**STANDARD BRIEFING NOTE 1**

**Human Rights and a Social Model of Mental Health Care**

This Briefing Note contains key points, key terms, background information and examples of practical application as well as links to further information and local contacts. It does not contain legal advice and should be used as a starting point for further research t rather than an authoritative source. Feedback on its contents is welcome.

**Key Points**

* Human rights compliant mental health care strategies are essential for ensuring effective, efficient and high-quality mental health care and protecting and promoting the dignity, citizenship, rights and wellbeing of South Australians experiencing mental illness and mental health disabilities.
* The [*United Nations Convention on the Rights of Persons with Disabilities*](https://www.humanrights.gov.au/our-work/disability-rights/united-nations-convention-rights-persons-disabilities-uncrpd) (UNCRPD) provides a framework for government and non-government bodies to move from a medical model of mental health care to a social model of mental health care, with positive rights outcomes for persons with mental health disabilities.
* Participation and inclusion are crucial elements in adopting rights-based approaches to mental health care. Through participation and inclusion the needs and concerns of persons with mental illness become clearer, persons with mental illness have the opportunity to raise issues and hold decision-makers accountable, persons with mental illness become more visible and persons without mental illness have the opportunity to learn and change from the experience.
* Participation (along with decision-making supports) allows persons with mental illness to make their own treatment decisions.
* While the mental health law of Australia requires careful review to ensure that it complies with the UNCRPD, some human rights informed models of mental health care have been developed in Australia and elsewhere, including by the Queensland Mental Health Commission who [*'Shifting Minds Queensland Mental Health, Alcohol and Other Drugs Strategic Plan - 2018-2023'*](https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf) provides a practical, accessible template for others to consider.

**Key Terms**

United Nations Convention on the Rights of Persons with Disabilities

The UNCRPD was drafted between 2002 and 2006, in a process that involved governments and NGOs, and included input from disability related organisations. It was adopted by the UN General Assembly in 2006 and came into force in 2008. You can see the list of countries that have ratified the UNCRPD [here.](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en) The UNCPRD does not create any new rights – instead it tries to explain how existing human rights recognised in other Conventions should be implemented to maximise inclusion and limit stigma and discrimination. The UNCRPD is composed of a preamble followed by 50 articles, each derived from the [Universal Declaration of Human Rights](https://www.un.org/en/universal-declaration-human-rights/index.html) and core human rights treaties. The first four articles lay out the general principles of the document and are discussed below.

Medical model of mental health care

The ‘medical’ model of mental health care has an emphasis on difference and illness which has given rise to practices that separate persons with mental illness from mainstream society and can lead to stigmatisation and prejudice. An extreme example is the asylum movement of the nineteenth century. Other less extreme models are those described as ‘welfare models; where persons with mental illness are seen as passive beneficiaries of care or assistance. Often these models do little to help persons with mental illness to overcome barriers in society.

Under the medical model of disability, the focus is on an individual’s impairment as conceived from a medical perspective. The medical model regards disability as an impairment that needs to be treated, cured or rehabilitated. Under the medical model, disability is seen as a deviation from normal health status, rather than a reflection of human diversity as under the social model of disability promoted by the UNCRPD.

The medical model of disability is based on two assumptions which have a negative impact on the human rights of persons with disabilities:

* Persons with disabilities are viewed as the objects of pity and charity who need welfare and protecting;
* Disability can negate legal capacity.

The first assumption legitimises segregated facilities for persons with disabilities including special schools, employment in sheltered workshops and institutionalised living arrangements. The second assumption legitimises laws that negate legal capacity and promote substitute decision-making arrangements.

Social model of mental health care

The ‘social model’ of mental health focuses on how society responds to mental illness or impairment. It changes the focal point away from the ‘disability’ or ‘illness’ and towards the need for society to change to enable everyone to participate in an equal and meaningful way. This model is closely tied to human rights values of dignity, equality and personal freedom, and the need to promote social inclusion. It demands that policy and law makers have regard to personal autonomy in order to support the right of persons with mental illness or disabilities to decide freely about their own lives. The UNCRPD adopts the social model of disability from its Preamble, which asserts that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others".

