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The World Psychiatric Association’s “Bill of Rights”: A curious contribution to human rights

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ABSTRACT



In 2016 the World Psychiatric Association (WPA) published a “Bill of Rights.” This article considers and analyzes what is at stake in a global professional clinical organization developing such a document that purports to support its efforts to tackle the social injustices experienced by people with mental health issues globally. It critically examines the text of the Bill and suggests that, while the document promises serious engagement with human rights (as distinct from ethics), it fails to meet existing international human rights standards. For the WPA to be a present and engaged partner in the implementation of international human rights standards it should not merely encourage governments to take action, but start with inward-facing tasks. These include establishing minimum human rights-based criteria for its own members and holding them to account, so as to nudge psychiatrists towards a human rights-based approach that would benefit people with mental health issues around the world.

KEYWORDS

Ethics; human rights; international law; mental health; social justice; World Psychiatric Association

Social justice for people with mental health issues

There is a long history of struggle by those who have received psychiatric diagnoses both to render visible and to combat the profound discrimination and inequality they experience [1]. Such discrimination is now more widely acknowledged across multiple domains—including psychiatry and other clinical specialities. This is evidenced by the 2016 special edition of the *International Review of Psychiatry* on “Social Justice for People with Mental Illness” [2]. The edition points out how discrimination against people with mental health issues, “is widespread and much more common in low income countries,” and calls for steps to be taken to roll out treatments to people who currently have no access. The articles in the special issue highlight that laws around the world prevent people with mental health issues from exercising human rights, such as the right to work [3] and the right to vote [4]. Dinesh Bhugra, the President of the World Psychiatric Association (WPA) notes that

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these “discriminatory laws may well reflect underlying stigma against individuals with mental illness at a number of levels” [5]. He urges, “national associations to explore psychiatry’s contract with representative policy-makers, stakeholders, patients, their carers and families, and their groups.” We welcome this commitment of the WPA’s leadership to highlighting social injustices faced by people with mental health issues.

The special edition also contains a “Bill of Rights for Individuals with Mental Illness” [6], authored by Bhugra, who, the article emphasizes, “alone is responsible for the content and writing of the paper”. To date, the Bill has been endorsed by the Asian and Latin American federations of psychiatric associations, psychiatric associations in Armenia and the Emirates, the Royal Australian and New Zealand College of Psychiatrists, and several British mental health NGOs such as Mind and SANE.¹ In this article, we consider and analyze what is at stake for a global professional clinical organization to publish such a document intended to support its efforts to tackle the social injustices experienced by its beneficiaries.

The World Psychiatric Association’s engagements with ethics and human rights

The WPA has, historically, been at some distance from human rights discourse. It has tended, rather, to approach normative questions and problems affecting psychiatry through the lens of ethics. The 1977 Declaration of Hawaii [7], which was the first WPA position statement regarding such issues, “laid down ... *ethical guidelines* for psychiatrists all over the world” [italics added]. Clarence Blomquist—who drafted the text, and who was trained in both psychiatry and practical philosophy—noted “the sometimes diverse approaches to medical ethics and the physician/patient relationship in Europe and the U.S.,” and explained that he tried, when drafting, “to gain more concern for the patients’ autonomy and right to participate in decisions about their own lives and health but to avoid a rigid legalistic system and to give place for man’s legitimate need for trust, confidence and care” [8]. Over a decade later, in 1989, the WPA published a “Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill” which, at times, mobilized a language of rights [9]. It was at least in part a response to what had been perceived by the WPA as an “anti-psychiatric” tone [10] within the preamble and articles that had been proposed in the Daes report [11], published in 1986, which was the first of two reports resulting from the United Nations (U.N.) Commission for Human Rights appointing two Special Rapporteurs to investigate and report on the lamentable conditions in institutions for people with mental health issues and intellectual disabilities.

The 1989 document described itself as a “condensed catalogue of the WPA’s Executive Committee and Ethics Committee statements and

viewpoints that *largely reflect* the body of general guidelines on the rights of mental patients” [italics added] [9]. The deployment of “largely” makes clear that the Statement and Viewpoints departed in certain respects from other contemporaneous documents specifying the rights of people with mental health issues. The Madrid Declaration on Ethical Standards for Psychiatric Practice (first approved in 1996, and with most recent amendments made in September 2011 in Buenos Aires) maintained the focus on and language of ethics [12]. It alluded to law only at a few key moments, for example in specifying that, “[w]hen the patient is gravely disabled, incapacitated and/or incompetent to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient.” This statement departs from human rights guarantees that had been in place for five years by the time the Buenos Aires amendments were made: the 2006 U.N. Convention on the Rights of Persons with Disabilities (CRPD) states that all people with mental health issues (and other disabilities) have the right to legal capacity, meaning that everyone has equal rights irrespective of a psychiatrist’s opinion of the appropriateness of the person’s preferences or of the nature or degree of the person’s mental health issue.

