



Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation



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ABSTRACT

Background: Good mental health legislation is essential for ensuring high quality mental health care and protecting human rights. Many countries are attempting to bring mental health legislation in line with the UN – Convention on the Rights of Persons with Disability (UN-CRPD). The UN-CRPD requires policy-makers to rethink the ‘medical model’ of mental illness and existing laws. It also challenges WHO guidelines on drafting mental health law, described in the WHO Resource Book on Mental Health, Human Rights and Legislation (WHO-RB).

Aims: This study examines the relationship between the UN-CRPD and the WHO-RB.

Methods: It compares the documents, highlighting similarities and identifying areas of disagreement. The WHO-RB contains a checklist of human rights standards it recommends are met at national level. This study analyses each component on this checklist and identifies the relevant sections in the UN-CRPD that pertain to each. **Results:** Both the UN-CRPD and WHO-RB address more than just acute exacerbations of illness, providing guidelines on, inter alia, treatment, education, occupation and housing. They are patient-centred and strongly influenced by social rights. The UN-CRPD, however, gives just superficial consideration to the management of acute illness, forensic and risk issues, and does little to identify the role of family and carers.

Conclusion: The UN-CRPD has evolved from disability research and strong advocacy organisations. Careful consideration is needed to enable it to address the specific needs encountered in mental illness. Both the UN-CRPD and WHO-RB highlight common tensions that must be resolved by clinicians, and provide some guidance for stakeholders who commonly need to observe one principle at the expense of another.

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1. Introduction

1.1. International mental health legislation

Mental health law has a complex history, and while many laws were intended to aid individuals with mental illness, some have offered legal justification for discrimination and harmful social stereotypes (Melish, 2014). Mental health legislation emerged from the so-called ‘medical model’ which lead to an emphasis on difference and illness; this in turn promoted separation from mainstream society, stigmatisation and prejudice (Harpur, 2011). Nowhere is this more dramatically seen than in the in the asylum movement of the nineteenth century (Kelly, 2016a). Sporadic laws evolved firstly for the management of property belonging to people with mental illness; later laws sought to protect society from offenders influenced by mental illness (O’Neill, 2005).

The ‘medical model’ lead to a welfare model which saw individuals as requiring care to be provided for them. This care sought to help people with disabilities to overcome barriers in society but did nothing to address the existence of these barriers. Often, the provision of care further isolated them and erected additional barriers (Harpur, 2011). This model located the perceived deficit as being within the individual rather than identifying and addressing contributing factors within society which limited the person’s ability to realise their potential (Harpur, 2011; Schulze, 2010). Revisions of laws in some countries in the mid twentieth century were well-intentioned but excessively paternalistic, often stigmatising and continued to be informed by the ‘medical model’ (Lieberman & Ogas, 2015). The laws of Ireland, England and Wales typified this model, with a strong focus on involuntary treatment and a paucity of legislation ensuring the protection of people admitted to hospital on a voluntary basis, and minimal consideration of social and economic rights (Kelly, 2011).

Social movements in the 1960s and 1970s began collectively to question the assumptions underpinning this approach (Sabatello,

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2014). In recent decades, legislation and social reform have been harnessed to address the societal barriers individuals with impairments experience, with the aim of minimising the impact of these differences. The social model is replacing the 'medical model'; this model attributes disability to society's response to impairment rather than seeing impairment and disability as synonymous (Harpur, 2011). The World Health Organisation (1980) makes a clear distinction between these two concepts, it defines impairment as: "any loss or abnormality of psychological, physiological, or anatomical structure or function" (p. 27) whereas disability is the restriction or lack of functioning that results from impairment. Psychiatry has been slow to respond and is often hesitant in adopting a social model of disability. Only in recent decades have some countries attempted to reform legislation to make it more patient-centred. India's mental health legislation is particularly relevant to this discussion as it is currently being revised to make it concordant with the United Nations – Convention on the Rights of Persons with Disability (UN-CRPD) (Kelly, 2016b). It is one of many countries moving away from a welfare model to a social model.

Within human rights literature there is a separation between civil rights (addressed in the International Covenant on Civil and Political Rights) and social rights (addressed by the International Covenant on Economic, Social and Cultural Rights) (Schulze, 2010). The UN-CRPD aims to address social rights in addition to civil rights. The difference between civil rights and social rights has historically been somewhat fluid (Tushnet, 1992). Civil rights are seen as absolute, and must be provided irrespective of a society's economic position; these include for example freedom of association, religion and speech. Social rights, by contrast, are dependent on the wealth of the respective society and have economic implications; they include a right to housing, healthcare and education. Civil rights have a well-established position in international law and are widely accepted, whereas social rights have a more tenuous legal footing. This somewhat artificial separation has done much to hamper the cause of human rights (Schulze, 2010). The Vienna Declaration and Programme of Action (United Nations, 1993) sought to address this separation of civil and social rights and the UN-CRPD is the first human right treaty to implement its recommendations. This will have significant implications for future legislation relating to mental health and may well help promote more preventative and social interventions.

