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Mental health and the law: What else is needed for particularly vulnerable contexts facing armed conflict and development obstacles?

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Abstract

Mental disorders have high prevalence for disability and almost 80% of the global burden occurs in low- and middle-income countries. The impacts of mental health conditions can affect many sectors of society and threaten peace, human rights and development. However, international law jurisprudence has not sufficiently developed to guide mental health governance. This paper reviews the international

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legal protections for people who experience mental health conditions, including mental disorders and psychosocial disabilities. It focuses on State application of legal instruments in particularly vulnerable contexts, namely, least developed countries and situations of armed conflict. It argues that relying on existing treaties and soft-law instruments from the health and human rights angles is inadequate, and the Convention on the Rights of Persons with Disabilities is not the right fit. New hard- and soft-law instruments are urgently needed to meet positive obligations and safeguard rights in these vulnerable contexts. Some suggestions for the contents of future instruments are made.

Keywords: Mental health, mental disorders, armed conflict, least developed countries, Convention on the Rights of Persons with Disabilities, humanitarian action.

Introduction

Globally, mental disorders are among the top seven causes of health-related disability.[1] Almost 80% of the global burden occurs in low- and middle-income countries,[2] and many of these countries are also the most susceptible to armed conflict. The global prevalence of mental disorders is 10.6% of the population,[3] and for populations affected by armed conflict, the prevalence increases to 22.1%.[4] Despite the high prevalence, people with mental health conditions have not been prioritized as a target of humanitarian aid, development activities or law reform.[5]

"Mental health conditions" is a broad term to cover mental disorders, psychosocial disabilities and other mental states associated with significant distress, impairment in functioning, or risk of self-harm. When distress or impairment reaches a clinically significant level, leading to a disturbance in cognition, emotional regulation or behaviour, it is considered a mental disorder.[6] Mental disorders

1 Global Burden of Disease Collaborative Network, "Global Burden of Disease Study 2019", Results, Institute for Health Metrics and Evaluation (IHME), Seattle, WA, 2021, available at: https://ourworldindata.org/grapher/share-of-total-disease-burden-by-cause (all internet references were accessed in November 2022).

2 World Health Organization (WHO), *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group*, Geneva, 2010, available at: www.who.int/publications/i/item/9789241563949; WHO, *World Mental Health Report: Transforming Mental Health for All*, Geneva, 2022, available at: www.who.int/teams/mental-health-and-substance-use/world-mental-health-report.

3 Global Burden of Disease Collaborative Network, above note 1.

4 Fiona Charlson, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford and Shekhar Saxena, "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis", *Lancet*, Vol. 394, No. 10194, 2019.

5 Report of the Special Rapporteur, Paul Hunt, on The Right of Everyone to the Enjoyment of the Highest Available Standard of Physical and Mental Health, UN Doc. E/CN.4/2003/58, 13 February 2003.

6 WHO, "Mental Disorders", 8 June 2022, available at: www.who.int/news-room/fact-sheets/detail/mental-disorders. Note that, across the sectors, the terms "mental illness" and "mental disorder" are used interchangeably. This paper will use the terminology "mental disorders", as outlined by the WHO and the American Psychiatric Association, unless referring to the specific language of a legal instrument where, for example, the term "mental illness" is used.

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include, among others, depressive disorders, anxiety disorders, schizophrenia, bipolar disorder and post-traumatic stress disorder. A psychosocial disability refers to the social consequences of a disability and the way that life is impacted by a mental disorder, such as limitations from being in certain environments, concentration, coping with life challenges, managing stress and interacting with others. The term "disability" arises if a person faces barriers to their equality with others.

The impact of mental health conditions reaches many sectors of society. The impacts include high unemployment rates, homelessness, poor educational and health outcomes, and poverty; and these issues are directly linked to the Sustainable Development Goals adopted in 2015.[7] Positive mental health for individuals protects dignity and is linked to good development outcomes, including: improved productivity, health, academic achievement, relationships, social networks, quality of life and coping with adversity.[8] For communities as a collective, this positive effect is magnified because good mental health for individuals also improves their ability as a breadwinner or caregiver, and as a supporting member of the family and community to which they belong. People are resilient, and if their mental health needs are addressed, they will be more likely to find reasons for hope, to help others and to participate in economic activities.

