August 2022

Draft guidance on mental health, human rights, and legislation: **NSS input**

This response is made on behalf of the National Secular Society.

The NSS is a not-for-profit, non-governmental organisation founded in 1866, funded by its members and by donations. We advocate for separation of religion and state and promote secularism as the best means of creating a society in which people of all religions and none can live together fairly and cohesively. We seek a diverse society where all are free to practise their faith, change it, or to have no faith at all. We uphold the universality of individual human rights, which should never be overridden on the grounds of religion, tradition or culture.

More information about our organisation can be found here:
https://www.secularism.org.uk/about.html

We welcome the opportunity to submit an input on the draft joint WHO/OHCHR guidance on mental health, human rights and legislation. We campaign to protect patients from the harm caused by the imposition on them of other people's religious values. We advocate for a secular approach to current major health issues. We are opposed to religious influences in medicine where these adversely affect the manner in which medical practice is performed. We support patient autonomy and challenge pro-religious discrimination particularly in those areas of medicine where reasonable personal choice is threatened.

1.3 Mental health law and human rights, p.19

"An additional concern is the explicit use of a reductionist Western biomedical model in mental health law, which works to the detriment of other holistic and person-centered and rights-based approaches and strategies for understanding and addressing mental health experiences (61, 62). This includes different cultural conceptions of and approaches to mental health, such as those held by indigenous peoples and related understandings of well-being, healing and community, to the detriment of both the individual and the collective."

While cultural sensitivity and holistic, person-centred and rights-based approaches are welcome inclusions into mental health care, we caution that use of the phrase "reductionist Western biomedical model" may lead to policies which reject objective, scientific and evidence-based healthcare in lieu of 'alternative medicine' models that are not supported by evidence and may be based on religious views. Sometimes, 'alternative medicine' models are pushed by people with a specific religious or personal agenda who do not prioritise the healthcare needs of the patient.

In a worst case scenario, this could lead to poorer mental health outcomes for people in different communities if it is assumed that 'culture-specific' care is more appropriate to them. For example, treating indigenous peoples according to indigenous spiritual beliefs where there is no evidence as to their effectiveness, rather than conventional mental health treatment, could lead to worse mental health outcomes for people in these communities than in non-indigenous communities.

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The guidance should stress that, while cultural sensitivity is important, best practice mental health care should be objective and evidence-based.

1.5 Applying the human rights framework to legislation on mental health, p.27

"Promoting the provision of a range of community-based mental health services and support, including non-medical interventions"

We agree that community-based mental health services can play an essential role in supporting mental health. However, we caution against any policies that would encourage closer integration of faith-based community mental health services into general health and mental health policies and systems without firm safeguards in place.

Public services that are intended for the whole community, especially those funded by public money, should be provided in a secular context, open to all, without discriminating against anyone on grounds of personal characteristics including religion or belief, sex or sexual orientation.

Recent years have seen a drive to contract out the provision of public services in the UK. This has resulted in many more religious organisations seeking to become community service providers, including for mental health.

We have no doubt these services are provided out of kindness and benevolence, and that many religious organisations have given genuine help to people in distress. Some faith-based organisations operate by strict codes to ensure religious agendas do not encroach on the support given, because they acknowledge that mixing evangelism with victim support poses a very real risk of exploitation and harm[1].

But not all groups follow such ethical principles. For example, in 2018 we heard from a former 'patient' of a Christian 'rehab centre' who said the charity banned him from reading anything apart from religious texts, compelled him to take part in long and intensive prayer sessions, and expressed hostility towards homosexuality. We have also been told by several members of the public that the explicit Christian ethos of organisations such as Alcoholics Anonymous is alienating to those struggling with addiction who are not Christian.

Any strategies to increase and support provision on community-based mental health services should ensure those services are delivered in a manner that does not impose any religious beliefs on people.

2.4.4 Gender-responsive mental health care, p.72

"Laws should protect the rights of intersex children and ban unnecessary and irreversible medical or surgical treatment without their informed consent."