In its Bill, the WPA promises serious engagement with human rights, as distinct from ethics. This is to be welcomed, as the implementation of international norms takes place at the grassroots—in communities, schools, hospitals, and so on—and does not stop with standard setting. Indeed, the work of implementation is even more complex, as standards require enforcement mechanisms that hold people and organizations to account for alleged violations through formal legal processes.

In tracking the linguistic and potentially substantive movement on the part of the WPA towards rights, we should first of all recall that the relationship between (bio)ethics and human rights is both complex and vexed. Of the many differences between the two that Richard Ashcroft, an expert in both domains, has identified and analyzed [13], one is particularly apposite to our discussion here. From the perspective of human rights advocates, it might be expressed as what Ashcroft calls the “political quietism of bioethics.” From the side of (bio)ethics, it would be the opposite: in other words, for “the professions, for governments, and for certain kinds of institutions (hospitals, research institutes, universities, some industrial concerns),” bioethics might rather “represent a more attractive vehicle for consultation and dispute resolution than would a human rights-oriented institution, precisely because of the lower ideological temperature of bioethics relative to human rights and the lesser likelihood that it can be taken up by a possibly rather protean social movement.”

The history of the WPA standards and declarations bears this out. A framework of ethics, as first formalized in Blomquist’s drafting of the Hawaii

Declaration, arose in the midst of fraught and politicized struggles over the abuse of psychiatry in the Soviet Union. It is generally accepted by the psychiatric community that at that time, a “code of ethics was the only means to reconcile the various member countries on issues of misuse of psychiatry” [14].

What is the situation, though, today? Does the Bill of Rights signal a substantial engagement by the WPA with human rights, or is its invocation of the language of rights belied by its cleaving to longer-held commitments and positions that it has developed through the prism of psychiatric ethics?

The purpose of and the audience for the “Bill of Rights”

Our contention is twofold. First, the Bill only partially commits to existing international human rights standards, and second, it is unlikely to have much traction because it contains no accountability and monitoring mechanism.

First then, the Bill invokes international human rights law: its second paragraph expresses support for the “efforts of the international community as expressed through various international human rights Covenants and Conventions, and, more particularly, the 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD).” However, it excises many rights that are more challenging to psychiatry. It does so in the face of a range of publications (by lawyers, clinicians, social scientists, philosophers, mental health service users, and diverse advocacy groups) that interrogate the relationship between international human rights law and psychiatric practice and that offer potential ways forward in relation to the new legal and ethical landscape opened by the CRPD [15–27]. Through these excisions, the Bill seeks to maintain an aspiration for a “lower ideological temperature” that is less likely to inflame some of its national associations. Perhaps individual psychiatrist members of those national associations are more likely to be nudged into human-rights-compliant practice by the carrot of ethics than the stick of the law. The excision can be read as deeply ideological within the wider, heterogeneous mental health landscape, wherein it is hard not to interpret the invisibility of certain issues that are particularly contentious flash-points in mental health—as we discuss below—as in some way a motivated decision.

Our second contention is that the Bill is unlikely to change practice on the ground because it fails to establish monitoring mechanisms or accountability procedures. The Bill references the CRPD, an international treaty that contains provisions obliging governments to implement a range of human rights (Articles 10–30). The CRPD does not stop at setting standards, but rather it enjoins States to establish structures that make it more likely that the Convention will be implemented. These include a governmental focal point to carry out joined-up policymaking (Article 33(1)), an independent mechanism to monitor progress in implementing the Convention (Article 33(2)), and a duty to involve people with disabilities (including those with mental health issues

and their representative organizations) in this pursuit (Article 33(3)). It also contains duties on governments to fund research and development in universal design and new technologies (Article 4(1)(f) and (g)), to provide rights-based training to professionals involved in providing services to people with disabilities (Article 4(1)(i)), and to carry out comprehensive law reform and to mainstream disability (including mental health) across governmental policies and programs (Article 4(1)(c)). In this way, the CRPD lists not only normative aspirations but detailed programmatic tasks too. It establishes an international monitoring scheme whereby each State Party is assessed by a specific U.N. Committee on a regular basis (Articles 34–36), and the relationship between the Committee and governments is itself regulated (Article 37).

