

Is There a Human Legal Right to Mental Health?

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Abstract

While recent decades have seen an increased focus on the idea of rights to health and health care, these ideas were particularly advanced by the United Nations (UN) Convention on the Rights of Persons with Disabilities in 2006 and the importance that the World Health Organization attached to the essential role of law in advancing the right to health in 2017. The UN made explicit the rights of persons with mental illness in 1991 with its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. There are, however, potential disadvantages with legalistic and rights-based approaches to health and health care: protecting rights can be expensive (especially in courts of law), result in paradoxical unfairness (owing to unequal access to legal systems), diminish efficiency and increase opportunity costs (as scarce resources are diverted from care provision), lead to conflict between rights (such as rights to liberty and treatment in severe mental illness) and prioritise individual rights over families and communities in ways that are not always accepted in certain societies. Despite these issues, human rights still offer a credible, logical and generally helpful approach to issues of injustice, such as the unequal distribution of health care. Against this background, India commenced what is effectively the world's largest experiment in rights-based health care in 2018 when its Mental Healthcare Act, 2017 granted a legally binding right to mental health care to India's population of over 1.3 billion people, one sixth of the planet's population. The legislation states that 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government'. Realising this right will be complex and challenging in practice, but the experience in India will help inform future debates about the usefulness of rights to health and health care in improving the experiences of the physically and mentally ill around the world, especially among vulnerable groups such as older adults, children, the homeless and others.

Keywords: Human rights; Health; Mental health; Justice; Ireland; India

Introduction

In 1817, the House of Commons of Great Britain (then including Ireland) established a committee to investigate the plight of the mentally ill in Ireland. The committee heard disturbing evidence:

There is nothing so shocking as madness in the cabin of the peasant, where the man is out labouring in the fields for his bread, and the care of the woman of the house is scarcely sufficient for the attendance on the children. When a strong young man or woman gets the complaint, the only way they have to manage is by making a hole in the floor of the cabin not high enough for the person to stand up in, with a crib over it to prevent his getting up; the hole is about five feet deep, and they give the wretched being his food there, and there he generally dies. Of all human calamity, I know of none equal to this, in the country parts of Ireland which I am acquainted with.¹

The situation in nineteenth-century Ireland was not unique, as the majority of people with mental illness in Ireland, England and many other countries lived lives of vagrancy, destitution, illness and early death.² Two centuries later, in 2010, the *Guardian* newspaper reported on the death of a man with schizophrenia in his squalid flat in central London:

Mayan Coomeraswamy was found dead . . . Ulcers in his stomach were a strong sign of hypothermia. The 59-year-old, who had schizophrenia, lived in a dirty, damp and freezing flat, with mould . . . His boiler had broken, the bathroom ceiling had collapsed, and neighbours began to complain about the smell. His brother [said]: ‘Even an animal couldn’t have lived in that’.

Everyone knew the conditions Coomeraswamy was living in, but he refused to move for cleaning and refurbishment. . . . Despite four years of pleading from his family, NHS [National Health Service] care staff would not intervene—wrongly thinking they would be violating his human rights.³

Much has changed in the two centuries between these two reports, but it is still not clear to what extent, if any, continued rhetoric about human rights—the right to liberty, the right to health care, and so forth—has assisted in protecting and promoting the interests of people with severe illness, including mental illness. Despite their many merits, are human rights sometimes used as an excuse for neglect? Is there a right to health and mental health? Is there a conflict between the right to liberty and the right to health care, if such a right even exists?

This piece examines rights to health and mental health, and uses the example of India’s recently established right to mental health care to explore some of the key issues involved in these important, ongoing and generally unresolved debates.

Rights to health and health care

The concept of human rights has a lengthy history. Over time, various types of rights have been described, including moral rights, fundamental rights and legal rights. These rights overlap to significant but incomplete extents. Moral rights are rights to which humans are entitled based on moral codes, but many of these are not enshrined in law owing to differences of opinion over moral principles. Fundamental rights are rights that are deemed by most people to be basic

¹ Select Committee on the Lunatic Poor in Ireland, *Report from the Select Committee on the Lunatic Poor in Ireland with Minutes of Evidence Taken Before the Committee and an Appendix* (London: House of Commons, 1817): 23.

² Brendan D. Kelly, “Is There A Human Right to Mental Health?” *Psychiatry Professional* 2, no. 1 (Spring 2013): 10–4.

³ Eleanor Harding, “Acts of Contradiction.” *Guardian*, 31 March 2010; Courtesy of Guardian News & Media Ltd.

to human existence, such as the right to life, even though the precise extent and nature of these rights are also debated. Legal rights are rights that are enshrined in law. In relation to health and mental health, moral and fundamental rights are commonly discussed, but national legislation in most countries tend to eschew the articulation of legal rights to health or mental health, owing to the many variables that determine a person's health or mental health.

