup> A shift to community rehabilitation programs requires an inevitable initial outlay—with government buy-in often difficult to obtain.<sup>74</sup> Yet, plenty of efficacious alternatives to coercive care can be implemented relatively cheaply through "task-shifting" via non-specialized lay staff "with a rich understanding of the socio-cultural context."<sup>75</sup> Interventions focused on mental health promotion and prevention in LMICs have been shown to be cost-effective.<sup>76</sup> However, absolutely crucial to the success of such programs is ringfenced health budget finance, which will require considerable lobbying globally; current government spending on mental health worldwide in terms of percentage of the health budget is woeful.<sup>77</sup>

#### *Restricting the availability of hospitalization*

Until the abolition of involuntary hospitalization and medical treatment, mental health legislation will remain the gatekeeper governing admission to psychiatric facilities and consent to treatment. Traditionally, the right to liberty has been subject to exceptions based on criminality, dangerousness (to self or others, necessarily judged subjectively rather than "watertight safeguards"), or necessity.<sup>78</sup> In some countries, such as Malawi, a hospital order may be lawfully obtained on the opinion of a "relative, partner or assistant" of the person with disabilities solely on the basis of "unsoundness of mind," with no need for a medical diagnosis or a particular degree of illness severity.<sup>79</sup> General Comment 35 suggests that "any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others," but the Special Rapporteur on the right to health has criticized such "broad and subjective grounds."<sup>80</sup> Any such legislative justifications must be further



circumscribed, be based on objective criteria, and include the procedural protection of at least two professional opinions except in a clearly and tightly defined “emergency.”<sup>81</sup>

### *International cooperation*

Wealthier nations with significant community care infrastructure already in place have little excuse for delay in the implementation of policy and legislation prioritizing community rehabilitation with a view to phasing out compulsion. UN Sustainable Development Goal 17 requires states to provide, seek, and accept international cooperation where necessary.<sup>82</sup> However, “[i]nternational assistance should not support ... health systems that are discriminatory or where ... human rights violations occur ..., particularly ... large psychiatric institutions and other long-term segregated care institutions.”<sup>83</sup>

### *Restraint*

Draconian practices such as seclusion and physical or chemical restraint frequently occur in psychiatric detention. They are often used too hastily to prevent anticipated aggression instead of de-escalation techniques, to control or punish, or merely for staff convenience.<sup>84</sup> It is strongly arguable that restraint lacks any therapeutic justification, and M. Chieze et al. recently estimated a 25–47% incidence of post-traumatic stress disorder after intervention.<sup>85</sup> Accordingly, the Special Rapporteur on torture has advocated for the immediate and total cessation of all restraint measures.<sup>86</sup> However, some argue that this is not viable.<sup>87</sup> Certainly, any inclusion of restraint and seclusion in mental health legislation prior to a complete ban on coercion must be severely curtailed. It must be permissible only in an emergency for the shortest period of time commensurate with any risk. Other procedural protections required are swift and regular reviews of restraint after commencement. Legislation should also demand that careful records be kept of such interventions, with an independent review of all such decisions to discourage their use and increase staff accountability.

### (3) Non-discrimination and empowerment

Non-discrimination requires those with psychosocial disabilities to be treated in the same way as others, including with regard to their choices on whether and where to accept treatment, and what type of treatment they desire. It is tied to the principle of empowerment, which in the psychiatric context means maximizing the choice, influence, and control of those with psychosocial disabilities over events in their lives, thereby enabling self-management of disability to the highest degree possible.<sup>88</sup> This fits with the biopsychosocial model of care, which is based on relationships of therapeutic reciprocity, rather than one-sided domination and control. The UN recognizes that “[e]mpowerment is a basic precondition for the recovery of many persons who struggle with critical psychosocial challenges,” and respect for autonomy has been evidenced to improve health outcomes. K. Sugiura et al. usefully list a number of mental health laws passed between 2011 and 2017 with innovative provisions intended to increase the autonomy of those with psychosocial disabilities.<sup>89</sup>

### *Consultation with service users*

Under article 4(3) of the CRPD, states must “consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations” in strategic planning on mental health and the development and implementation of legislation and policies. Any new law should crystalize such rights. Those with psychosocial disabilities should be appointed to monitoring bodies and involved in decisions affecting psychiatric patients at the individual and strategic levels. For example, panelists of the UK’s first-tier tribunals reviewing compulsory hospital detention have traditionally comprised a psychiatrist, a lawyer, and a lay member who is usually a social worker. Instead, the latter could be someone with lived experience of psychosocial disability to provide a service user’s perspective.