In contrast, poor mental health at an individual level depletes people's inner resources, and mental health conditions can be exacerbated and become long-term problems. At a community level, poor mental health hinders social cohesion and community contribution,[9] and this can lead to unhealthy cycles of social unrest and propensity for violence and armed conflict. Communities can struggle to regain a sense of agency, and efforts to rebuild strong communities can be negatively impacted, both in the short term, and they can also undermine the long-term well-being of a population. As a result, these impacts of mental health conditions may threaten peace, human rights and development. Despite the prevalence and burden of disease, and the important role of mental health, international law jurisprudence has not sufficiently developed to guide mental health governance.

This paper will outline the international legal protections for people who experience mental health conditions, including mental disorders and psychosocial disabilities.[10] It will focus on State application of legal instruments in particularly vulnerable contexts. For the purpose of this paper, particularly vulnerable contexts include least developed countries (LDCs) and situations of armed conflict. This paper will argue that reliance on existing treaties and legal instruments is inadequate and that new hard- and soft-law instruments are urgently needed to meet positive obligations and safeguard rights.

7 UN General Assembly, Transforming our World: The 2030 Agenda for Sustainable Development, General Assembly Resolution 70/1, UN Doc. A/RES/70/1, 21 October 2015.
8 *Ibid.*
9 *Ibid.*
10 This paper focuses on the legal instruments. A deeper discussion on economic and resource issues is beyond the scope of this paper.

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LDCs and situations of armed conflict

LDCs are low-income countries experiencing severe obstacles to sustainable development due to structural instability, economic insecurity, disaster vulnerability, and poor medical infrastructure and human assets.[11] The United Nations (UN) lists forty-six LDCs: 72% in Africa, 20% in Asia, 6% in the Pacific, and 2% in the Caribbean.[12] These countries comprise 12% of the global population; however, they account for less than 2% of the gross domestic product (GDP).[13] Only six countries have graduated from LDC status since 1994, revealing the challenges of overcoming development barriers. Other particularly vulnerable contexts are those which are affected by armed conflict. Of the ten world's poorest countries, eight have suffered from large-scale armed conflicts.[14] While armed conflict can occur as a result of many factors, there is a nexus between those facing development barriers such as economic stagnation, political and social inequalities, and environmental degradation, and those with security issues and the incidence of violence.

The following section will outline relevant international law instruments as they relate to mental health law, and highlight limitations which apply in particularly vulnerable contexts, that is, LDCs and situations of armed conflict. It will focus on UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UNMI principles)[15] adopted by the General Assembly Resolution in 1991; the World Health Organization's (WHO's) ten basic principles of mental health law (WHO MHL principles), developed in 1996;[16] and the Convention on the Rights of Persons with Disabilities (CRPD).[17]

Relevant international law instruments regarding mental health protections

In terms of hard law, there is no specialized treaty which outlines detailed international legal protections specific to mental health. Some treaties mention mental health, but they do not contain sufficient provisions, specific to mental health, to create positive duties for States; to limit the exercise of procedural discretions regarding mental health; nor to ensure effective remedies for

11 United Nations (UN) Conference on Trade and Development, "UN Recognition of the Least Developed Countries", 2021, available at: https://unctad.org/topic/least-developed-countries/recognition.
12 *Ibid.*
13 *Ibid.*
14 Frances Stewart, "Root Causes of Violent Conflict in Developing Countries", *British Medical Journal*, Vol. 324, No. 7333, 2002.
15 UN General Assembly, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, General Assembly Resolution 46/119, UN Doc. A/RES/46/119, 17 December 1991.
16 WHO, *Mental Health Care Law: Ten Basic Principles*, Geneva, 1996.
17 UN General Assembly, Convention on the Rights of Persons with Disabilities, General Assembly Resolution 61/106, UN Doc. A/RES/61/106, 24 January 2007 (CRPD).

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violations. For example, the WHO Constitution (1946) declares that the highest attainable standard of health is a fundamental right of every human being. This creates a legal obligation on States to ensure access to healthcare and to address health determinants, such as water, food, housing, health-related information and education, and gender equality. As we cannot separate mind and body, mental healthcare is contained within healthcare, but this has not always been automatically assumed by States without explicit mention. This general right to health is also outlined in Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) whereby States Parties are to take steps to realize the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health".[18] While mental health is specifically referenced as a human right in the ICESCR, the specificities of mental healthcare are absent, as is sufficient legal interpretation and commentary on the treaty, with relation to mental health. The CRPD has made some steps in the right direction, but as can be seen later in this paper, it also does not answer the necessary questions for mental health.

