

# A review of mental health legislation in Commonwealth member states

Soumitra Pathare, Laura Shields and Renuka Nardodkar

Promotion of mental health and human rights can be seen as complementary approaches to advancing the well-being of persons worldwide (Gostin and Gable, 2009). Violations of rights can affect mental health; one way of preventing human rights violations is through mental health law reform aligned to the promotion of the rights of persons with mental illness (PWMI) and leading to a progressive, well-formulated mental health law.

In an effort to protect and promote the rights of PWMI, several international conventions, although not aimed specifically at PWMI, have provisions which promote and protect the rights of PWMI. More recently, the UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted by the General Assembly in 2006 and serves as a comprehensive and legally binding framework for promoting and protecting the rights of PWMI (Drew et al., 2011). Globally, the CRPD has been celebrated as a universal standard for the promotion of human rights of persons with disabilities (Drew et al., 2011). Thirty-eight Commonwealth countries have ratified the CRPD while 11 others have signed the convention. It is, however, unclear whether countries which have ratified the convention have adapted their mental health legislation to reflect the binding provisions outlined in the CRPD. This article reviews the situation across Commonwealth member states to obtain an insight as to how mental health legislation in the Commonwealth complies with the CRPD and adopts a rights-based approach.

For this article, we analysed dedicated mental health legislation in Commonwealth member states. We were able to obtain copies of mental health laws from 45 countries but were unable to obtain copies of mental health laws of four countries (Rwanda, Saint Lucia, St Kitts and Nevis, and St Vincent and the Grenadines) and were also unable to obtain an official English translation of the mental health law in Cyprus. An extensive online search and correspondence with Commonwealth Health Professions Alliance (CHPA) partners revealed that Cameroon, Maldives and Mozambique did not have dedicated mental health legislation.

Our review (Pathare and Sagade, 2013) yielded several key findings, described below, which together highlight the need for mental health law reform across Commonwealth countries.

## Many mental health laws are outdated

Of the 45 Commonwealth country laws included in our review, 20 per cent of laws were enacted before 1960, when psychotropic medicines were introduced; 60 per cent of laws were enacted prior to the introduction of the MI Principles in 1991; and 90 per cent of laws were enacted before the CRPD. At the time of review, the

oldest mental health law still in force in a Commonwealth country dated from 1902, while the most recent was from 2012, indicating the wide variability in legislation throughout the Commonwealth. The relevance of classifying laws according to their date of enactment is that a law drafted prior to 1991, for example, is unlikely to include provisions in line with MI principles; similarly, laws drafted prior to 1960 are likely to reflect a time when there were limited treatment options available in the community and when institutionalisation of PWMI was prevalent.

## Stigmatising terminology used in mental health laws

The archaic terminology used in mental health laws to refer to PWMI also highlighted the need to amend legislation. 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 (47 per cent) of laws in Commonwealth countries use one of these terms, which reinforce stereotypes of PWMI and thus perpetuate the stigma faced by PWMI.

## Outdated mental health laws and non-compliance with the CRPD

While analysing mental health legislation, we found that outdated mental health laws were less likely to comply with provisions of human rights conventions, thus increasing the risk of violation of human rights, as described below:

**Right to health care:** The right to health care means that mental health care is treated on par with physical health care, and access to mental health care (particularly at the community level) is mandated in legislation and policy (in line with article 19 of the CRPD). Our review found that only five (11 per cent) of the Commonwealth mental health laws equated physical and mental health, and 11 (24 per cent) emphasised community-based care, although the primary focus of even these 11 laws was on institutional care and its regulation.

Further, access to care is compromised if mental health services are inappropriate to meet needs or are unaffordable. Our review revealed that 18 (40 per cent) laws gave governments the right to recover treatment costs incurred (including involuntary treatment in public mental health facilities) from the property or estate of PWMI or their relatives, friends or caregivers. This provision is problematic as it can be exploitative of PWMI and denies the right to social protection.



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*Professionalism is about dignity and rights. Pictured: nurses in Solomon Islands*

**Right to information and awareness of rights:** PWMI should have access to information about their care, in line with provisions in the International Covenant on Civil and Political Rights, the MI Principles and the CRPD. Our review found that only 12 (27 per cent) laws made specific provisions regarding access to information for PWMI. Even in circumstances where a provision exists on access to information, many PWMI may be 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 assist in exercising those rights. However, our review highlighted that mental health laws of only 13 Commonwealth countries (29 per cent) require professionals to inform PWMI of their rights while receiving care.