### *Respecting will and preferences*

The right to the highest attainable standard of

health enshrined in article 25 of the CRPD must be “on the basis of free and informed consent,” which must be obtained *prior* to any treatment.<sup>90</sup> However, substitute decision-making is the prevalent treatment model and often overrides the wishes of those with psychosocial disabilities, usually on the basis of their “best interests.” This concept “contradicts respect for the will and preference of individuals.”<sup>91</sup> General Comment 1 demands the complete prohibition of substitute decision-making in favor of supported decision-making, since those with disabilities “enjoy legal capacity on an equal basis with others in all aspects of life” under article 12(2).<sup>92</sup> Such capacity must be respected “at all times, *including in crisis situations*.”<sup>93</sup> Plainly this is not the case anywhere at present; doctors, social workers, and sometimes family members have legal powers to compulsorily detain people on the basis of mental disorder, with patients forced to take psychotropic medication. Mental health laws must maximize empowerment, with supported decision-making the rule, not the exception. Any divergence from a person’s wishes should always be explained (to both the individual concerned and any staff involved in their care), recorded, and regularly reviewed. Useful global examples of context-appropriate approaches to implementation of supported decision-making in mental health care have been highlighted in recent research.<sup>94</sup> Different models include formal and informal networks, support agreements, an independent advocate who “genuinely represents *and defends* the wishes and interests of the individual” in accordance with General Comment 35, advance directives, legal capacity assistance from a trusted person of the individual’s choice, and peer support.<sup>95</sup> The Special Rapporteur on the rights of persons with disabilities has called specifically for more recognition and integration of the latter into legislative frameworks.<sup>96</sup>

States have a duty to provide support to those with psychosocial disabilities where necessary. Paragraph 17 of General Comment 1 views “support” as a broad term encompassing both informal and formal support arrangements of various types and intensity. The Special Rapporteur on the rights

of persons with disabilities cautions against a “one size fits all” approach to supported decision-making as being discriminatory and likely ineffective, and lists various possible types of necessary support, such as sign language expertise.<sup>97</sup> A code of practice or regulations can be drafted to flesh out further details.

### *Advance planning*

Advance planning provisions complement the empowerment approach and should be included in mental health laws, as recommended by the Special Rapporteur on the right to health.<sup>98</sup> Unfortunately, current legislation tends to permit the overruling of advance decisions in various circumstances. For example, the validity and applicability of “advance directives” permissible under section 24 of the UK’s Mental Capacity Act of 2005 can be challenged under section 25 on several subjectively assessed bases. Proposed new mental health legislation would also permit deviation from such directives for “compelling reasons.”<sup>99</sup> Joint crisis plans include elements of advanced directives through shared decision-making between service users and professionals. There is some evidence of their cost-effectiveness and ability to improve therapeutic relationships.<sup>100</sup> Any new legislative criteria for overriding decisions on hospital treatment made prior to admission must be unequivocal and limited in scope. Advance decisions made after the abolition of coercion will require respect even when a refusal of hospitalization or medication is contrary to clinical opinion.

### *Guardianship*

Also contrary to article 12 of the CRPD are guardianship provisions, obliging those with psychosocial disabilities to reside in a particular place and sometimes to follow a particular treatment regime.<sup>101</sup> Current procedural protections include limiting guardianship to a remedy of last resort, selection of the guardian by the person with psychosocial disability, periodic review of guardianship orders, and the right to appeal decisions that remove or restrict legal capacity. Nonetheless, “[a]ll such reforms fall short in respecting the rights of persons with

disabilities.”<sup>102</sup> Many of the efforts toward introducing supported decision-making regimes maintain elements of substitute decision-making, or coexist with regimes.<sup>103</sup> However, Costa Rica’s Law No. 9379 of 2016 has abolished all forms of guardianship, creating instead the legal figure of “guarantor of equality before the law of persons with disabilities.” Similarly, Peru recently abolished both guardianship and substitute decision-making through a bill drafted by multi-stakeholder commissions.<sup>104</sup> Guardianship—and consent provided for hospitalization, treatment, or accommodation contrary to the wishes of a person with psychosocial disability by legal guardians or family members—cannot be justified and should be banned immediately.<sup>105</sup>