In addition to the gaps, dispersion of mental healthcare laws makes it hard to consolidate the guidance. In some States, resources for mental health services are outlined in local law,[19] but, in most, the funding of the services is seen as the responsibility of the Executive and policy makers. This means that trying to gather mental health laws and socio-economic rights which are spread throughout different laws can make it problematic for enforcement, and protections can become piecemeal and incomplete. It also offers States a wide margin of appreciation in implementing standards and incorporating the provisions into domestic legislation. This has not helped to advance the agenda for mental health rights. As a result, there remains a gap in hard law and its application, and subsequently a gap in mental health protections.

With regards to soft-law guidance on the topic of mental health in vulnerable contexts, this can be found in: The International Committee of the Red Cross (ICRC) Guidelines for Mental Health and Psychosocial Support[20] and the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings.[21] The ICRC publication includes the framework and approach to mental health and psychosocial support during and after armed conflicts and other situations of violence. This guideline raises

18 Constitution of the World Health Organization, New York, 22 July 1946 (entered into force 7 April 1948); UN General Assembly, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights and Optional Protocol to the International Covenant on Civil and Political Rights, UN Doc. A/RES/2200, 16 December 1966.

19 For example, mental health law in Brazil (no. 102216) legislates the government to allocate resources to mental health governance and services that are inclusive.

20 ICRC, *Guidelines on Mental Health and Psychosocial Support*, 2017, available at: www.icrc.org/en/publication/4311-guidelines-mental-health-and-psychosocial-support.

21 IASC, *Guideline: Mental Health and Psychosocial Support in Emergency Settings*, 2007, available at: https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Guidelines%20on%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings%20%28English%29.pdf.

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awareness of the mental health needs of affected populations and how mental health and psychosocial support should be provided. The IASC Guidelines were created to coordinate action among government and non-government humanitarian actors in the domain of mental healthcare in emergencies. They provide a multi-sectoral, inter-agency framework for effective coordination, identification of useful practices (and flag potentially harmful practices), clarification of different interventions, and form part of an advocacy package. While both guidelines are well regarded in the international humanitarian sectors, they are designed for practitioners and do not provide specific and binding guidance for States for advancing legal protections for people with mental health conditions.

Two other sources of guidance in international mental health law are the UNMI principles[22] adopted by a General Assembly Resolution in 1991; and the WHO MHL principles, developed in 1996.[23] As they are human rights instruments, they have universal application during times of armed conflict and peace. At their creation in the 1990s, they were seen to be pioneering in the field. Both are non-binding but may be argued to have normative value such that many States have accepted them as voluntary guidance.[24]

Critics of the UNMI and WHO ML principles say that the protection of human rights for people with mental illness is more limited in these documents than those offered under the International Bill of Rights.[25] For example, the UNMI principles refer in nineteen of the twenty-five principles to "patients" and not "people", so it can be argued that they provide a standard, dependent on medical status.[26] In contrast, the International Bill of Rights applies to all people at all times by virtue of being human. Nevertheless, General Comment No. 5 of the ICESCR supported the UNMI principles as a guide to the protections for people who have mental health conditions that all States should be striving to implement.[27]

While the advent of these principles acknowledged the need to protect people with mental health conditions, many particularly vulnerable contexts are challenged in implementing them. The challenges relate to resource limitations such as the absence of qualified personnel, inadequate infrastructure, security

22 UN General Assembly, above note 15.

23 WHO, above note 16.

24 The Special Rapporteur on the Right to Health can report on which States are implementing relevant laws related to mental health in the context of the UN General Assembly Resolution and others. See UN Office of the High Commissioner of Human Rights (OHCHR), "Special Rapporteur on the Right to Health", available at: www.ohchr.org/en/special-procedures/sr-health. See also, for reports on mental health and human rights, OHCHR, "Mental Health and Human Rights: OHCHR and the Right to Health", available at: www.ohchr.org/en/health/mental-health-and-human-rights.

25 Melinda Jones, "Can International Law Improve Mental Health? Some Thoughts on the Proposed Convention on the Rights of People with Disabilities", *International Journal of Law and Psychiatry*, Vol. 28, No. 2, 2005.

26 According to the UNMI principles, a "'[p]atient' means a person receiving mental health care and includes all persons who are admitted to a mental health facility". UN General Assembly, above note 15, Annex, definition (f).

27 UN Committee on Economic, Cultural and Social Rights, General Comment No. 5: Persons with Disabilities, UN Doc. E/1995/22, 9 December 1994.

