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Sub-Committee on Mental Health in the Irish Parliament
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Dainius Pūras
Professor, Clinic of Psychiatry, Vilnius university
Former UN Special rapporteur on the right to physical and mental health (2014-2020)

Introduction and Executive Summary

1. With this submission, I present my summary comments on the global situation and changes in the normative framework, policies and practices, with regard to mental health and human rights, based on my experience as the UN Special Rapporteur on the right to health (2014-2020). While not directly involved with the current process in Ireland, I am pleased to see a commitment to an inclusive and comprehensive discussion about what critical elements are needed to support the necessary transformations in law and practice to support the right to mental health. The comments below reflect informal observations of the global state of mental health and human rights, which has direct relevance to the national conversation happening in Ireland.

Context

2. The field of mental healthcare must deeply reflect upon the experiences from the 20th century and last decades. Human rights of persons who need and use mental health services have been largely ignored or side-lined by paternalistic calls to end suffering through access to treatment. This has led to a litany of harmful psychiatric practices and systemic failures such as the lobotomy, insulin coma therapy, widespread institutional long-term care of persons with psychosocial disabilities, excessive inpatient treatment in psychiatric hospitals, with different forms of coercion widely used, often amounting to degrading and inhuman treatment.

3. While after the World War II and especially since adoption of the UN Convention of the Rights of Persons with Disabilities (CRPD) in 2006, more serious attention has been paid to human rights in mental healthcare services, the global situation remains unacceptable. It is important to highlight that the human rights situation within mental healthcare services is equally alarming in Global South and Global North.

4. While in the Global South the main problem is that mental health services are simply unavailable to persons who may need them, in the Global North, including some of the most economically advanced countries, there are other issues of increasing concern. The biomedical model, which dominates mental health scene for last four decades, has been increasingly overused, with coercive measures on the rise in many countries. Those who maintain support of the dominance of the biomedical (neurobiological) model have been

promising for decades that effective treatment with psychotropic medications will result in a substantial reduction of stigma in mental health care.

5. The main goal of the status quo in psychiatry remains—to reach persons diagnosed with mental disorders, and provide treatment—voluntarily or involuntarily. While the right to the enjoyment of the highest attainable standard of health contains obligations to ensure *accessibility* to healthcare services, the right equally confers a duty to ensure services are of sufficient quality, including supported by evidence. The available evidence suggests that compulsory treatment is no more effective than voluntary treatment and support in the community and hence, non-consensual service provision raises significant concerns related to quality. More importantly, services must be *acceptable* to be compliant with the right to health. *Acceptability* means services must be ethical as well as respectful of individual and collective cultural differences.

6. Any calls for expanding accessibility, particularly through means of coercive legislation must be carefully scrutinised, particularly in light of international obligations enshrined within the Convention on the Rights of Persons with Disabilities and the International Covenant on Economic, Social, and Cultural Rights. Although calls for accessibility (including involuntary treatment) have been made with good intentions, focusing on such a pattern of the status quo appears to have failed in terms of ethics and effectiveness, disempowering users of services and in many instances doing more harm than good.

7. To a large extent the systemic global failure in the field of mental health services is related to prevalent use of non-consensual measures, that are allowed to be used by providers of mental health services. At the clinical level, coercion corrupts the therapeutic alliance and undermines core ethical goals to do no harm. Although mental health laws in many countries are supposed to protect the rights of persons with psychosocial disabilities, in practice, these laws are systematically deployed to override basic rights of many users of services through the widespread use of non-consensual measures. In other words, what is supposed by the law to be used as exception, quite often in practice turns into the rule.

8. Two main grounds invoked to support the status quo of mental health services and to tolerate overriding basic human rights of many users of mental health services and are not based on sound evidence: "dangerousness" and "medical necessity".

9. With regard to concept of "dangerousness", psychiatry must not serve as a coercive apparatus of social control and protection. Compellingly, there is strong evidence that demonstrates persons with psychosocial disabilities are most often victims of violence, and not the perpetrators. Using medical coercion as a method to address such structural problems, like violence and suicide, is not an effective way of addressing problems that are social, economic, and public health issues. Instead, there should be cross-sectoral commitments public policy transformation, managed through a public health and human rights based approaches.

10. With regard to "medical necessity", this concept, again, is largely subjective and unsupported by a strong evidence base. To deprive persons of liberty, to keep them in

inhumane and degrading environment, to provide treatment with force and to expect that their mental health will improve – is not in line with modern human rights based approach.

11. In the last decade, the normative framework around disability and mental health has been rapidly shifting towards recognition that transformative change is needed in mental health polices and services from status quo towards prioritizing rights based mental health services that are free from coercion and fully embrace human rights based approach.[1]

12. Three resolutions of the UN Human Rights Council (2016[2], 2017[3], 2020[4]), reports of the UN Special Rapporteur on the right to health (2017[5], 2019[6], 2020[7]) Un Special rapporteur on the rights of persons with disabilities (2016?[8]), Report of the UN High Commissioner for Human rights[9], statements of UN Treaty bodies are beginning to signal a very clear direction for modern mental health policies and services worldwide. This direction is – to move away from status quo, based on legacy of discrimination, coercion, disempowerment, power asymmetries to investing in rights based services, that are free from coercion and empower users of mental health services.