#### (4) Target-setting to reduce and eventually eliminate coercion within a specific and reasonable period

While consensus on the eradication of compulsion in psychiatry is unlikely any time soon, CRPD implementation must be conscientious. This requires timebound targets for the reduction and elimination of force in health care settings. Time frames for the introduction or national rollout of community rehabilitation options should be incorporated into both policy and legislation. A US federal court recently criticized the state of Mississippi for “policy changes that both decrease and increase institutionalization,” with citizens “trapped in a snail’s-pace deinstitutionalization” process.<sup>106</sup> A specific and reasonable time limit for an end to coercive measures within legislation and policy makes justiciable any failure to abide by the specified period. The total prohibition of coercion within 10 years is suggested as a reasonable time frame which all signatory states should aim to meet, with high-income states having little excuse for failing to comply earlier. States should create or empower a body to police the meeting of policy and legislative targets. Although each state must set goals and targets within the parameters of its own particular context and resources, an outer time limit set by the CRPD Committee itself would greatly assist in preventing drift.

## Other benefits of updating mental health legislation

### *Improving care standards and reducing stigma*

WHO’s Mental Health Gap Action Programme (mhGAP) emphasizes that “[m]ental health law codifies and consolidates the fundamental principles, values, aims, and objectives of mental health policies and programmes.”<sup>107</sup> An often undervalued benefit of mental health law is its more subtle and less measurable effects. As H. Liebling and L. Davidson et al. have observed, “mental health legislation also has an important symbolic as well as functional role, and can progress a moral imperative for improved mental health systems.”<sup>108</sup> Laws can gradually change the understanding, values, and discriminatory beliefs of the general public and mental health professionals alike. Codifying strict parameters for control and requiring a partnership approach between clinician and beneficiary will slowly change attitudes on the acceptability of custodial settings and coercion, reducing the stigma surrounding psychosocial disability. Decreasing compulsion will significantly alter the status quo, even if full compliance with international human rights standards remains unfeasible for some years to come.<sup>109</sup> Legislative change should coincide with public awareness campaigns explaining legal intentions and rights. Training and professional development components should include legal rights and obligations for all clinical staff, ensuring reconsideration of the levels of acceptable risk to others. Gradually, pervading and long-held paternalistic views and prejudices will alter. Thus, paradoxically, mental health laws that legitimize compulsory detention and medical treatment on the basis of disability—for a limited and tightly circumscribed period—can be a powerful tool for change.

## Conclusion

In 2018, the Special Rapporteur on the right to health declared the field of mental health to be “on the verge of freeing itself from a pattern of coercion and institutionalization.”<sup>110</sup> Any cause for celebration was somewhat premature. However, he

correctly observed that “[w]e are at a crucial point in terms of influencing how we ... shape the next [decade] as regards ending the cultural dependence on confinement and incarceration.”<sup>111</sup> P. Bartlett highlights the practical repercussions of the present impasse succinctly thus:

*However important the new human rights paradigm may be, and however much the new paradigm should be promoted, the existing, non-compliant structures will be around for many years to come. For the people enmeshed in those structures, the substantive and procedural protections of the old paradigm may well still bring considerable benefits.*<sup>112</sup>

That is, of course, if there are any such protections. Almost a third of 111 countries reporting to WHO in 2017 had no stand-alone mental health legislation whatsoever, and such legislation existed in only 36% of low-income states. Countless vulnerable patients residing in the other 64% continue to be subjected to compulsory psychiatric detention and treatment without legal basis or procedural protection.<sup>113</sup>