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considerations, access challenges, and non-existent, incomplete or piecemeal mental health rule of law. Additionally, questions about the suitability of international legal definitions and legal instruments remain unanswered. Each of these challenges will be elaborated below.

Prevention and equity of access, but how with resource limitations?

Principles 1 and 2 of the WHO MHL and UNMI principles highlight the prevention of mental illness and equity of access to mental healthcare. While ideal goals, realizing these protections may be difficult for many particularly vulnerable contexts that are resource-restricted due to low GDP, security issues, armed conflict and/or vulnerability to disaster. In 2015 it was estimated that 58% of all people living with dementia reside in low- and middle-income countries; and it is also expected that by 2050, Asia will account for nearly half of the world's cases of dementia (due to population volume and an ageing population of illness co-morbidities)[28]. Such prevalence rates mean that there is a great need for medical and psychiatric care, and for social services to support daily psychosocial needs. In parallel, changing lifestyle patterns in communities have also affected morbidity. Historically, ageing family members were cared for within the family unit, but due to increasing urbanization of the population and geographic dispersion, or family separation due to conflict, this family-as-carer role has increasingly become harder to fulfil. People living longer due to advances in medical technology has also meant increasing vulnerabilities and co-morbidities needing intervention. In States affected by armed conflict, there may be a redirection of the scarce healthcare resources away from mental healthcare and into treatment for the wounded and sick. Essentially, the legal principles of prevention of mental illness are admirable but can sometimes only be attained through a greater access to mental healthcare and social services, which is lacking in particularly vulnerable contexts due to low State capacity and resources.

A further challenge to realizing these principles is the geographic maldistribution of mental health services in many States. In China, for example, about 80% of psychiatrists practise from cities, although about 80% of the population lives in rural areas.[29] This means reduced equity of access and a challenge in meeting the WHO MHL and UNMI principles 1 and 2.

Furthermore, analysis of humanitarian data shows that people living in the most fragile ecosystems are most prone to environmental shocks such as natural disasters.[30] While disaster risk is a global experience, its negative impacts can more greatly affect particularly vulnerable contexts because of their reliance on natural resources and less resilience to climatic alterations.[31] It is thus cyclical

28 Alzheimer's Disease International, *World Alzheimer Report 2015*, London, October 2015, available at: www.alzint.org/u/WorldAlzheimerReport2015.pdf.
29 Allan Tasman, "Too Few Psychiatrists for Too Many", *Psychiatric Times*, Vol. 32, No. 4, 2015.
30 M. M. G. T. De Silva and Akiyuki Kawasaki, "Socioeconomic Vulnerability to Disaster Risk: A Case Study of Flood and Drought Impact in a Rural Sri Lankan Community", *Ecological Economics*, Vol. 152, 2018.
31 *Ibid.*

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that the most vulnerable people (due to cumulative exposures) are the most prone to mental health conditions, and the most prone are more vulnerable.

As a result of these concerns, particularly vulnerable contexts will find challenges in applying the principles of prevention and equity of mental health access when they are not in control of the social determinants of health, such as high incidence of difficult-to-manage diseases, conflict, poor social services, and exposure to environmental shocks that deplete coping resources.

Best practice mental health assessments, but are there enough qualified personnel?

Principles 3 and 4 of the WHO MHL and UNMI principles require that mental health assessments be conducted using international manuals[32] such as the *ICD-11 International Classification of Diseases*.[33] In reality, the use of this manual involves the education and availability of trained staff, both scarcely available in particularly vulnerable contexts where there are few psychiatrists or psychologists. Research has shown that the ratios of psychiatrists per capita in the Global North are around 10–16 per 100,000; in contrast, the numbers of psychiatrists in Africa are 0.33 per 100,000; Western Pacific around 0.32; and Southeast Asia around 0.2.[34] For perspective, the United States, with only about 5% of the global population, has about 30% of the world's psychiatrists.[35]

The "brain drain" caused by emigration to more developed countries of psychiatrists who originate from low- and middle-income countries has also impacted on the population ratios of psychiatrists.[36] It is predicted that many particularly vulnerable contexts would have more than double the number of psychiatrists per 100,000 population (e.g. Bangladesh, Myanmar, Afghanistan), and some would have five to eight times more psychiatrists per 100,000 (e.g. Pakistan, Sri Lanka, Liberia, Nigeria and Zambia), if this did not occur.[37] The World Psychiatric Association Taskforce on the "brain drain" conducted a study to examine push and pull factors for emigration. They found that professional isolation, limited multi-disciplinary opportunities with other mental health professionals, training limitations, and poor treatment conditions for people with mental health conditions were key factors for emigration.[38] Armed conflict and