**Practical Application and Background**

***How does the idea of ‘disability’ fit with the idea of ‘mental illness’?***

The UNCPRD does not explicitly define disability – and this is deliberate and in line with the social model of care. Instead it is based on the idea that disability is an evolving concept, resulting from the ‘interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others’ (article 1). Article 1 of the UNCPRD states that persons with disabilities include ‘those who have long-term physical, mental, intellectual or sensory impairments’ (article 1). It is important to note that the UNCPRD takes an inclusive approach to the idea of disability, with article 1 being understood as providing a ‘floor’ rather than a ‘ceiling’ when it comes to understanding how the protective framework contained in the UNCPRD should be applied. As seen from the examples below, this broad definition gives rise to both challenges and opportunities when it comes to applying the UNCPRD within the framework of more ‘traditional’ medical orientated models of mental health care.

Care must also be taken to ensure that the consequences of different categories of ‘illness’, ‘mental illness’ and ‘mental health disability” are understood. Only ‘mental health disability’ falls within the ambit of the UNCRPD.

***How does the UNCRPD apply to mental health care design and implementation?***

The UNCRRD represents a ‘paradigm shift’ when it comes to recognising and promoting the rights of persons with disabilities, including persons with mental health disabilities (noting that not all persons with mental illness are said to have a disability and some fall outside the protections of the UNCRPD). It does this by moving away from an approach where persons with mental illness are considered passive receivers of treatment, protection or care towards an approach where persons with mental illness are *subjects of human rights*, able to make decisions about life and the future and claim rights on their own behalf. This means that someone with a mental illness is not an ‘object to be fixed’ but rather a person with rights and choices about how he or she wants to live and what treatments, if any, he or she wishes to use. It also means that persons with mental illness are not a *burden on society* but active members of society with something to contribute. It also demands that persons with mental illness should have avenues to defend their rights (complaints mechanisms, rights advocacy etc) and to change society so that society becomes more enabling. From a practical point of view, this means ensuring that persons with mental illness are at the forefront of health care design, implementation and evaluation. It also means ensuring that the objectives or outcomes of mental health care go beyond ‘fixing’ or ‘treating’ mental illness and empower persons experience mental illness to articulate, assert and defence their rights and to contribute broadly to society.

***How do these ideas work in practice? What are some examples?***

A number of studies listed in the ‘Further Information’ section of the briefing note describe how the UNCPRD has been used to inform health care design, implementation and evaluation. A snapshot of some of these examples is provided below.

* [Shifting Minds Queensland Mental Health, Alcohol and Other Drugs](https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf)

The Queensland Mental Health Commission (the Commission) is an independent statutory agency established under the Queensland Mental Health Commission Act 2013, that has adopted a human rights UNCPRD approach to health care design and implementation. The Commission explains that ‘protection of human rights is fundamental to supporting recovery of people living with mental health problems, mental illness, and alcohol and other drug use. It enables individuals to be socially included, be safeguarded from discrimination and to live with dignity and purpose through participation in education, employment and access to services such as health and housing services.’ This approach has informed its ‘Shifting Minds’ 2018-2020 Strategic Plan which includes the following priority actions: promoting and monitoring least restrictive practices in policy and legislation; reducing restrictive practices, and improving responses to human rights complaints; aligning the Mental Health Act 2016 with the proposed Queensland human rights legislation (for example, advocating for a review of the policy of locking mental health wards in Queensland in view of the impact locked wards have on the human rights of both voluntary and involuntary patients); funding research and supports reforms for a more recovery-oriented and human rights focused mental health, alcohol and other drugs system in Queensland, including new mental health laws and protections.; and providing rights and information for inpatients within mental health wards; e.g. community visitors; and rights and information regarding involuntary treatment in the community.

### [United Kingdom Department of Health: Valuing People Now](https://scholar.google.com/scholar_lookup?title=Valuing+people+now:+Summary+report+March+2009+-+September+2010&publication_year=2010&)

In 2009, the United Kingdom’s Department of Health launched a nationwide initiative designed to improve care and services for persons with intellectual disability. The initiative, Valuing People Now, was based on four key principles of rights, independence, choice, and inclusion. Key priorities were the modernization of day care facilities; provision of support for the transition to supported community accommodation; establishment of supported living arrangements for service users with older caregivers; development of local specialized services; provision of direct payments; and increased use of person-centered planning approaches.