We agree with this guidance. However, it will not effectively protect children unless it encompasses all children of all sexes. This includes protecting the rights of male children by banning unnecessary and irreversible penile circumcision, including for religious reasons. The WHO and OHCHR already rightly acknowledge that there is no religious or cultural justification for any form of cutting on the genitals of girls (FGM) – the same principles should also be applied to male genital cutting.

The foreskin is a normal body part with physical, sexual and immunological functions. Surgically removing it from non-consenting children has been associated with various physical and psychological difficulties; these are likely to be greatly under-reported because people who have

[1] For examples, see: https://www.secularism.org.uk/opinion/2020/02/faith-groups-should-practice-without-preaching-when-helping-the-vulnerable

experienced sexual harm are often reluctant to reveal it as societal dismissal or stigmatisation may compound the harm.

Throughout history, male circumcision has been advocated as a pseudo-medical cure for a variety of ailments ranging from TB to epilepsy to warts to excessive masturbation. However, any marginal health claims are extremely contested. No national medical, paediatric, surgical or urological society in the world of which the NSS is aware recommends routine circumcision of all boys as a health intervention. There is now a growing medical consensus that existing ethical principles of non-therapeutic childhood surgery should no longer include an exception for non-therapeutic excision of the foreskin[2].

Members of the UK public have bravely come forward to the NSS with their testimonies that non-consensual infant male circumcision has been detrimental to their mental and physical health wellbeing. We can supply these testimonies on request.

We urge the WHO and OHCHR to extend their policies of protecting girls and intersex children from non-consensual, non-therapeutic genital cutting to boys.

2.4.6. Culturally-appropriate mental health care: Box 39. What the law can say, p.74

"Mental health services shall provide care and support that is appropriate to, and consistent with, people's cultural and spiritual beliefs and practices."

While sensitivity to people's cultural and spiritual beliefs is important in all health care, we are concerned this guidance could lead to problems where a person's spiritual beliefs or religious affiliation conflict with established best practice in mental health care. This is especially important where children are concerned, who may find their parents' religious beliefs imposed on them to the detriment of their mental health.

It is true that for many people, religion is an important source of wellbeing. However, it is also true that for many others, religion has caused serious harm to both their mental and physical health. It is extremely important that potential religious harms to mental wellbeing are identified and addressed without fear of accusations of 'religion-phobia' or 'religious illiteracy'.

The issue of mental wellbeing is particularly serious in high-control, insular religions. Common features of such religions include restricting information that members are permitted to access, discouraging interaction and relationships with people outside the religion, and coercive requirements to attend regular worship sessions.

In high-control, insular religious communities, leaders may forbid members from viewing any material that has not been approved by themselves. Schools run by such communities, such as *yeshivas* in Charedi Jewish communities, often teach a limited curriculum that omits knowledge necessary to prepare children for life in 21st century society.

A narrow education, coupled with limited access to information beyond the community, can have serious consequences for individuals growing up in these communities. A recent report from UK Jewish counter-extremism group Nahamu highlighted how a lack of secular education means Charedi Jews are at risk of forced marriage and abuse within marriage[3].

[2] For more information, please see the recent NGO core report to the United Nations Committee on the Rights of the Child from the International NGO Council On Genital Autonomy: http://ingocga.org/wp-content/uploads/2022/04/INGOCGA-Core-Report.pdf
[3] http://nahamu.org/wp-content/uploads/2021/02/Position-Paper-on-FM-Nahamu-Feb-2021.pdf

Those who wish to leave high-control religious communities as adults frequently lack the knowledge, skills and social networks to survive life 'outside' and cannot function without a high level of support from specialist charities. This frequently includes counselling for the traumas endured both within the community itself, and the high level of adjustment needed to leave.

Insular, high-control religions use threats of punishment to control members' thoughts and behaviours. One common method is 'shunning', in which a member who has 'transgressed' is forced to leave the community and friends and family are forbidden from contacting them. Due to these communities' insular natures, many members have few or no family or friends outside the community, meaning this punishment is extremely traumatic and life-changing. In March last year the Belgian chapter of the Jehovah's Witnesses was fined €96,000 for breaking human rights laws over its use of shunning, which has left former members suicidal[4]. Other religious communities that practise shunning include the Plymouth Brethren Christian Church and Charedi Jewish communities.