The best-known statement of rights is the 1948 United Nations (UN) *Universal Declaration of Human Rights*, which states that 'all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood'.⁴

The UN emphasizes that rights are universal, stating that 'everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.⁵ The emphasis on universality was necessary, not least because previous declarations of rights had commonly been interpreted in such a way as to exclude certain groups, including the mentally ill.

The *Universal Declaration of Human Rights* also articulates health-related rights:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁶

This is not quite a specific 'right to health', but rather a broader right to a reasonable standard of living consistent with, and necessary for, good health. The careful wording of the Declaration points to a key issue in human rights debates at the time of its appearance and ever since: are economic, social and cultural rights (such as a right to health care) to be treated in precisely the same way as civil and political rights, or are certain rights (such as a right to health care) better dealt with through policy rather than law?

This issue was a focus of controversy and, as a result, two separate covenants were adapted by the UN General Assembly in 1966: the *International Covenant on Civil and Political Rights*⁷ and the *International Covenant on Economic, Social and Cultural Rights*.⁸ The key differences between these covenants was the immediacy with which these two categories of rights were to be observed: civil and political rights were to be implemented at once, while economic, social and cultural rights were to be implemented progressively as countries developed at different rates and from different baselines.

Against this background, the *International Covenant on Economic, Social and Cultural Rights* requires state parties to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.⁹ The steps required 'to achieve the full realization of this right shall include those necessary for':

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;

⁴ United Nations, *Universal Declaration of Human Rights* (New York: United Nations, 1948): Article 1.

⁵ *Ibid.*, Article 2.

⁶ *Ibid.*, Article 25(1).

⁷ United Nations, *International Covenant on Civil and Political Rights* (New York: United Nations, 1966).

⁸ United Nations, *International Covenant on Economic, Social and Cultural Rights* (New York: United Nations, 1966).

⁹ *Ibid.*, Article 12.

- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁰

This is quite clearly a right to ‘the highest attainable standard of physical and mental health’. In 2008, the Office of the UN High Commissioner for Human Rights and World Health Organization (WHO) published a fact-sheet on *The Right To Health*, further emphasising that ‘the right to health is a fundamental part of our human rights and of our understanding of a life in dignity’.¹¹ They point out that the right to health is ‘an inclusive right’ that contains both freedoms and entitlements, including:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- The right to prevention, treatment and control of diseases;
- Access to essential medicines;
- Maternal, child and reproductive health;
- Equal and timely access to basic health services;
- The provision of health-related education and information;
- Participation of the population in health-related decision-making at the national and community levels.¹²

In addition, ‘health services, goods and facilities must be provided to all without any discrimination’ and ‘all services, goods and facilities must be available, accessible, acceptable and of good quality’.¹³

Even though fulfilling these rights is clearly challenging for many countries, recent decades have seen increased public and academic discussion of rights to both health¹⁴ and health care.¹⁵ This seems to indicate a growing willingness to make rights-based progress in these areas. Such moves are, however, likely to be counter-balanced by an awareness that human rights approaches to certain issues have significant limitations that need to be borne in mind.¹⁶ More specifically, protecting human rights can be expensive (especially in courts of law), can result in paradoxical unfairness (owing to differential difficulties accessing the legal system), can diminish efficiency and increase opportunity costs (as scarce resources are diverted from care provision), can lead to conflict between competing rights (such as the right to liberty and the right to treatment, in certain cases of severe mental illness) and can prioritise individual rights over the perspectives of families and communities in ways that are not always accepted in certain societies.

Notwithstanding these issues, which apply to all rights and not just health-related rights, the WHO strongly re-emphasised ‘the vital role of law’ in ‘advancing the right to health’ in 2017.¹⁷ Clearly, the right to health is an evolving, important and remarkably enduring concept with considerable support among key actors, including the UN and WHO, and is therefore a

¹⁰ Ibid.

¹¹ United Nations Office of the High Commissioner for Human Rights and World Health Organization, *The Right To Health: Fact Sheet No. 31* (Geneva: United Nations High Commissioner for Human Rights, 2008): 1.

¹² Ibid., 3–4.

¹³ Ibid., p. 4.

¹⁴ John Tobin, *The Right to Health in International Law* (Oxford: Oxford University Press, 2012); Jonathan Wolff, *The Human Right to Health* (New York and London: W.W. Norton and Company, 2012).

¹⁵ Atul Gawande, “Is Health Care A Right?” *New Yorker*, 2 October 2017.