In contrast, the WPA's Bill of Rights is devoid of any monitoring or accountability mechanism, prompting questions about how the WPA can measure the commitment of its member associations and how the public can, in turn, hold the WPA to account. Omitting a feedback loop that could measure the Bill's impact on people with mental health issues on the ground is a missed opportunity.

The audience of the Bill is difficult to ascertain. It calls on *governments* to take action, but governments are under an obligation to implement international human rights treaties they have ratified, irrespective of pronouncements by nongovernmental organizations such as the WPA. If nudging governments were the Bill's only function, the WPA would have no need to issue such a document. The Bill seems to speak more to the WPA's members (regional, national, and subnational associations of psychiatrists), encouraging them to engage in law and policy reform. Given that governments are supposed to hold psychiatrists to account, the Bill is more a nod directly to psychiatrists. In this respect, the Bill follows clearly in the tradition of the WPA's standards and declarations, which largely interpellate psychiatrists as those responsible for upholding ethical practice.

The term "Bill of Rights" dates from a 1689 Act of the English Parliament. Today, it is generally understood to mean a document endorsed by a country's parliament, which enshrines rights and commits that country's government to take certain actions and to refrain from taking others. In the late 1970s, it was suggested that doctors should establish a Bill of Rights to regulate themselves so as to uphold their professional autonomy [28]. There are a few other examples of nongovernmental proclamations [29], but we found no examples of a global professional group unilaterally anointing rights upon their *beneficiaries* rather than collating rights for their members. Indeed, such Bills of Rights have, on occasion, received criticism precisely for wielding the language of rights. Not only has the (U.S.) Library Bill of Rights, for example, been described as "rife with examples of rhetoric unsupported by the legal principles that usually undergird 'rights'"; it has been heavily criticized for "the false representation that [it] serves as a legal guarantee or as an accurate reflection

of current legal doctrine”[30]. The WPA’s Bill of Rights—authored by one person granting rights that do not mirror international human rights law, to everyone with mental health issues in the world—could be criticized on similar grounds.

The document calls for “ALL governments” (emphasis in the original) to end discrimination on the basis of mental health status. Rights violations happen partly because of systemic inequalities and a lack of attention by governments, and so reiterating governmental obligations is simple enough. More difficult is changing practice, which the Bill steers away from attempting. Domains exercising public power—police, prisons, education, social work—have undergone reforms for a multitude of reasons. These include public commitments from people who lead those bodies, but norms are rarely sufficient to change behavior. To reduce torture around the world, for example, practice has been regulated by law, and professionals held to account by way of statutory requirements for taped police interviews, access to advocates, and monitoring of police stations [31].

Missed opportunities

Progressive global leadership of psychiatry is central to the larger imperative of protecting the rights of people with mental health issues, but the Bill of Rights is a missed opportunity for the WPA to be a galvanizing agent of change. The Bill could, for example, have set out a commitment for every psychiatrist to undergo human rights training (implementing a key CRPD State obligation; see Article 4(1)(i)), which includes trainers with mental health issues (Article 4(3) of the CRPD). Most clubs have minimum entry criteria as well as accountability mechanisms to keep their membership in line. As a club of national psychiatric associations that vary widely in their commitment to human rights, the WPA could have used the Bill to establish basic minimum entry requirements that each association would need to meet before it is accepted, or demitted on transgression. For example, if the WPA’s position is that electroshock therapy given in its unmodified form (without anaesthesia or muscle relaxants) breaches minimum standards, it would eject its member the Indian Psychiatric Society for endorsing this practice [32].

The Bill suffers from substantive problems too, as it cherry-picks from well-established international human rights law. It supports living “independently in the community as other citizens,” but it appears to fall short of endorsing “full inclusion and participation in the community,” required by Article 19 of the CRPD, and which entails a more complex set of obligations including access to housing stock, accessible transport, inclusive education, and so on (this also applies equally to people who are not citizens of the jurisdiction in question). Another example is the right to health. Human rights law splits

economic, social, and cultural rights such as the right to health into four parts: accessibility, availability, acceptability, and quality—a formulation that the World Health Organization has used in operational guidance [33]. The Bill of Rights specifies that the right to health should be accessible and available, but is silent about whether healthcare should be acceptable or of satisfactory quality. Highlighting the omission of two words may seem pedantic, but the WPA has issued a text aligned to human rights law, a domain where words matter as they carry specific interpretive meaning. This particular omission gives the impression that the WPA is more concerned with the mass roll-out of treatments than the user experience.