It is also common for religious communities to use threats of divine punishment to instil obedience. This may be particularly effective on children, who tend to have more vivid imaginations, have more difficulty discerning fact from belief and are more likely to accept statements from authority figures as fact.

In extreme cases religions may use threats of violence to discourage people from transgressing or leaving the religion. The NSS has found examples of Islamic registered charities promoting or signposting teachings that individuals who leave Islam or do not demonstrate sufficient religiosity should be put to death[5].

In some cases, religious indoctrination may play a role in grooming individuals to join extremist causes, including violent extremism and terrorism. Frequently, those with compromised mental health, such as those experiencing social isolation, are particularly vulnerable to extremist indoctrination.

Beliefs in demonic possession, witchcraft and other supernatural 'ailments' are a component of some religious traditions that are on the rise in the UK. These beliefs can sometimes result in abusive practices, particularly towards children. They may sometimes result from ignorance about mental health issues.

For these reasons, the guidance should stress that religious practices or beliefs that demonstrably harm mental health should be challenged, rather than affirmed, by mental health workers.

We are also concerned the words "spiritual beliefs" may potentially exclude people who do not have religious beliefs, as a nonreligious philosophical outlook is often not considered "spiritual". This could mean the guidance creates an asymmetric duty of care in favour of religious over non-religious people, i.e. the needs of religious people will be accommodated in their mental health care, but not those of nonreligious people.

There are some settings in the UK where religious pastoral support, i.e. 'chaplaincy', is one of the only forms of mental health support available. Such support is invariably Christian in nature and is therefore unsuitable for people who don't belong to any religion, or to minority religions. This issue is particularly acute in the armed forces and prisons, where chaplaincy is the main source of pastoral care and is almost exclusively Christian. Research published this year concluded that the lack of

[4] https://www.thebulletin.be/court-hits-jehovahs-witnesses-eu96000-fine-discrimination
[5] https://www.secularism.org.uk/news/2019/06/islamic-charities-push-death-for-apostates-and-female-subjugation

equivalent chaplaincy services for nonreligious people in prisons may amount to unlawful discrimination on the basis of religion or belief[6].

We therefore encourage WHO and OHCHR to consider making this guidance more explicitly inclusive of the needs of nonreligious people.

Finally, we are concerned chaplaincy systems in hospitals in the UK and around the world open the doors for religious ministers with more extreme views who may prioritise religious agendas over the best needs of the patient. For example, the so-called 'hospital liaison committees' (HLCs) sent by the Jehovah's Witnesses to 'counsel' Jehovah's Witness patients are often present to ensure the patient does not defy the religion's teachings on accepting blood products through the threat of shunning. This includes cases where refusal of blood is likely to result in death[7]. Any attempts to incorporate religious ministry into mental health or pastoral services must ensure patients are protected from harmful forms of ministry.

"Indigenous peoples and other relevant communities, as appropriate, shall be engaged and consulted in the design and implementation of mental health services."

While engaging with a wide range of community perspectives can be positive in designing and implementing mental health services, we advise caution when engaging with these communities via 'community leaders'. These 'leaders', often self-appointed, frequently have very different views from the people they claim to represent on a wide range of issues, and may be motivated to maintain the status quo, often by promoting conservative religious values. Additionally, community leaders tend not to represent marginalised voices within their own community – for example, women and LGBT+ members.

Community engagement should therefore seek the views of a wide range of members of the community, including those who are marginalised and those who dissent from the views of 'community leaders'.

[6] https://www.secularism.org.uk/news/2022/05/discriminatory-prison-chaplaincy-may-be-unlawful-paper-warns
[7] https://www.secularism.org.uk/news/2020/09/rethink-relations-with-jehovahs-witnesses-committees-nss-urges-nhs