

# The need to reform mental health legislation in Commonwealth countries

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**The United Nations Convention on the Rights of Persons with Disabilities (CRPD) serves as a comprehensive and legally binding framework for the rights of persons with mental illness. The extent to which countries have adapted their mental health legislation to reflect the binding provisions outlined in the CRPD is unclear. This paper reviews the situation across the Commonwealth.**

## Shifting the discourse of mental health legislation

Historically, persons with mental illness (PWMI) were viewed as dangerous. This view later shifted to one of PWMI being vulnerable and requiring protection by sympathetic professionals and society. Internationally, this was reflected in the adoption of the Principles for the Protection of Persons with Mental Illness (commonly called the MI Principles) by the United Nations (UN) General Assembly in 1991. More recently, the UN Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly in 2006, has shifted the discourse towards the entitlements and rights of PWMI – a more collaborative, empowering discourse. However, our review of Commonwealth mental health legislation (Pathare & Sagade, 2013) suggests that many countries have yet to incorporate this discourse into their mental health laws. The review examined the laws of 45 countries, 28 of which had, at that time, ratified the CRPD. By December 2013 (at the time of writing of this editorial), 38 Commonwealth countries had ratified the CRPD.

Many of the laws are outdated – our review found 20% of the 45 Commonwealth countries had laws that had been enacted before 1960, when psychotropic medicines were introduced, 60% laws enacted prior to the introduction of the MI Principles and 90% laws enacted before the CRPD. At the time of the review, the oldest mental health law still in force in a Commonwealth country dated from 1902, while the most recent was from 2012. A law drafted prior to 1991 is unlikely to include provisions in line with MI principles and, similarly, laws drafted before 1960 are likely to reflect a perspective when there were few treatments for severe mental illness and incarceration was the norm.

The outdated nature of many mental health laws is also illustrated through the terminology employed. Our review found the word ‘lunatic’ used in laws in 12 countries, ‘insane’ in 11, ‘idiot’ in ten, ‘imbecile’ in two and ‘mentally defective’ in

two. Overall, 21 laws in Commonwealth countries (47%) use one of these terms, reinforcing the incapability of PWMI and thus reinforcing stigma.

## Rights and services

Ensuring the right to health means mental healthcare is equated with physical healthcare, access to mental healthcare is specified in legislation and community-based care is mandated within law (in line with Article 19 of the CRPD). Our review found only 5 (11%) of the 45 Commonwealth mental health laws equated physical and mental health, and 11 (24%) had some provision for promoting community-based care. However, the broad thrust of these 11 laws was towards institutional treatment and regulation. Arguably, community-based care and deinstitutionalisation are matters of broader health policy and not legislation; however, mental health laws themselves may be a barrier to enacting and implementing such policies.

Many PWMI receiving treatment are either unaware of their rights or not in a position to ask about their rights. Thus, a provision in legislation mandating health authorities to inform service users of their rights will help them to exercise those rights. Our review highlighted this deficiency, as the mental health laws of only 13 Commonwealth countries (29%) give patients the right to be informed of their rights while receiving care.

## The transition from guardianship to supported decision-making

Under Article 12 of the CRPD, which is reaffirmed by Article 13, PWMI have the right to recognition as persons before the law and are entitled to equal benefit and protection of the law. Article 12 has been celebrated worldwide by disability activists as representing a ‘paradigm shift’ in our perception of PWMI. However, professionals and service providers have been less enthusiastic, primarily owing to concerns about the decision-making capacity of PWMI and the lack of practical models for implementation.

Traditionally, concern about capacity led to the inclusion of guardianship provisions in mental health legislation – we found that 24 Commonwealth countries (53%) had guardianship provisions in their mental health legislation; of these, 7 (29%) allowed only limited guardianship (restricted to property matters), while 14 (58%) had provisions for both limited and plenary (full) guardianship. Plenary guardianship conflicts with obligations under the CRPD, as it does not allow PWMI to retain decision-making abilities, rendering them

non-persons before the law, contrary to Article 12. Limited and partial guardianship are preferred over plenary guardianship, as PWMI then retain some decision-making abilities, although, ideally, provisions for supported decision-making would be in place in legislation, in line with Article 12.

While the notion of supported decision-making is a relatively new concept and it would be premature to evaluate its implementation in legislation across Commonwealth countries, some (e.g. Australia, Canada, Scotland) have replaced guardianship provisions in mental health legislation with supported decision-making provisions, largely through separate capacity legislation. These countries could share lessons learned on transitioning to supported decision-making models with more resource-scarce Commonwealth states. Supported decision-making can be tailored to fit a country's legislative framework and resources, and can even make use of existing community resources (e.g. peer support to become 'supporters'). This more adaptive approach counters the argument that these rights for PWMI are particularly problematic in low- and middle-income countries, primarily due to fragmented public health systems and resource scarcity, based on a presumption that supported decision-making will be resource intensive. This is not necessarily true: Kumar *et al* (2013) showed it was feasible in India for PWMI to write a psychiatric advance directive (PAD; one form of supported decision-making), despite active symptoms, and to engage carers in the PAD process with little in the way of additional resources.

There are also major procedural problems with existing guardianship provisions in mental health legislation. Of the 24 countries with such provision, only 3 (13%) had legislation that gives the person who is the subject of the guardianship application the right to appear before a court at the guardianship hearing and to be represented there. In addition, 16 countries (67%) had no provisions for appealing to a higher court against a guardianship order; nor did 19 (79%) countries provide for regular time-bound review of guardianship orders, contrary to the requirements of Article 13(1) of the CRPD.

### **Involuntary admission and least restrictive care**

The last few decades have seen a movement towards voluntary care. Our review found that 32 countries (71%) had provisions for voluntary admission; however, few had laws stating that voluntary admission and treatment are the preferred alternatives. The majority of laws specified that persons voluntarily admitted to a mental health facility can be treated only after informed consent is obtained.

Currently, all Commonwealth laws allow involuntary admission and treatment for PWMI. We found laws in only 24 countries (53%) mandate that the mental disorder be of a specified severity to allow involuntary admission; in the remaining countries, there is no such requirement. Often,

laws allow involuntary admission only if there is a serious risk of harm to self or others, or a likelihood of serious deterioration in the patient's condition if treatment is not provided. This was the case in 31 Commonwealth countries (69%). Amendment of these provisions may be necessary to comply with the CRPD. In fact, the UN High Commissioner for Human Rights goes as far as to say that any form of involuntary admission or non-consensual treatment is considered non-compliant with the CRPD and provisions relating to involuntary admission and treatment should be removed from all mental health legislation (Mendez, 2013).

### **Moving forward**

Although there is substantial encouragement from regional, national and international actors to reform mental health legislation, as well as the shifting discourse on rights, many mental health laws still espouse guardianship, institutionalisation and protectionism as opposed to models of supported decision-making, community-based care and entitlement. The key goals of mental health legislation should be to facilitate better access to and the quality of mental healthcare, and to promote the rights to social inclusion of PWMI. A number of countries are currently reforming their legislation, the result of which may be more progressive mental health law. While legislation by itself cannot improve the situation in the absence of well designed and implemented policies and services, it is a necessary and important step.

Future work in this area should look at subsidiary legislation, which may have important provisions for rights protection, and explore civil, political and economic laws, as well as social and cultural rights for PWMI. The Commonwealth should provide technical and financial support, in particular for those countries with limited resources.

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