32 UN General Assembly, above note 15; WHO, above note 16.
33 WHO, *ICD-11 – International Classification of Diseases, 11th Revision*, Geneva, 2019/2021, available at: https://icd.who.int/en; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., text rev., 2022, available at: https://doi.org/10.1176/appi.books.9780890425787.
34 Rachel Jenkins *et al.*, "International Migration of Doctors, and Its Impact on Availability of Psychiatrists in Low and Middle Income Countries", *PLoS One*, Vol. 5, No. 2, 2010.
35 *Ibid.*
36 Benedetto Saraceno, Mark van Ommeren, Rajaie Batniji, Alex Cohen, Oye Gureje, John Mahoney, Devi Sridhar and Chris Underhill, "Barriers to Improvement of Mental Health Services in Low-Income and Middle-Income Countries", *Lancet*, Vol. 370, No. 9593, 2007.
37 *Ibid.*
38 Oye Gureje, Sheila Hollins, Michel Botbol, Afzal Javed, Migue Jorge, Violet Okech, Michelle Riba, Jitendra Trivedi, Norman Sartorius and Rachel Jenkins, "Report of the WPA Task Force on Brain Drain", *World Psychiatry*, Vol. 8, No. 2, 2009.

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instability within their country of origin can be speculated as also playing a role. Having standards that mental health assessments must be conducted using international manuals is aspirational; however, in practice, very few particularly vulnerable contexts can meet this principle. With less mental health professionals staying in their country of origin, it becomes a problem hard to resolve for such countries to meet the necessary assessment standards.

Mental healthcare under least restrictive means, but how with no suitable facilities?

UNMI principle 9 and WHO MHL principle 4 both stipulate that people with mental disorders should be provided with healthcare which is the least restrictive practice.[39] The principles guide that community-based mental health services should be made available to people who are of lower acuity (with less severe symptoms), and institution-based treatments should be provided for people who are higher in acuity (with more severe symptoms). However, issues arise when in particularly vulnerable contexts there are no community services or facilities to implement the least restrictive practice, or a mental health facility has been destroyed and health professionals have fled due to armed conflict. In all of these scenarios, considerations of the need for an involuntary admission to a hospital are impossible and/or in many cases detention facilities are used for containment of people with mental health conditions.[40] Detention facilities are created for deterrence and punishment rather than treatment and care. They are not equipped or staffed for the provision of health services, nor are they conducive to good mental health. Holding people with a mental health condition in a detention facility exposes them to risk of discrimination and a decline in their mental state. People with mental health conditions should be diverted to the mental health system.

With regards to places of mental health service provision, according to the WHO, 68% of countries have psychiatric training programmes, and, of these, 38% have the availability of psychiatric wards, 39% have rehabilitation beds, 55% have places to care for people who are deemed high risk due to their mental disorder, and 50% offer day service/outpatient-type support.[41] However, if particularly vulnerable contexts do not have these services due to development- or conflict-related barriers, and budget does not allow for such improvements, this leads to questions regarding whether the liberty of people who have a mental health condition can be addressed by least restrictive means according to the legal standard.

39 UN General Assembly, above note 15; WHO, above note 16.

40 It is beyond the scope of this paper to deepen the discussion on the needs of people with mental health conditions within detention environments, or people deprived of their liberty due to mental disorders with no criminal charge, or considerations of internment, even though this discussion is still much needed in mental health law reform.

41 WHO, *Atlas: Psychiatric Education and Training across the World 2005*, Geneva, 2005.

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Decisions about people with mental health conditions without mental health rule of law

UNMI principle 1 and WHO MHL principle 10 indicate that decisions about people with mental health conditions must be made in accordance with the rule of law in that jurisdiction and not arbitrarily.[42] However, there are many jurisdictions without adequate rules of law around mental health. According to the WHO, 25% of countries have no mental health legislation at all.[43] The international disparity is evident, whereby 92% of countries in Europe have mental health laws; however, only 67% in Africa, and 13% of the Western Pacific have such laws.[44] Without such legislation, it is thus feasible that particularly vulnerable contexts might make decisions about people with mental health conditions arbitrarily.

Even worse is that, in some countries, domestic laws actively violate human rights.[45] For example, in some countries the mental health laws are considered discriminatory whereby they encourage the authorities to imprison and forcibly commence treatment.[46] In such circumstances, having no laws at all would be better than having ones which defy the principles and violate human rights. These countries are in urgent need of mental health legal reform.