**Involuntary admission and least restrictive care:** There has been a shift over the last few decades from involuntary to voluntary care and this is evidenced by our review, which found that 32 countries (71 per cent) had provisions for voluntary admission; however, few had laws stating that voluntary admission and treatment are the preferred alternative. 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. Mental health laws in just 24 countries (53 per cent) mandate that the mental disorder must be of a specified severity to allow involuntary admission; in the remaining countries, there is no such requirement.

**Regular review of involuntary admissions:** Having review mechanisms in place and specified in mental health legislation is important as they provide a statutory safeguard with legal bodies to monitor involuntary admissions and treatment as well as appeals for care-related decision. Absence of such review mechanisms contravenes guarantees entitled to PWMI in article 14(b) of CRPD. Our review noted that more than two-thirds of mental health laws (31 out of 45) did not have provision for a judicial/quasi-judicial body to review involuntary admissions and treatment.

Furthermore, we found that mental health laws in only 26 (58 per cent) of Commonwealth countries had provisions for setting up an independent body to monitor mental health facilities and mental health care settings to prevent exploitation, violence and abuse inside as well as outside the mental health facilities. An additional finding was the underrepresentation of PWMI and their caregivers on such regulatory bodies.

**The need for a transition from guardianship models to supported decision-making models:** Articles 12 and 13 of the CRPD stress that PWMI have the right to equal recognition as persons before the law and are entitled to equal benefit and protection of the law. Article 12 has been celebrated by disability activists worldwide as representing a 'paradigm shift' in our perception of persons with disabilities. However, some health professionals have been less enthusiastic about this paradigm shift, primarily due to concerns about the decision-making

capacity of PWMI and the lack of implementable supported decision-making models.

Concerns about legal and mental capacity mean that persons with mental illness in many countries are assigned a guardian to make decisions on their behalf. Our review found that 24 Commonwealth countries (53 per cent) had guardianship provisions in their mental health legislation. Of these, seven (29 per cent) allowed only limited guardianship (restricted to decisions on property matters), while 14 (58 per cent) had provisions for both limited and plenary (full) guardianship. Plenary guardianship conflicts with obligations under the CRPD (particularly Article 12), as it does not allow PWMI to retain any decision-making abilities, rendering them non-persons before the law. Limited and partial guardianship are preferred over plenary guardianship as PWMI retain some decision-making abilities, although, ideally, supported decision-making provisions should be put in place, such as arrangements which respect the person's autonomy, will and preferences in the exercise of one's legal capacity in accordance with Article 12 of the CRPD.

While the notion of supported decision-making is a relatively new concept and it would be premature to evaluate its implementation in legislation across the Commonwealth, some member countries (e.g. Australia, Canada and 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').

There are also a number of procedural problems with existing guardianship provisions in mental health legislation. For example, of the 24 countries with guardianship provisions only three (13 per cent) allow for the person subject to the guardianship application the right to appear personally and be represented at the guardianship hearing. In addition, 16 countries (66 per cent) have no provisions for appealing to a higher court against a guardianship order and 19 (79 per cent) do not provide for regular time-bound review of guardianship orders, contrary to the requirements of article 13(1) of the CRPD.

**Respect for dignity:** Our review revealed that provisions asserting the right to dignity are lacking in 37 mental health laws, while only 23 countries have provisions related to protection against cruel, inhuman and degrading treatment. Informed consent of PWMI for participating in clinical and experimental research is specifically mandated in mental health legislation in only five member states. Laws in only two Commonwealth countries restrict involuntary admission of minors with mental health problems and laws in three countries have banned irreversible treatments in PWMI.

## Future directions for mental health law reform

Although there is substantial encouragement from regional, national and international actors to reform mental health

legislation, as well as to shift the 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 quality of mental health care, and to promote the rights of social inclusion of PWMI. One positive development is that a number of countries are already reforming their legislation, the result of which may be more progressive mental health laws.

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 movement should also consider providing technical and financial support to member countries with limited resources to help them review and amend their mental health legislation and protect, promote and fulfil the rights of all persons with mental illness in the Commonwealth.

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**DR SOUMITRA PATHARE** (spathare@cmhlp.org) is coordinator of the Centre for Mental Health Law and Policy at the Indian Law Society, India. Soumitra has worked as a WHO consultant to many countries, providing technical support for drafting mental health policies, and amending and replacing mental health legislation. He is also a member of the Ministry of Health and Family Welfare, Government of India – the policy group set to draft a new mental health policy and plan for the country.

**DR LAURA SHIELDS** is a research associate at the VU University Amsterdam in the Netherlands and a research fellow at the Centre for Mental Health Law and Policy and the Mental Health Law and Policy Action Lab at the Indian Law Society in Pune, India.

**RENUKA NARDODKAR**, MSc in Clinical Research, is working as research associate at the Centre for Mental Health Law and Policy and Mental Health Law and Policy Action Lab at the Indian Law Society, Pune, India.