

# Human rights framework: An ethical imperative for psychiatry

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Mental health legislation, policy and practice can affect human rights (Dudley et al., 2012). This intersection of human rights and mental health has been a subject of considerable attention recently. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), 2006 highlighted the issue of human rights of people with mental disabilities by including mental disabilities in its ambit. It is imperative for the profession of psychiatry to adopt human rights discourse into its training, practice and language, to champion the goals of mental health promotion and advocacy. This would involve a comprehensive understanding of contemporary human rights framework adopted by the CRPD and its implications for involuntary treatment and economic, social and cultural rights of people with mental disabilities.

## International human rights framework

The contemporary human rights framework, based on conception of respect for inherent dignity of all humans, was crystallised by the United Nations through Universal Declaration of Human Rights (1948), which along with the International Covenant on Economic, Social and Cultural Rights (1966) and International Covenant on Civil and Political Rights (1966) forms the 'International Bill of Human Rights' (Dudley et al., 2012). Economic, social and cultural rights (also called positive rights) include the right to housing, food, education, employment, health and social inclusion and cultural

participation. Civil and political rights (sometimes called negative rights) include right to liberty; freedom from torture, cruel or degrading treatment; freedom from exploitation, violence or abuse; and the right to equal recognition before the law. While this dichotomy helps in conceptual understanding of human rights, it is well-recognised that all human rights are inter-dependent and indivisible (Dudley et al., 2012).

## United Nations CRPD, 2006

The International Bill of Human Rights did not explicitly mention human rights of persons with disabilities. The CRPD (available at: [www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html](http://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html)), which was adopted by the United Nations in 2006 and came into force in 2008, is the first international treaty that embeds the rights of people with disabilities in the international human rights law. It specifically mentions people with mental disabilities in its first article. The term disability (as against disorder/illness) signifies a social model wherein disability results from interactions between person with impairment and environmental barriers that hinder his or her full and effective participation in society.

The CRPD marks a paradigm shift in the understanding of and attitudes towards disability, by changing the status of a person with disability from a passive recipient of care to an active subject with rights. It not only promotes the human rights of people

with disabilities but also provides mechanisms for implementation, as article 4 requires the ratifying countries/State Parties to adopt appropriate legislative, administrative and other measures for the implementation of the rights recognised in the Convention. A 'Committee on the Rights of Persons with Disabilities' (hereafter called the CRPD Committee) has been established as per article 34 to monitor implementation of the CRPD, through periodic reports submitted by the State Parties. Furthermore, the countries which ratified the optional protocol of the CRPD are subject to inquiry by the CRPD Committee, following communication from individuals or groups indicating serious or systemic violations of the Convention. All the conventions and covenants which form international human rights regime are subject to challenges of implementation, as they are not generally enforceable unless incorporated into domestic law (Dudley et al., 2012). Nevertheless, the above mechanisms make the CRPD a stronger instrument for the protection of disability rights than the previous declarations.

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## Involuntary psychiatric treatment

The CRPD challenges traditional mental health legislation as it states that 'persons with disabilities have the right to equal recognition before the law' (article 12); 'the existence of a disability shall in no case justify a deprivation of liberty' (article 14); and 'every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others' (article 17) (Callaghan and Ryan, 2014). Article 12 has been at the heart of a renewed debate regarding involuntary psychiatric treatment and there is a range of interpretations of this article, because of what some experts have called 'ambiguities' in the text of the CRPD and its 'silence' on the issue of involuntary psychiatric treatment (Callaghan and Ryan, 2014; Dawson, 2015). Article 12(2) requires the State Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Article 12(3) then requires the State Parties to take appropriate measures to provide access to the 'support' that persons with disabilities may require in exercising their legal capacity.

The CRPD Committee emphasised through General Comment 1 on article 12 in 2014, that a human rights-based model of disability implies a shift from substitute decision-making to supported decision-making, arguing that the 'best interest' paradigm needs to be replaced by 'will and preferences paradigm' or 'the best interpretation of will and preferences of the individual' (available at: <https://www.ohchr.org/en/hrbodies/crpd/pages/gc.aspx>). There is general agreement that the CRPD requires that effective and timely support be available to those who as a result of their disability may struggle to make decisions (Callaghan and Ryan, 2014; Dawson, 2015; McSherry, 2014). However, the CRPD Committee then goes one step further in the General Comment 1 by interpreting CRPD as prohibiting

involuntary treatment under any circumstances and calling upon States Parties to abolish all substitute decision-making regimes, e.g., under guardianship and mental health legislation.