¹⁶ Wiktor Osiatyński, *Human Rights and Their Limits* (Cambridge: Cambridge University Press, 2009).

¹⁷ World Health Organization, *Advancing the Right to Health: The Vital Role of Law* (Geneva: World Health Organization, 2017).

useful tool for patients, families and health-care workers who advocate for reform of health systems. The WHO has placed particular emphasis on the role of law in this process, so the next part of this piece will present one example of the progressive use of law to articulate and—hopefully—realise a right to health care, in the specific context of mental health care, in the world’s second most populous country, India.

India’s Mental Healthcare Act, 2017

Insofar as they have been articulated to date, rights to health and apply to mental health in the precisely same way as they do to physical health. The UN made this explicit in 1991 with its *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.¹⁸ These principles state, *inter alia*, that:

- All people are entitled to receive the best mental health care available and to be treated with humanity and respect;
- There shall be no discrimination on the grounds of mental illness; all people with mental illnesses have the same rights to medical and social care as other ill people;
- All people with mental illnesses have the right to live, work and receive treatment in the community, as far as possible;
- Mental health care shall be based on internationally accepted ethical standards, and not on political, religious or cultural factors;
- The treatment plan shall be reviewed regularly with the patient;
- Medication shall meet the health needs of the patient and shall not be administered for the convenience of others or as a punishment;
- Physical restraint or involuntary seclusion shall be used only in accordance with official guidelines;
- Mental health facilities shall be appropriately structured and resourced;
- An impartial review body shall, in consultation with mental health practitioners, review the cases of involuntary patients.

In 2001, the WHO devoted its *World Health Report* to the theme of *Mental Health: New Understanding, New Hope*, emphasising the importance of realising these rights in practice.¹⁹ Recommendations from that report included providing treatment for mental illness in primary care, when possible; increasing availability of psychotropic medication; providing mental health care in the community, where possible; educating the public; involving communities, service-users and families in delivery of care; establishing national policies, programmes and legislation in mental health; developing human resources and links with other sectors; monitoring mental health in the community; and supporting research.

Consistent with this, the 2006 UN Convention on the Rights of Persons with Disabilities (CRPD) articulated a broad range of rights for people with disabilities, aiming ‘to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’.²⁰ The

¹⁸ United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations, Secretariat Centre For Human Rights, 1991).

¹⁹ World Health Organization, *Mental Health: New Understanding, New Hope* (Geneva: World Health Organization, 2001).

²⁰ United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations, 2006): Article 1.

Convention specifies that ‘persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.

Against the background of these right-based developments in mental health, India commenced a major new piece of legislation, the Mental Healthcare Act, 2017, on 29 May 2018. Compared to the preceding legislation, the new Act introduces a new definition of ‘mental illness’, an updated consideration of ‘capacity’ in relation to mental health care, new ‘advance directives’ to permit people with mental illness to direct future care, new ‘nominated representatives’ (who need not be family members), various governmental authorities to oversee services, mental health review boards to review admissions and other matters, revised procedures for admission and treatment with and without patient consent, and *de facto* decriminalisation of suicide.

Overall, the Indian legislation is unique in a number of important respects that hold great significance not only for India but also for other countries that seek to align their national mental health laws with the CRPD and other UN and WHO statements of recent decades.

One of the key reasons for this significance is that India’s 2017 Act is the first piece of mental health legislation in the world to seek explicitly to give effect to the CRPD. More specifically, the Act’s Preamble states that ‘it is necessary to align and harmonise the existing laws’ with the CRPD, which India ratified on 1 October 2007.²¹ As a result of this commitment, the new Indian legislation places strong emphasis on human rights and reflects many of the key concerns and priorities of the CRPD. This aspect of the new legislation marks out India as the country that has made the most ambitious effort to date to implement the CRPD in the field of mental health.

Perhaps most importantly, however, India’s 2017 Act grants a legally binding right to mental health care to its entire population of over 1.3 billion people, one sixth of the planet’s population. More specifically, the legislation states that ‘every person shall have a right to access mental health care and treatment from mental health services run or funded by the appropriate Government’.²² There is to be no discrimination of any description in the realisation of this right:

The right to access mental healthcare and treatment shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers.²³

To achieve this rather ambitious goal, ‘the appropriate Government shall make sufficient provision as may be necessary, for a range of services required by persons with mental illness’.²⁴ These services ‘shall include’:

- (a) Provision of acute mental healthcare services such as outpatient and inpatient services;
- (b) Provision of half-way homes, sheltered accommodation, supported accommodation as may be prescribed;
- (c) Provision for mental health services to support family of person with mental illness or home based rehabilitation;

²¹ Mental Healthcare Act, 2017: Preamble.