1.2. *The UN Convention on the Rights of Persons with Disability*

One of the driving documents in reforming mental health legislation in recent years is the UN-CRPD (United Nations, 2006). This convention was drafted between 2002 and 2006, in a process that involved both governmental and non-governmental organisations and drew heavily on input from disabled people's organisations (Schulze, 2010). The convention was adopted by the General Assembly of the UN in 2006 and came into force in 2008 (Steinert, Steinert, Flammer, & Jaeger, 2016). Currently there are 160 signatories to the convention. Equatorial Guinea, Botswana, South Sudan, Eritrea, Somalia, and Tajikistan are among the countries yet to sign the treaty. The United States of America, Suriname, Ireland, Netherlands, Libya, Belarus, Uzbekistan, Kyrgyzstan, Bhutan and the Democratic People's Republic of Korea (North Korea) are the main signatories yet to ratify the treaty.

The UN-CRPD does not create any new rights, but rather highlights how existing rights must be implemented in the realm of disability to maximise inclusion and limit stigma and discrimination (Schulze, 2010). The UN-CRPD is composed of a preamble followed by 50 articles, each derived from the Universal Declaration of Human Rights (United Nations, 1948) and core human rights treaties. The first four articles lay out the general principles of the document. This includes definitions, the purpose and general principles. Articles five to 30 provide legislation for the prevention of discrimination on the basis of disability and protect both civil and social rights. This includes, for example, the right to education (Article 24), health (Article 25), privacy (Article 22), mobility (Article 20), independence (Article 19) and freedom from torture

(Article 15) for individuals with disabilities. Women (Article 6) and children (Article 7) are identified as groups at risk of discrimination on multiple levels and their rights are specifically affirmed. Articles 35 to 50 set out the practicalities of implementing this at an international level.

Article 1 of the UN-CRPD states that persons with disabilities include those with long term mental or intellectual impairments (United Nations, 2006). The inclusion of mental health rights with disability rights is key to removing stigma and reducing discrimination of individuals with mental healthcare needs (Morrissey, 2012). Article 1 is a clear expression of the paradigm shift from the medical or welfare model to the social model. This is done by reference to the barriers that limit full and effective participation (Harpur, 2011). Despite this the UN-CRPD gives no definition of what is included in the concept of long-term mental or intellectual capacity.

The preamble to the UN-CRPD lays out twenty-five formative principles which shape and inform the document. These include the International Bill of Human Rights, the Convention on the Rights of the Child, the World Program of Action Concerning Disabled Persons and the Universal Declaration of Human Rights. These principles shed light on the evolution of the UN-CRPD, which has emerged from disability research rather than from the fields of psychology or psychiatry. They do not mention statements pertaining specifically to mental illness; in particular, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991). These principles are only mentioned once by Schulze (2010), in her discussion of the negotiations leading to the development of the UN-CRPD. These principles represented 'soft law' and have been supplanted by the UN-CRPD. However, their omission from both the preamble of the UN-CRPD and the discussion leading to its composition may suggest a desire to distance the UN-CRPD from mental health legislation. No mention is given to other regional conventions on mental health. The reference to mental 'impairment' in Article 1 of the convention, is, possibly, the only specific mention of mental ill-health in the document.

These factors suggest further careful consideration may need to be given to the application of the UN-CRPD in the context of mental health. The practice of psychiatry can present some of the most challenging ethical questions in medicine; issues concerning privacy, autonomy, dignity, independence, health and legal capacity arise on a daily basis and practices like seclusion and involuntary treatments are sources of much ethical debate. Failure to consider the specific implications of the UN-CRPD in the area of mental health may result in the unnecessary limitation of individual's rights. Without clear guidance there is a risk of idiosyncratic resolution of areas of conflict, or the UN-CRPD being ignored as it could be considered impractical for severe or acute episodes of illness. Some potential internal conflicts in the UN-CRPD are laid out in Table 1.

Article 25(b) of the UN-CRPD commits ratifying countries to providing "those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities.". This protects an individual's right to receive treatment. However, in the case of mental illness this right to treatment will, at times, be in conflict with an individual's right to freedom. Smebye, Kirkevold, and Engedal (2016) highlight how a person with dementia's autonomy can impact on the autonomy of the carer or the health care provider's commitment to non-maleficence. Psychiatry is not the only specialty in medicine where the rights of an individual may be in conflict with the rights of others. In the area of infectious diseases, governments balance the rights of the individual with the public health needs (with varying degrees of success) (Silva & Smith, 2015; Todrys, Howe, & Amon, 2013).

The UN-CRPD views health care as a human right rather than a civil right (Silvers & Francis, 2013). This may account for the more theoretical and principle based approach the UN-CRPD takes. Human rights

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