Consent to treatment without a definition

Consent to treatment is another challenging area for the implementation of mental health protections in particularly vulnerable contexts. Article 7 of the International Covenant on Civil and Political Rights provides that no one shall be subjected without their free consent to medical or scientific experimentation;[47] and UNMI principle 5 discusses self-determination, and that consent is required before any type of interference, such as diagnostic procedures, medical treatment and mandatory commitment to hospital. However, there is no suitable mental health definition in international law of free consent, especially as it pertains to involuntary mental health treatment for people who are experiencing psychosis, suicidal or homicidal ideation[48]. Where a person's risk of harm to self or others has been deemed in need of medical intervention for safety considerations, without a definition and adequate mental health legislation this is hard to attain for particularly vulnerable contexts, and in fact all States.

42 UN General Assembly, above note 15; WHO, above note 16.
43 WHO, *Atlas: Mental Health Resources in the World 2001*, Geneva, 2001.
44 *Ibid.*
45 Mental Disability Rights International, *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey*, Istanbul, 28 September 2005, p. 32, available at: www.driadvocacy.org/wp-content/uploads/turkey-final-9-26-05.pdf.
46 Natalie Drew *et al.*, "Human Rights Violations of People with Mental and Psychosocial Disabilities: An Unresolved Global Crisis", *Lancet*, Vol. 378, No. 9803, 2011.
47 UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, 999 UNTS 171.
48 The UNMI principles have some definition of consent, but competing rights in law can sometimes nullify it (see the section of this paper below under the heading "Disability instruments: Are they the right fit?" where the clash of the right to liberty and the right to treatment is discussed).

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The African Commission on Human and Peoples' Rights[49] and the Inter-American Court on Human Rights[50] have ruled on matters relating to the rights of persons with mental disorders and psychosocial disabilities. Additionally, there is a range of case law under the European Convention on Human Rights related to persons with mental disorders/illness. For example, in *Herczegfalvy v. Austria*, the European Court of Human Rights held that the position of powerlessness experienced by persons institutionalized due to a mental disorder should allow for enhanced vigilance in the application of the human rights norms.[51] This shows the importance of law in the field and how it can be used to improve mental healthcare.

Disability instruments: Are they the right fit?

In an attempt to address the gaps, in 2008 the prominent disability instrument, the CRPD,[52] took effect. As of 2022, the CRPD has 164 signatories and 185 parties, and has been quickly ratified by many States, some with reservations such as Australia, which exercises a margin of appreciation in administering medication involuntarily when it is considered a last resort, and France, which does not consider it legally binding.[53]

The CRPD adopts a human rights-based approach to disability and was designed to supersede previous international soft-law developments, including the UNMI and WHO MHL principles. It was intended to reflect the most advanced international human rights standards on the rights of persons with psychosocial disabilities.

Some agencies have used the CRPD for legislative change. For example, an Indian non-governmental organization represented the rights of people with mental health conditions against the State in the High Court of Karnataka, India, using the CRPD. They were raising awareness of the lack of rights-based legislation; discrimination against people with mental disorders in the domestic legislation; and inactivity in the implementation of the National Mental Health Plan of India.[54] The successful case led to legislative and policy reforms, including improved hospital standards for mental healthcare, creating an open psychiatric ward (where doors are not locked) and establishing a budget for mental health resource allocation.

This case illustrated how international and local development agencies have a critical role in oversight and redress for mental health law reform, although they

49 African Commission on Human and Peoples' Rights, *Purohit and Moore v. The Gambia*, Communication No. 241/2001, Judgment, 15–29 May 2003.

50 Inter-American Court of Human Rights, *Ximenes-Lopes v. Brazil*, Series C, No. 149, Judgment, 4 July 2006.

51 European Court of Human Rights, *Herczegfalvy v. Austria*, Application No. 10533/83, Judgment, Merits and Just Satisfaction (Court Chamber), 24 September 1992.

52 CRPD, above note 17.

53 *Ibid.*

54 National Human Rights Commission and National Institute of Mental Health and Neurosciences, *Mental Health Care and Human Rights*, New Delhi, 2008, available at: www.antoniocasella.eu/archipsy/nagaraja_2008.pdf.

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should not be the primary method for addressing human rights violations. Judicial review, monitoring mechanisms, and access to legal remedies in domestic law must be available to people with mental health conditions on an equal and accessible basis in all countries, including particularly vulnerable contexts.