²² *Ibid.*, Section 18(1).

²³ *Ibid.*, Section 18(2).

²⁴ *Ibid.*, Section 18(3).

- (d) Hospital and community based rehabilitation establishments and services as may be prescribed;
- (e) Provision for child mental health services and old age mental health services.²⁵

This is a very extensive and detailed articulation of a right to mental health care. As a result of this and its various other provisions, India's Mental Healthcare Act, 2017 addresses some 55.4 percent of the 175 relevant human rights standards outlined by the WHO in its 2005 *Checklist on Mental Health Legislation*.²⁶ When other relevant Indian legislation is taken into account, 68 percent of the WHO human rights standards are now addressed in Indian law, and this figure compares very favourably internationally. Significant areas of low concordance in India (as in many other countries) include the rights of families and carers, competence and guardianship, non-protesting patients and involuntary treatment in the community.

Overall, while India's 2017 Act contains many important, progressive and challenging provisions, the most significant and dramatic provision is this 'right to access mental healthcare and treatment'. It clearly represents the logical continuation of arguments and positions articulated by the UN and WHO over past decades and, more recently, in the CRPD. As a result, India's new mental health legislation is both timely and ground-breaking, and its implementation over the coming years will provide much-needed information about human rights in practice in the field of mental health care.

Conclusions

The last five decades of the 1900s saw increased focus on the idea of rights to health and health care. While there was—and still is—significant debate about the relative advantages and disadvantages of legalistic and human rights-based approaches to these issues, the first two decades of the 2000s saw these ideas gather momentum, underscored by the CRPD (2006) and the emphasis that the WHO firmly placed on 'the vital role of law' in 'advancing the right to health' as recently as 2017.²⁷

Against this background, India's Mental Healthcare Act, 2017 is an exceptionally important and ambitious initiative, placing human rights at the very centre of mental health care in the world's largest democracy. Notwithstanding its enormous ambition and great potential, however, important questions clearly remain about the 2017 Act. Mental health services in India are currently substantially under-resourced, with less than 1 percent of the national health-care budget allocated to mental health, compared to 13 percent of the NHS budget in England.²⁸ This makes access to mental health care a key issue in any attempt to improve the human rights of the mentally ill in India.

It remains unclear, however, if rights-based legislation is the only or even the best way to achieve this. More specifically, it has yet to be established if the merits of a highly legalised, human rights-based approach to mental health care in India will outweigh the demerits of such a strategy. While the potential merits of the approach are clear (better care, better protection of

²⁵ *Ibid.*, Section 18(4).

²⁶ World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005); Richard M. Duffy and Brendan D. Kelly, "Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation," *International Journal of Mental Health Systems* 11 (2017): 48.

²⁷ World Health Organization, *Advancing the Right to Health*.

²⁸ Vikram Patel et al., "The magnitude of and health system responses to the mental health treatment gap in adults in India and China," *Lancet* 388, no. 10063 (December 2016): 3074–84; Richard M. Duffy and Brendan D. Kelly, "India's Mental Healthcare Act, 2017: Content, Context, Controversy," *International Journal of Law and Psychiatry* 62 (2019): 169–78.

rights, etc.), the potential demerits might well include additional costs if rights are not realised (especially legal costs); possible delays, complexities and unfairness in accessing courts in order to pursue apparent violations of rights; opportunity costs for other services during implementation of the new legislation; balancing competing rights (e.g. the right to liberty and the right to treatment for some people with severe mental illness); and the Act's strong emphasis on the rights of individuals rather than families or communities, which might not fit with the values or practices of certain parts of Indian society.

What is clear, however, is that India has now embarked on the world's largest experiment in rights-based mental health care. There will be many lessons to learn from this experience over the coming years. This information will help inform future debates about the usefulness of rights to health and health care in improving the experiences of the physically and mentally ill around the world, especially among vulnerable groups such as older adults,²⁹ children³⁰ and the homeless.³¹

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²⁹Palanimuthu Thangaraju Sivakumar et al., "Implications of Mental Healthcare Act 2017 for geriatric mental health care delivery: A critical appraisal," *Indian Journal of Psychiatry* 61, suppl. 4 (April 2019): S763–7.

³⁰Eesha Sharma and John Vijay Sagar Kommu, "Mental Healthcare Act 2017, India: Child and adolescent perspectives," *Indian Journal of Psychiatry* no. 61, suppl. 4. (April 2019): S756–62.

³¹Gopalrao Swaminath, et al., "Mental Healthcare Act, 2017 and homeless persons with mental illness in India," *Indian Journal of Psychiatry* no. 61, suppl. 4. (April 2019): S768–72.

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