Positive outcomes from evaluation included: more acute liaison nurses had been recruited, increased access to employment opportunities and community accommodation, higher levels of service user involvement in health planning and greater access to person-centered planning approaches and health facilitators. However, an independent review of Valuing People Now found that although the initiative had enhanced some areas of choice, participation, and quality of life for people with intellectual disabilities, it had only affected a minority of service users and may have disproportionately excluded people with the most severe disabilities. In addition, the review found little evidence that Valuing People Now had increased choice of public services for service users.

### [The Scottish Government’s National Dementia Strategy](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5070696/#r38)

In 2010 the Scottish Government launched its first human-rights based nationwide dementia strategy in 2010. A particular emphasis was placed on reshaping institutional infrastructure and the local environment to become more dementia friendly. A community outreach program was established, informing local business owners and community service providers of steps they could take to make their services more amenable to dementia patients. Several training programs for the demonstration site staff were conducted, including dementia awareness; post-diagnosis training; the use of assistive technology; best practice workshops; dealing with stress and distress; and palliative care. A post-diagnosis support program was developed and provision of day services was increased. Peer to peer support was encouraged through the establishment of “dementia cafes” for service users and caregivers.

Positive outcomes from evaluation included a 40% reduction in falls, reduction in anti-psychotic and mood elevating pharmacotherapy, improved access to assistive technology, and fewer hospital admissions were reported. Both staff and patients reported lower levels of distress as a result of the program. Service providers received higher grades on their Care Inspectorate reports. Communication between caregivers and staff improved, resulting in greater treatment and work satisfaction.

* [Duffy and Kelly Table of Internal Conflicts within UNCRD and Mental Health Care](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436#bb0180)

For a more critical analysis of the challenges associated with implement the UNCPRD in the mental health service area see the below Table prepared by Duffy and Kelly[[1]](#footnote-1) that compares key principles of the UNCPRD with common mental health care practices and provides links to further academic commentary on these practices.

| **Involved articles** | **Conflicted principles** | **Example** | **References** |
| --- | --- | --- | --- |
| **3.a with 3.a** | Autonomy conflicted with dignity | Patient with self-neglect requiring hospital admission secondary to a psychotic illness expressing a desire to leave hospital | ([Delmar, 2013](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0050), [Delmar et al., 2011](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0055), [Smebye et al., 2016](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0210)) |
| **10 with 14.1** | The right to life conflicted with the right to liberty | An individual with suicidal intent secondary to mental illness refusing admission | ([Shah, 2012](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0185), [Shah and Buckley, 2009](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0190)) |
| **22 with 25.b and 10** | The right to privacy conflicting with the right to health and life | Doctors obtaining collateral histories about patients who have refused but pose a risk to themselves or others | ([Petrik, Billera, Kaplan, Matarazzo, & Wortzel, 2015](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0160)) |
| **15.1 with 25.b** | The right to freedom from cruel and inhumane treatment and the right to health | A patient with depression which has failed to respond to medication, responded to ECT in the past lacking the capacity to consent | ([UK ECT Review Group, 2003](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0240)) |
| **12.2 with 25 and 26** | The right to legal capacity with the rights to health and rehabilitation | New onset psychosis with poor insight refusing treatment. | ([Karson, Duffy, Eramo, Nylander, & Offord, 2016](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0080)) |
| **3a with 25.b** | The right to autonomy with the right to heath | A patient receiving methadone may not be able to give informed consent due to their addiction to the substance being offered. | ([Levy, 2016](https://www-sciencedirect-com.access.library.unisa.edu.au/science/article/pii/S0160252716302436%22%20%5Cl%20%22bb0110)) |