This paper has argued that mental health legislation remains essential worldwide to protect the international human rights of those with psychosocial disabilities. While to date such laws have legitimized psychiatric compulsion, they can simultaneously (1) reduce coercion through stringent substantive and procedural protections and empowering provisions that enhance the right to autonomy and (2) enshrine the principles of least restriction and last resort. New or improved laws can help drive up standards of mental health care, increase protection for human rights, and reduce prejudice and stigma. A global commitment to “holding” legislation as a precursor to a complete ban on coercion would be an antidote to the current stalemate regarding full implementation of the CRPD. The global pandemic makes the need for an end to psychiatric compulsion even more pressing. It is already having a substantial impact on people’s mental health, with a significant rise in stress and anxiety across the globe. Long-term psychological effects are likely from the prolonged strain caused by severe restrictions on liberty resulting from

quarantines and lockdowns. In the pandemic’s aftermath, the use of compulsion as a method of treatment is highly likely to be re-traumatizing.

The current inertia is inexcusable. The CRPD Committee has the wherewithal to end the current stasis by endorsing the updating of mental health legislation that, while not fully compliant with the CRPD, significantly *improves* compliance and thus rights protection for those with psychosocial disabilities. Small steps toward goals are always more realizable than huge leaps, and advanced adherence to international human rights and good practice standards through such legislation would improve the lives of millions. Accordingly, the CRPD Committee should issue a general comment to that effect as a matter of urgency, thereby providing the necessary “reluctant permission” for the progressive realization of respect for articles 12 and 14 of the CRPD. It should set a specific and pragmatic target date for full compliance (for example, within a decade), with earlier fulfilment where possible. In accordance with article 4(3) of the CRPD, those with psychosocial disabilities must be consulted about and involved in all modernizing processes. Only with the CRPD Committee on board with staged progress will there be any real global advance in the promotion, protection, and fulfilment of the rights of those with psychosocial disabilities, rooted in respect for human rights and individual empowerment, rather than compulsion.

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89. Pūras (2018, see note 6), para. 52. See also Mezzina (see note 68); Sugiura et al. (see note 65).

90. Committee on the Rights of Persons with Disabilities (2014, see note 10), para. 41.

91. Devandas-Aguilar (2017, see note 32), para. 48.

92. Committee on the Rights of Persons with Disabilities (2014, see note 10), para. 42.

93. *Ibid.*

94. See, for example, Sugiura et al. (see note 65).

95. Human Rights Committee (see note 17).

96. Devandas-Aguilar (2017, see note 32), para. 54.

97. *Ibid.*, para. 55.

98. Pūras (2018, see note 6), paras. 50, 66.

99. Independent Review of the Mental Health Act 1983 (see note 27).

100. C. Henderson, C. Flood, M. Leese, et al., "Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial," *BMJ* 329/7458 (2004), p. 136. However, *cf.* G. Thornicroft, S. Farrelly, G. Szmukler, et al., "Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial," *Lancet* 381 (2013), pp. 1634–1641.

101. Devandas-Aguilar (2017, see note 32), para. 51.

102. *Ibid.*, para. 50.

103. *Ibid.*, paras. 48, 64.

104. Peru, Legislative Decree No. 1384. Available at <https://www.mindbank.info/item/6782>.

105. Pūras (2018, see note 6), para. 50.

106. *US v. Mississippi* (DOJ), No. 3:16-CV-622-CWR-FKB (D Miss. 9-3-19), p. 13.

107. World Health Organization (2008, see note 35).

108. Liebling and Davidson et al. (see note 23), p. 88.

109. World Health Organization, *QualityRights guidance and training tools* (Geneva: World Health Organization, 2017). See further M. Funk and N. Drew, "WHO QualityRights: Transforming mental health services," *Lancet Psychiatry* 4 (2017), pp. 826–827.

110. Pūras (2018, see note 6), para. 11.

111. *Ibid.*, para. 16.

112. P. Bartlett, "Mental disability, the European Convention on Human Rights and Fundamental Rights and Freedoms, and the Sustainable Development Goals," in Davidson (2019, see note 7), p. 283.

113. World Health Organization (2018, see note 51), pp. 18–21; World Health Organization, *Social determinants of mental health* (Geneva: World Health Organization, 2014).