This interpretation of the CRPD has been termed radical by some experts, who have called for a more realistic interpretation (Dawson, 2015). It has been argued that while individual autonomy, will and preferences need to be respected and new supported decision-making mechanisms need to be implemented, there are times when substitute decision-making in the form of involuntary psychiatric treatment is required, where an individual lacks decision-making capacity (Callaghan and Ryan, 2014). These authors point to situations where the right to refuse treatment is in direct conflict with the right to health and argue that failing to account for decision-making capacity in these cases may jeopardise the right to the highest attainable standards of physical and mental health, social inclusion and adequate standard of living. They draw attention to the article 12(4) of the CRPD, which specifies that any measures relating to exercise of the legal capacity must: respect the rights, will and preferences of the person; be proportional and tailored to the person's circumstances; be free of conflict of interest and undue influence; apply for the shortest possible time; and be subject to safeguards and monitoring by a competent authority.

Therefore, it may be argued that the article 12(4) allows for involuntary psychiatric treatment as the last resort, under exceptional circumstances, with strong safeguards in place. This interpretation also implies that the diagnosis of a mental illness and assessment of risk to the individual or others do not constitute sufficient grounds for involuntary treatment unless the individual lacks decision-making capacity and all the supported decision-making provisions have been exhausted. The CRPD thus describes a trajectory for promoting

human rights by prioritising respect for inherent dignity and worth of every human being and minimising coercion. In order to ensure that minimisation of involuntary psychiatric treatment is a tangible reality, and not just an aspirational slogan, systematic operationalisation is required by legislating and providing voluntary alternatives, e.g., community-based services, access to early intervention, open wards, advance health directives, supported decision-making, co-produced individual recovery plans and participation of people with mental disabilities and their carers in mental health policy and planning (Mezzina et al., 2018). Finally, culture change in mental health services requires what Mezzina et al. (2018) call 'our own emancipation from institutional thinking and practice' to respect the autonomy of persons with mental disabilities.

## Economic, social and cultural rights

While involuntary treatment has been central to the debate regarding human rights and psychiatry, the CRPD also emphasises economic, social and cultural rights including the right to life (article 10), independent living and inclusion and participation in community (article 19), home and family (article 23), education (article 24), health (article 25), habitation and rehabilitation (article 26), work and employment (article 27), adequate standard of living and social protection (article 28) and participation in cultural life (article 30). Compliance with CRPD, therefore, requires provision of economic, social and cultural rights, especially the right to the highest attainable standard of health through accessible health services (McSherry, 2014). McSherry notes that the traditional focus of mental health laws on involuntary treatment for serious mental disabilities has skewed the system such that the right of access to treatment for individuals with high-prevalence mental disabilities has been compromised. Thus, those who want

access to mental health services are turned away because they are not unwell enough and those who do not want treatment are subject to involuntary treatment through the civil or forensic mental health system. She emphasises the need for a legal framework to shift the focus away from involuntary treatment and detention, to provide accessible and high-quality mental health and support services.

Academics and policy makers differ on whether to protect economic, social and cultural rights through legislation or through policy. Governments worry about legal repercussions if positive rights are legislated but not adequately delivered due to resource constraints. However, the CRPD article 4(2) allows for progressive realisation of those rights, subject to available resources and within the framework of international cooperation. Neither the international conventions nor domestic legislation can guarantee delivery of social reform, but they provide an impetus for change. Positive rights may be legislated either in mental health legislation or in an overarching human rights act, so that any subsequent legislative review or policy direction would have to ensure the protection and promotion of economic, social and cultural rights of people with mental disabilities. Moreover, it would publicly announce a society's commitment to economic, social and cultural rights for all its citizens. The realisation of these rights could then be incremental and progressive. There is a strong economic as well as moral argument to protect positive rights, as the burgeoning economic burden of mental disabilities can be minimised by addressing the social determinants of health through prevention rather than treatment and through empowerment instead of welfare. At a more fundamental level, the neoliberal pursuit of free markets

needs to be carefully balanced with inclusive human development, by bringing together themes of justice, empowerment, recovery, citizenship and human rights.

## Psychiatry, human rights and society

Viewing the ethical issues in mental health through a human rights lens would help psychiatry achieve a better balance between competing priorities than traditional risk-averse practices. A relevant question then is – how would human rights-based mental health legislation and the practice operate in the context of highly risk-averse media, politicians and society? The sensationalism of media against mental disabilities and risk-aversion in political circles both reflect ignorance and prejudice in society. Psychiatrists have to be on the forefront in dealing with these challenges by strong advocacy for human rights, dispelling myths and breaking down the barriers of stigma and discrimination, through public awareness-raising campaigns to promote mental health and social inclusion. A fair and equitable society, which respects the right to social inclusion of individuals with mental disabilities and provides access to mental health promotion, prevention and early intervention, would be the least likely to require involuntary treatment. Hence, prioritising positive rights would pave the way for the protection of negative rights of people with mental disabilities.

## Conclusion

The concept that people with mental disabilities have the same human rights as everyone else is more accepted today than a few decades ago. The competing priorities of

different sets of rights such as the right to autonomy, right to health, right to life and right to social inclusion need to be cautiously balanced in every instance. Economic, social and cultural rights of persons with mental disabilities must be protected and promoted, in addition to civil and political rights. This human rights discourse, when integrated into mental health legislation, policy and practice, may be the golden road to mental health advocacy.

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