**Further Information**

* UN Department of Economic and Social Affairs Disability <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/guiding-principles-of-the-convention.html>
* Australian Human Rights Commission <https://www.humanrights.gov.au/our-work/disability-rights>
* V.D. Fina, R. Cera, G. Palmisano (Eds.), The United Nations Convention on the Rights of Persons with Disability: A commentary, Springer, Cham (2017), pp. 1-40 [View Record](https://www-scopus-com.access.library.unisa.edu.au/inward/record.url?eid=2-s2.0-85019894833&partnerID=10&rel=R3.0.0) [Google Scholar](https://scholar-google-com.access.library.unisa.edu.au/scholar_lookup?title=From%20invisible%20citizens%20to%20agents%20of%20change%3A%20A%20short%20history%20of%20the%20struggle%20for%20the%20recognition%20of%20the%20rights%20of%20persons%20with%20disabilities%20at%20the%20United%20Nations&publication_year=2017&author=T.%20Degener&author=A.%20Begg)
* J. Dawson ‘**A realistic approach to assessing mental health laws' compliance with the UNCRPD** International Journal of Law and Psychiatry, 40 (2015), [View Record in](https://www-scopus-com.access.library.unisa.edu.au/inward/record.url?eid=2-s2.0-84930485190&partnerID=10&rel=R3.0.0) [Google Scholar](https://scholar-google-com.access.library.unisa.edu.au/scholar?q=A%20realistic%20approach%20to%20assessing%20mental%20health%20laws%20compliance%20with%20the%20UNCRPD)
* B.D. Kelly ‘**Mental health legislation and human rights in England, Wales and the Republic of Ireland’** International Journal of Law and Psychiatry, 34 (2011),
* UK Law Commission ‘**Mental capacity and deprivation of liberty,** The Law Commission, London (2017) [Google Scholar](https://scholar-google-com.access.library.unisa.edu.au/scholar_lookup?title=Mental%20capacity%20and%20deprivation%20of%20liberty&publication_year=2017&author=Law%20Commission)
* F. Morrissey ‘**The United Nations Convention on the Rights of Persons with Disabilities: A new approach to decision-making in mental health law’** European Journal of Health Law, 19 (2012), 423-440 [View Record in](https://www-scopus-com.access.library.unisa.edu.au/inward/record.url?eid=2-s2.0-84869393703&partnerID=10&rel=R3.0.0) [Google Scholar](https://scholar-google-com.access.library.unisa.edu.au/scholar_lookup?title=The%20United%20Nations%20Convention%20on%20the%20Rights%20of%20Persons%20with%20Disabilities%3A%20A%20new%20approach%20to%20decision-making%20in%20mental%20health%20law&publication_year=2012&author=F.%20Morrissey)
* M. Schulze ***Understanding the UN Convention on the Rights of Persons with Disabilities*** (3rd ed.), Handicap International, New York (2010)
* Duffy & Kelly 2017, ‘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’, *International Journal of Law and Psychiatry*, vol. 54, pp. 26–35
* P. Harpur ‘**Time to be heard: How advocates can use the Convention on the Rights of Persons with Disabilities to drive change’** Valparaiso University Law Review, 45 (2011), pp. 1271-1296
* Agustina Palacios ‘The Social Model in the International Convention on the Rights of Persons with Disabilities’ Age of Human Rights Journal. 2015;(4):91-110
* Dhanda, A., 2006. Legal capacity in the disability rights convention: stranglehold of the past or lodestar for the future. *Syracuse J. Int'l L. & Com.*, *34*, p.429.
* Kayess, R. and French, P., 2008. Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities. *Human rights law review*, *8*(1), pp.1-34.
* Gooding, P., 2013. Supported decision-making: a rights-based disability concept and its implications for mental health law. *Psychiatry, Psychology and Law*, *20*(3), pp.431-451.
* Porsdam Mann S, Bradley VJ, Sahakian BJ. Human Rights-Based Approaches to Mental Health: A Review of Programs. *Health Hum Rights*. 2016 Jun;18(1):263-276. PubMed PMID: 27781015; PubMed Central PMCID: PMC5070696.

**Local Contacts**

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1. Duffy & Kelly ‘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’, (2107) 54 *International Journal of Law and Psychiatry*, 26, Table 1. [↑](#footnote-ref-1)