Similarly, the document omits the word “torture” when setting out the right to be free from cruel, inhuman, and degrading treatment or punishment. It is uncontroversial to state that some psychiatric practice may be considered torture: unmodified electro-convulsive therapy is an example [34, 35]. Allowing readers of the Bill to infer that the WPA is ignoring well-established and deep-rooted problems in parts of psychiatry risks the organization being perceived as a bad-faith negotiator in a complex change process. Psychiatric leadership is urgently needed to end torture and other forms of ill-treatment carried out in the name of psychiatry, science, and treatment [36]. For a document called a “Bill of Rights” to omit this acknowledgement is not an encouraging starting point. Other rights are also missing. While the WPA is keen for people to be treated for mental health issues (this is—alongside access to physical healthcare—the top of the WPA’s list), the document says nothing about consent, one of the most important debates at the interface of psychiatry and rights (see Article 25(d) of the CRPD). Also absent is the right to rehabilitation, particularly important in underpinning the recovery of people who have spent time in psychiatric or social care institutions (see Article 26 of the CRPD).

Given the often coercive nature of psychiatry [37], mental health service users should have access to complaints systems and the courts to seek redress for alleged violations of their rights (see Article 13 of the CRPD), yet the Bill is silent on justice. This may mean that some readers of the Bill infer—rightly or wrongly—that psychiatrists have some investment in limiting victims from complaining and taking cases against them. Instead of appearing to fear such litigation, the WPA should welcome it for the potential to expose bad practice, maintain minimum standards, and arguably to strengthen trust with mental health service users.

The role of psychiatrists in implementing human rights

While the Bill contains some welcome elements, our analysis suggests that it remains largely an exhortatory document, which does not, despite its title, significantly depart from the WPA’s earlier sets of ethical standards and

declarations, and from those documents' address to clinical practitioners. It is difficult, too, not to be aware of the wider context in which this Bill of Rights was drafted. In the midst of often fractious public debate that is often ignorant about—if not hostile to—psychiatry *in toto*, it is perhaps unsurprising that psychiatry—not least in the form of the WPA—is keen to emphasize its professionalism and the effectiveness of its treatments and practices. While this might help explain certain absences in the Bill (references to torture or access to complaints systems, for example), it does not excuse those absences within a document that expressly locates itself within and endorses the international human rights project.

In conclusion, we are left troubled by the Bill because it ends up foreclosing any substantive engagement with the complex challenges—of coercion, institutionalization, consent, and ensuring full inclusion in the community—that face all those in the global mental health community. The CRPD has opened new norms, new possibilities, and new hopes for people with mental health issues, but hard thinking and hard work are needed for these to be realized, not least in relation to the clinical practice of psychiatry.

A contribution from psychiatry was largely missing during the negotiation of the CRPD, but in its implementation psychiatry must be, and must be seen to be, a present and engaged partner. Both analytical and material resources from all stakeholders who are committed to ensuring social justice for people with mental health issues are indispensable. We welcome the efforts of those psychiatrists and other mental health clinicians who—often in collaboration with legal and advocacy organizations—have contributed clinical, analytical, and policy-related acuity to making progress with these difficult question [27, 38]. We look forward to psychiatry offering a more audible voice in multidisciplinary discussions over human rights in the future.

For the WPA to play a useful part in this reform process, its first task should be to continue to reform itself—at the very least by establishing minimum membership criteria aligned to international human rights standards and a mechanism for holding its member associations to account. Unless such action is taken, this Bill will likely generate some limited academic interest (such as our own article) but is less likely to have an impact on improving the lives of people with mental health issues.

Search strategy and selection criteria

Each author identified relevant legal instruments, ethical standards and declarations, as well as academic publications on human rights, ethics, and discrimination in relation to mental health issues and disability. Their significance was agreed through consensus. The information presented from these materials and the arguments made in relation to them were agreed by both authors.

Note

1. Several endorsements are listed on the WPA's website: http://wpanet.org/WMMD16/BillofRights_Mentalillness_FINAL.pdf. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) endorsement is at <https://www.ranzcp.org/News-policy/News/New-Bill-of-Rights-to-safeguard-the-rights-of-peop.aspx>.

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