While its contribution to the protection of persons with disabilities is of course noteworthy, the CRPD has been argued to require reconsideration of mental health and mental capacity law. With its foundations in the rights-based model, it introduced a new theory into international law whereby it relied on the social model of disability such that disability is considered by social determinants rather than limitations or impairments. While the social model can be argued as a favourable approach, the CRPD, however, offers no definition of which disabilities are in scope. As such, how it should be implemented for the mental health sector has lacked clarity.

Other criticisms of the CRPD refer predominantly to Article 12 and Article 14. Article 12 states that all persons with disabilities must be allowed to exercise legal capacity,[55] thus prohibiting practices such as forced admission and treatment, guardianship and other forms of substitute decision-making. Article 14 on the right to liberty and security of the person states that persons with disabilities should not be deprived of their liberty unlawfully or arbitrarily.[56] This means that "persons with mental health conditions cannot be involuntarily detained in mental health services or other facilities such as institutions, sheds, or houses".[57]

Some health practitioners argue that Articles 12 and 14 of the CRPD undermine the rights to the highest attainable standard of health, because measures such as guardianship, involuntary admission and treatment are necessary to prevent danger to oneself or others and to ensure that people receive the care and support they need. This is especially pertinent where a symptom of the mental health episode is poor judgement and decision-making.[58] It thus becomes a clash of the right to liberty and the right to treatment. Other mental health practitioners who are critics argue that, under the CRPD, persons experiencing psychosis, or manic spending in the context of bipolar disorder, or older persons with dementia, who may be unable to care for their own needs or finances, cannot be compelled to have a guardian and this is problematic as it can cause irreparable harm to their life.[59] Other scholars have posited that specific/specialized mental health law leads to stigmatization,[60] and exclusively focusing

55 Committee on the Rights of Persons with Disabilities, General Comment No. 1 (2014), Article 12: Equal Recognition before the Law, UN Doc. CRPD/C/GC/1, 19 May 2014.
56 *Ibid*., Art. 14.
57 *Ibid*.
58 Melvyn Colin Freeman, Kavitha Kolappa, Jose Miguel Caldas de Almeida, Arthur Kleinman, Nino Makhashvili, Sifiso Phakathi, Benedetto Saraceno and Graham Thornicroft, "Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities", *Lancet Psychiatry*, Vol. 2, No. 9, 2015.
59 Paul S. Applebaum, "Saving the UN Convention on the Rights of Persons with Disabilities – From Itself", *World Psychiatry*, Vol. 18, No. 1, 2019.
60 Alfred Allan, "The Past, Present and Future of Mental Health Law: A Therapeutic Jurisprudence Analysis", *Law in Context*, Vol. 20, No. 2, 2003.

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laws on people who have a mental health condition should be repealed as it is discriminatory.[61] All of these criticisms argue against the CRPD in the domain of mental health, claiming that people's rights are undermined by some of the CRPD provisions. It can thus be presented that the CRPD does not adequately fit a mental health context.

In terms of the disability terminology, practitioners from the mental health sector may also debate the classification of people who live with mental health conditions as being disabled. It would be rare to find a label of disability for someone who suffers a chronic physical health condition such as asthma or diabetes. As such, it is discriminatory to label and fragilize someone who suffers chronic depressive or anxiety disorders by calling them disabled. Impacts on daily functioning resulting from a mental health episode were not likely the target audience for the drafters of the object and purpose of the treaty provisions in the CRPD and therefore the legal framework remains inadequate guidance for States to encompass the range of needs in the mental health domain.

In summary, despite the existence of the UNMI and WHO MHL principles, a gap exists in the international law instruments for safeguarding mental health rights. Additionally, the CRPD is not an adequate fit for the protections needed for mental health. For particularly vulnerable contexts suffering from underdevelopment whereby they have low GDP, low State capacity, poorly resourced and funded medical services, or destroyed infrastructure due to armed conflict, this gap widens. Given the breadth of particularly vulnerable contexts (LDCs and situations of armed conflict) across many countries and continents, this demonstrates a need for a global legal change.

