

Mental health, human rights, and legal capacity

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In September, 2021, our edited volume *Mental Health, Human Rights and Legal Capacity* was published.¹ The book takes an interdisciplinary approach to engage with evolving debates related to legal capacity in the field of mental health care, documenting perspectives from legal scholars, practitioners, policy makers, advocates, and people with lived experience of mental health conditions from diverse regions worldwide. The volume is intended to stimulate a conversation. Its objective is to document good practices while also recognising that there remain considerable barriers to the implementation of non-coercive models of mental health support, as required by the 2006 UN Convention on the Rights of Persons with Disabilities (CRPD). Ultimately, our aim is to illustrate that ending coercion in mental health care is both necessary and possible, and that supported decision making in community-based mental health settings is the way of the future.

The CRPD is playing a substantial role globally in mental health policy making and clinical practice. Article 12, along with its interpretive General Comment 1,^{2,3} enshrine a right to equal recognition before the law for all people, including those with mental health conditions (“psychosocial disabilities” in CRPD language). General Comment 1, in fact, declares that this right amounts to universal legal capacity, and mandates the immediate development of supported decision-making regimes to eliminate substituted decision making and coercion in mental health care.

These provisions have sparked debate and resulted in contention, but they have also spurred mobilisation among activists, policy makers, and the clinical community. A good example of the latter is the 2020 position statement by the World Psychiatric Association calling for widespread implementation of non-coercive mental health care supports.⁴ Similarly, law reform and research in the field of supported decision making have continued apace in varied contexts, with considerable progress having been made in areas such as legislative change and crisis support.⁵ Examples such as the alteration of the civil code in Peru¹ and the development of the Circle of Care model in India¹ also illustrate that this is not a phenomenon seen only in high-income regions, but rather that there is a readiness worldwide to legislate and implement models of mental health care that privilege a person's autonomy and their own decisions regarding treatment and support.

The issue of legal capacity is cross-cutting, affecting law, policy, clinical practice, and advocacy. It, therefore, requires an interdisciplinary approach to inquiry. Perspectives from a

diverse range of stakeholders are needed to realise the fundamental change that the CRPD signifies. Despite service users being the primary stakeholders in progress, research and practice have been slow to recognise such individuals as invaluable partners in service reform. Similarly, Article 12 and General Comment 1 are global in nature, and yet research related to their implementation has concentrated on high-income regions.⁶ More research is required on reforms, innovations, and best practices in areas such as supported decision making and crisis support emerging from low-income and middle-income regions.

Obstacles to ending coercion abound, ranging from stigma and discrimination, to lack of evidence-based research and, most important of all, the scarcity of adequate resourcing for rights-based approaches to mental health services. Some in the clinical community remain doubtful about the practicality of the CRPD's provisions, and have raised legitimate concerns about their implications in situations of acute risk, about issues of liability, and about the way in which universal legal capacity might impede their own duty of care.⁷ These are not insignificant considerations, nor should they be dismissed; rather, they are opportunities for dialogue. Continued research endeavours related to legal and policy reform and to effective supported decision-making models, are needed. In particular, investigation into the navigation of so-called hard cases—where supported decision making is a challenge to implement because of case specificities (eg, acute floridity or impairments of cognitive capabilities)—is required to implement the best interpretation of the will and preference standard that is required by the General Comment, thus replacing the best interests standard currently used to justify substituted decision making.⁸ Future work in this area ought to be driven by continued engagement with scholars, practitioners, advocates, and people with lived experience of mental health problems, representing perspectives from diverse geographies and cultures.

Ending coercion in mental health care is an ambitious agenda, but it is an achievable one. This is an opportune moment, exemplified by the fact that the recent Global Ministerial Mental Health Summit was centred on human rights.⁹ In the current global mental health landscape, where progress is being made to end the neglect of mental health as a public health and social policy priority, non-coercive models can be integrated from the outset rather than repeating older and more problematic systems of coercion, guardianship, substituted decision making, and forced institutionalisation. We believe these are crucial goals to address the stigma attached to all aspects of mental health care. There is ample potential to reimagine how mental health care is practised, and we hope to continue to contribute to these changes.

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