13. In 2021, the World Health Organization joined this movement by launching landmark Guidance on Community Mental Health Services[10]. This guidance demonstrates existing good practices and important opportunities to develop innovative, non-coercive, supportive services for persons with mental health conditions. This can be done in each country with a combination of legal and policy measures and with political will to abandon legacy of discrimination and reliance of coercion in the field of mental health and psychiatry.

14. There remain certain tactical and strategic disagreements about how to realize this change. While the UN CRPD Committee urges a ban all non-consensual measures, other experts (including former UN Special rapporteur on the right to health) suggest possibility of other avenues if states are not ready for such decision. Anyway, all legal and policy measures need to be in line with all principles of the CRPD, and to prioritize alternative to coercive measures. Incentives need to be created by legal and policy measures, so that users of mental health services could choose and enjoy increasing variety of supportive services in the community, while prevalence of instances of restraints, forced placement and treatment should be radically decreasing.

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[1] https://www.ohchr.org/en/special-procedures/sr-health/right-mental-health

[2] Resolution of the UN Human Rights Council on mental health and human rights, 2016. A/HRC/RES/32/18

[3] Resolution of the UN Human Rights Council on mental health and human rights, 2017 A/HRC/RES/36/13

[4] Resolution of the UN Human Rights Council on mental health and human rights, 2020, A/HRC/RES/43/13

[5] Puras, Dainius, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2017. A/HRC/35/21

[6] Puras, Dainius, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2019. A/HRC/41/34

[7] Puras, Dainius, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/75/163, 2020. A/HRC/44/48

[8] Devandas, Catalina, Report of the Special Rapporteur on the rights of persons with disabilities, A/HRC/34/58, 2016. https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/34/58

[9] Report of the UN High Commisioner for Human Rights , 2017. A/HRC/34/32

[10] Guidance on community mental health services: Promoting person-centred and rights-based approaches. World Health Organization, 2021. https://www.who.int/publications/i/item/9789240025707

15. Some influential professional organisations of psychiatrists in many countries remain opposed to emerging changes and continue to support the status quo. It is important to highlight that the right to health has been misinterpreted as a right to provide mental health services (even without consent of the person) as more important than other rights, such as right to refuse treatment, the right to bodily autonomy, and the rights to be free from discrimination, inhuman and degrading treatment and torture.

16. I must emphasise here, that all human rights are interdependent and indivisible, and there is no hierarchy of human rights—including for people experiencing mental health issues or distress. Another issue which is often a source of misunderstanding, is a position often presented by representatives of the psychiatric profession – that the changes in legislation, policies and services will leave persons who have psychosocial disabilities without any treatment and support. This is a faulty assumption. The changes which are needed are not laws that embed forced treatment, but reforms that require a diversity of supports and services are available in the community, which are respectful of the human rights of persons who need them and use them, and that include a variety of psychosocial and other interventions that are free from coercion and empower the users of services. There is important work happening to operationalise common values and principles, which are underpinned by a human rights framework, to help build these services in communities around the world.[11]

17. One final observation from the global experience is that changes in global mental health are needed also for the field of psychiatry and the profession of psychiatrists. In the "status quo", with obvious power asymmetries, overuse of biomedical interventions and biomedical paradigm, biased use of evidence (e.g., emphasis on "chemical imbalances" although this hypothesis of explanation of origin of certain mental health conditions was never proved), psychiatry as a field of medicine becomes too vulnerable and suffers from crisis of reputation and image. Psychiatry should recognize the crisis of values within its profession and the need to fully embrace human rights of persons with psychosocial disabilities, as it is enshrined in the CRPD and the evolving normative framework. Sharing power and expertise with other stakeholders (non-medical professionals, experts with lived experience) will place psychiatry as one of leaders in the global mental health movements towards end of discrimination of persons with psychosocial disabilities and other mental health conditions.

18. Good news is that the World Psychiatric Association (WPA) has made recently important steps in this direction. WPA is active in WHO QualityRights initiative, it was supporting main messages of the WHO Guidance on community mental health services. In 2020 the WPA issued a position statement: "Implementing alternatives to coercion. A key component to improving mental healthcare".[12]

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[11] Stastny, P., Lovell, AM., Hannah, J., Goulart, D., Vasquez, A., O'Callaghan, S. and Pūras, D., (2020). Crisis response as a human rights flashpoint: Critical elements of community support for individuals experiencing significant emotional distress. Health and Human Rights. 22 (1), 105-119 https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2020/06/Stastny.pdf

[12] https://www.wpanet.org/_files/ugd/e172f3_635a89af889c471683c29fcd981db0aa.pdf

19. Hopefully, national psychiatric associations and other professional groups of psychiatrists will support the emerging movement in the field of mental health towards elimination of legacy that discriminates and disempowers persons with psychosocial disabilities and other mental health conditions.