Global legal change in mental health law

Global legal change in mental health law could be accomplished by either developing new hard law such as an Additional Protocol to the CRPD focusing specifically on mental health (noting this does not alleviate the argument of fit), or the soft-law UNMI and WHO MHL principles should be redefined for particularly vulnerable contexts such as LDCs and situations of armed conflict. Whichever method is chosen, to be useful, the laws would need to address the following topics:

- Definition of mental illness and which mental disorders and psychosocial disabilities are considered in scope;
- Definition of consent, right to consent to treatment, and right to refuse treatment;
- Conditions in admitted facilities and residential facilities which resemble institutions;
- How to handle involuntary mental healthcare within the scope of human rights when someone is at risk of harm to themselves and others, especially if there are no suitable facilities;

61 Tom D. Campbell, "Mental Health Law: Institutionalised Discrimination", *Australian & New Zealand Journal of Psychiatry*, Vol. 28, No. 4, 1994.

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- If and when the use of mechanical and chemical restraints and electroconvulsive therapy is allowed;
- What to do if there are no qualified practitioners or facilities for assessment and treatment, especially in particularly vulnerable contexts;[62]
- Regulation of community-based orders;
- Specific guidance regarding minors and people in forensic facilities and hospitals in an LDC context;
- Confidentiality protections;
- Guidance on guardianship proceedings;
- A legal framework to support the use of advanced consent agreements so that people can designate their care requests when they are well and give the authority to a third party to execute in the event they become unwell;
- Requirement that review bodies satisfy natural justice or due process procedures;
- Creation of provisions in the law to ensure that people who are deemed by medical professionals to be medically incompetent must also have the right of review of their competency by an independent medical professional;
- In situations of armed conflict, people with mental health conditions have not been explicitly protected under international humanitarian law. Therefore, global legal change must also consider the protections during armed conflict, especially as contemporary conflicts are increasingly long and create chronic vulnerabilities.

Whether hard law in the form of a new CRPD treaty protocol or soft law such as revisions to the UNMI and WHO MHL principles adapted for particularly vulnerable contexts, effective change and development are needed to guide mental health law reform.

Conclusion

If globally mental disorders have high prevalence for disability and almost 80% of the global burden occurs in low- and middle-income countries, we are forced to no longer deprioritize them as a target of development and reform. If the impacts of mental health conditions may also threaten peace, human rights and development, we must act now, or else face more protracted crises.

62 Consider the use of digital technology and capacity building. Many people living with mental disorders have no access to mental healthcare, but most have access to a mobile phone. Digital technology has been shown to hold potential for improving access to, and quality of, mental healthcare in low- and middle-income countries. For a review, see John A. Naslund, Kelly A. Aschbrenner, Ricardo Araya, Lisa A. Marsch, Jürgen Unützer, Vikram Patel and Stephen J. Bartels, "Digital Technology for Treating and Preventing Mental Disorders in Low-Income and Middle-Income Countries: A Narrative Review of the Literature", *Lancet Psychiatry*, Vol. 4, No. 6, 2017. This would mean that psychiatric, psychological and social services could be provided by qualified people in places more distant from them, and that mental health law reform could involve legislating how this occurred consistent with the international legal framework. This would address the matter of qualified personnel per capita, perhaps slow the trend of the brain drain, and would also allow the matter of review of decisions.

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Similarly, if international law jurisprudence, including the CRPD, is inadequately guiding the governance of mental health development in particularly vulnerable contexts, and is in fact allowing violations of human rights to occur, there is no justification for inaction. As mental health law involves a relationship between the State, the community and the individual, with a high need for balancing coercion and human rights, it is critical to get it right.

In December 2019, the 33rd International Conference of the Red Cross and Red Crescent Movement marked an important milestone in the field of mental health and psychosocial support, namely, a Resolution was adopted to address the mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies.[63] The Resolution was signed by the Red Cross and Red Crescent Movement together with the 196 States as signatories of the Geneva Conventions. The Resolution is an urgent call for increased action and sets a joint agenda for States to: ensure early and sustained access to mental healthcare for emergency-affected populations; to increase local and community-based action and cooperation; and to integrate mental healthcare into all humanitarian activity including health, education and protection. With the advent of this Resolution, there cannot be a riper time to establish the international legal protections for people with mental health conditions, including mental disorders and psychosocial disabilities. This jurisprudence is critical to help particularly vulnerable contexts such as LDCs and situations of armed conflict tackle this issue, and to meet positive obligations and protect rights.

63 33rd International Conference of the Red Cross and Red Crescent, "Resolution 2: Addressing Mental Health and Psychosocial Needs of People Affected by Armed Conflicts, Natural Disasters and Other Emergencies", 33IC/19/R2, Geneva, Switzerland, 9–12 December 2019, available at: https://pscentre.org/wp-content/uploads/2020/10/solution.pdf.

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